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**Background.** Data increasingly support the immunologic and public health advantages for a shortened time interval from HIV diagnosis, initiation of antiretroviral therapy (ART), and subsequent virologic suppression. Much of the current research on rapid or same-day ART has been performed in large urban centers with the infrastructure and support needed for these programs. This study assessed the time from HIV diagnosis to linkage to care (LTC), initiation of ART, and time to virologic suppression (TVS) in newly diagnosed, ART-naïve subjects at a Midwestern academic institution after structured programmatic changes to reduce TVS.

**Methods.** IRB-approved, single-center, retrospective cohort including all newly diagnosed, antiretroviral-naïve adult patients seen in the Ryan White Clinic (RWC) at the University of Toledo Medical Center with an on-site 340B pharmacy for their initial visit between January 1, 2015 and December 31, 2017 (control) and January 1, 2017 and December 31, 2017 (intervention)—see Table 1. Diagnosis of HIV and ART initiation took place in separate facilities and were the responsibility of independent entities. Exclusion criteria were previously receiving HIV care, ART-experienced, pregnant, or an active opportunistic infection. The primary outcome of time from HIV diagnosis to virologic suppression (VL < 200 copies/mL) was compared between groups. Secondary outcomes include time from diagnosis to LTC (initial clinic appointment) and time to initiation of ART.

**Results.** 72 patients were screened and 60 met inclusion criteria; 24 in the 2015 group and 36 in the 2017 group; 88% were male, 48% white. Median (IQR) time from diagnosis to viral suppression was 137 days (77–318) in 2015 vs. 78 (52–152) days in 2017 (P = 0.028). Time from diagnosis to first clinic visit remained similar (13.5 days vs. 15.5 days, P = 0.791), while time from first clinic visit to initiation of ART decreased significantly (15 vs. 0 days, P < 0.001). Additional outcomes are provided in Tables 2 and 3.

**Conclusion.** Tim from first clinic visit to ART initiation was significantly shortened in this intervention and was the driving force to decreasing TVS. Additional research into barriers impacting time from diagnosis to LTC are needed to further shorten TVS.

| Table 1: Rapid start initiative |
|--------------------------------|
| 2015 | 2017 |
| Patient or HIV testing center calls for most available appointment | Patient or HIV testing center calls and Physician/Nurse Practitioner time slots available daily to accommodate new patient initial appointments and one week follow-up appointments |
| Diagnostic/baseline laboratory testing ordered prior to the initial visit | New patient laboratory testing order sets created to facilitate diagnostic work up and baseline assessment |
| Patient initiated on antiretroviral therapy (ART) at their next scheduled visit (usually 1-2 weeks after the initial visit) | Social workers and on-site pharmacist instructed on utilization of multiple resources to obtain same-day/next-day appointment ART |

| Table 2: Aggregated care cascade data from diagnosis to virologic suppression |
|--------------------------------|
| Primary Endpoints | 2015 n=152/24 | 2017 n=152/26 | P-value |
| Time of diagnosis to VL < 200 (D) | 137 (70–351) | 78 (52–152) | 0.028 |
| Time of diagnosis to VL < 40 (E) | 147 (95.5–145.5) | 127 (70–205) | 0.128 |
| Secondary Endpoints | 2015 n=24 | 2017 n=36 | P-value |
| No. of clinic visits at 24 weeks or less months | 3 (2–3.4–3.0) | 4 (3–3.4–3.0) | 0.900 |
| Time from diagnosis to clinic | 13.5 (7.2–23.1) | 11.8 (6.2–22.9) | 0.791 |
| Time from clinic to ART (D) | 14 (12–19.5–20.0) | 11 (10.5–14.5–20.0) | 0.001 |
| Time from clinic to ART (E) | 15 (10.5–20.0) | 10 (0–19.5–20.0) | 0.001 |

**Disclosures.** All authors: No reported disclosures.

1325. Inpatient Initiation of ART Improves Short-Term Mortality in People Living with HIV

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**Background.** Treatment of HIV is recommended as soon as possible and early initiation of combined antiretroviral therapy (cART) is associated with improved engagement in care; however, treatment with cART is often deferred in hospitalized patients despite being correlated with improved outcomes. We implemented an institutional intervention to ensure all people living with HIV (PLwH) were on cART during hospitalization to improve patient outcomes.

**Methods.** We prospectively identified all PLwH hospitalized at our institution and had ID physicians and pharmacists ensure they were on appropriate cART and linked to outpatient care. We retrospectively collected clinical and lab data to assess the impact of our intervention on inpatient mortality, 30-day mortality, 30-day readmission rate, and frequency of outpatient follow-up. Patients were excluded from analysis if they were admitted for hospice care.

**Results.** We identified 389 patient admissions in 275 unique patients, of which 304 admissions were already on cART at admission. After ID physician assessment, 37 of the 85 not on cART were initiated on therapy. We assessed the impact of this intervention on short-term outcomes as listed in Table 1. Despite the intervention group having similar immunologic and virologic baseline characteristics to those not initiated on cART, their inpatient and 30-day mortality was similar to those already on cART. Readmission rates also decreased in the intervention group. Thirteen of 24 patients in the intervention group who could be linked to outpatient care. We retrospectively collected clinical and lab data to assess the impact of our intervention on inpatient mortality, 30-day mortality, 30-day readmission rate, and frequency of outpatient follow-up.

**Conclusion.** Inpatient treatment with cART during hospitalization improves short-term mortality outcomes. This study also demonstrates the value of inpatient cART treatment as most patients achieved virologic suppression at subsequent outpatient follow-up.

| Table 1: Immunologic and virologic parameters by treatment group with hospital outcomes |
|--------------------------------|
| Primary outcomes | 2015 n=304 | 2017 n=350 |
| Mortality rate | 24% (n=74) | 19% (n=62) |
| Readmission rate | 19% (n=58) | 17% (n=61) |
| Virologic suppression (VL < 200 copies) | 60% (n=183) | 70% (n=245) |
| Inpatient mortality | 13% (n=41) | 17% (n=59) |
| 30-day mortality | 13% (n=39) | 17% (n=59) |
| 30-day readmission | 13% (n=39) | 17% (n=59) |

**Disclosures.** All authors: No reported disclosures.

1326. Comorbid Mental Health Disorders Are a Key But Manageable Barrier to Suppression of HIV Viral Load

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**Background.** Antiretroviral therapy (ART) and subsequent virologic suppression is associated with improved engagement in care; however, treatment with cART is often deferred in hospitalized patients despite being correlated with improved outcomes. We implemented an institutional intervention to ensure all people living with HIV (PLwH) were on cART during hospitalization to improve patient outcomes.

**Methods.** We prospectively identified all PLwH hospitalized at our institution and had ID physicians and pharmacists ensure they were on appropriate cART and linked to outpatient care. We retrospectively collected clinical and lab data to assess the impact of our intervention on inpatient mortality, 30-day mortality, 30-day readmission rate, and frequency of outpatient follow-up. Patients were excluded from analysis if they were admitted for hospice care.

**Results.** We identified 389 patient admissions in 275 unique patients, of which 304 admissions were already on cART at admission. After ID physician assessment, 37 of the 85 not on cART were initiated on therapy. We assessed the impact of this intervention on short-term outcomes as listed in Table 1. Despite the intervention group having similar immunologic and virologic baseline characteristics to those not initiated on cART, their inpatient and 30-day mortality was similar to those already on cART. Readmission rates also decreased in the intervention group. Thirteen of 24 patients in the intervention group who could be linked to outpatient care. We retrospectively collected clinical and lab data to assess the impact of our intervention on inpatient mortality, 30-day mortality, 30-day readmission rate, and frequency of outpatient follow-up.

**Conclusion.** Inpatient treatment with cART during hospitalization improves short-term mortality outcomes. This study also demonstrates the value of inpatient cART treatment as most patients achieved virologic suppression at subsequent outpatient follow-up.

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**Disclosures.** All authors: No reported disclosures.
Background. Kentucky sits at the epicenter of the HIV epidemic in the United States and harbors 54 of the top 220 HIV/HCV outbreak vulnerable counties in the United States; 44 of which are served by the Bluegrass Care Clinic at the University of Kentucky. Understanding the barriers to care at the frontlines of the epidemic is of critical importance in the work toward the eventual elimination of HIV in the United States and elsewhere.

Methods. The Bluegrass Care Clinic has achieved viral suppression in 90% of the HIV-positive patients enrolled in care. Given the catchment area served by this clinic, however, the un-suppressed 10% of patients likely represent the tip of an iceberg of undiagnosed patients or those lost to care from remote and at-risk communities. We developed a quality improvement project to specifically review the barriers to achieving viral suppression in this subset of patients in our clinic. Additionally, we developed an outreach algorithm for patients identified as having comorbid mental health issues to increase engagement in both HIV and mental healthcare.

Results. We found that nearly 45% of virally un-suppressed patients in our clinic had comorbid mental health disease and 30% had substance use disorders. Female sex was associated with being un-suppressed (P = 0.003); however, age and race were not predictive. Of the patients identified as having mental health barriers to care, 58% were able to be contacted using our outreach algorithm and 58% of these patients accepted referral into a mental health service. In this first 12 months of this program 26% of these patients achieved viral suppression and an additional 18% had substantial decreases in their viral loads.

Conclusion. This preliminary report highlights the importance of identifying and addressing barriers to care. Comorbid mental disorders have consistently been associated with greater difficulties in achieving viral suppression. We present an effective and successful program for engaging patients in mental healthcare using an interdisciplinary outreach program that is designed to be generalizable. These data set the stage for reaching the missing subset of patients who are not currently engaged in HIV care, a critical next step for universal test and treat and 90/90/90 strategies.

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1328. Post-War and Post-Ebola HIV Care Continuum in a Liberian Academic Center: Fresh Insights and Trends Over 5-Year Period

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Background. Two-thirds of people living with HIV (PLWH) reside in sub-Saharan Africa. The UNAIDS 90-90-90 target to end the HIV epidemic is an aspirational but achievable goal. The Continuum of Care model allows evaluating the progress toward this goal as well as identifying gaps in diagnosis, linkage to care, HIV treatment. In Liberia, the estimated number of PLWH is 40,000 with only 26,000 (65%) diagnosed, 14,000 (53%) on combination ART (cART), and of those, 53% virally suppressed. After a devastating war and Ebola epidemic, the country has only one academic medical center, John F. Kennedy (JFK) Hospital in Monrovia, with the largest HIV clinic caring for a cohort of 3,000 PLWH. This study was designed to evaluate the HIV care continuum at this center over a 5-year period.

Methods. Data from 2014 to 2018 were collected from a database at JFK hospital HIV clinic. Data were extracted for all patients tested for HIV. The proportion of those tested positive, who were linked to care, retained in care, and subsequently initiated on cART was analyzed. Only a sample of PLWH received HIV viral load monitoring test. Utilizing the HIV care continuum model, data on each step of the care cascade were reported as simple percentages or proportions.

Results. Over the 5-year study period, a total of 41,343 individuals were screened for HIV and 4,066 tested positive (10%), much higher than the national rate of 3–5%. Linkage to care was inconsistent; 87% (592/678) in 2014, 98% (622/636) in 2015, 61% (644/1057) in 2016, 73% (570/768) in 2017, and 64% (584/909) in 2018 were enrolled in the clinic. ART initiation improved over time; of the PLWH enrolled in the clinic, 75%, 64%, 76%, 86%, and 84% for the years 2014, 2015, 2016, 2017, and 2018, respectively, were initiated on cART, also higher than the national rate estimated at 53%. Only a sample of 100 patients had HIV VL performed and of those 53% had viral suppression. From the total clinic cohort of 5,280 PLWH, 19–28% of PLWH were lost to care with a 2–8% death rate annually.

Conclusion. Although the HIV Care Continuum rates at the largest academic center in Monrovia, Liberia were above national rates, they were suboptimal and fell below the 90-90-90 UNAIDS target. Current efforts are focused on understanding gaps in care and investigating opportunities to improve linkage to, and retention in care.

Disclosures. All authors: No reported disclosures.

1327. Correlates of Need for Ancillary Service Referrals Among Persons Receiving HIV Care in New York City: Findings from the Medical Monitoring Project

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Background. Retention of people with HIV (PWH) in HIV care is essential for optimal health outcomes. Unmet needs for ancillary services despite being actively engaged in HIV care is essential for optimal health outcomes. Unmet needs for ancillary services, such as housing, food, transportation, or mental health services may pose barriers to sustained retention in HIV care.

Results. A representative sample of people with HIV (PWH) aged ≥18 years and receiving HIV care in NYC between 2015 and 2016 was interviewed for the Medical Monitoring Project (MMP). Questions attempted to identify needs for ancillary services among participants. We explored correlates of expressed needs for ancillary services in the 12 months prior to the interview date.

Results. Of 654 PWH interviewed, 650 (99%) were current with HIV care. Of these, 323 (50%) expressed a need for ancillary services. Among the 323 PWH expressing needs, 209 (65%) were males, 163 (50%) were non-Hispanic blacks, 118 (37%) were Hispanic, and 111 (35%) were individuals identifying as gay (26%) or lesbian (9%). The median age was 50 (interquartile range (IQR) 40–58 years).

In the multivariate model, non-Hispanic blacks (OR: 2.5; 95% CI: 1.4, 4.6) and Hispanics (OR: 2.5; 95% CI: 1.4, 4.7) had higher odds than whites of expressing current needs for ancillary services. A higher need for ancillary services was expressed by PWH that were virally suppressed vs. not suppressed (OR: 1.7; 95% CI: 1.0, 3.0) and those with a history of injection drug use vs. those without (OR 2.2; 95% CI: 1.3, 3.7).

Conclusion. Half of the PWH in our sample expressed a current need for ancillary services despite being actively engaged in HIV. Providers should routinely screen their patients, especially non-Hispanic black and Hispanic patients and persons with substance use history, for unmet needs and proactively link them to social service providers in order to promote overall well-being and retention in HIV care.

Disclosures. All authors: No reported disclosures.

HIV Care Continuum at JFK, Liberia