1352. Improved HIV markers and decreased emergency room usage and hospital admission with initiation of a pilot specialty pharmacy at a southeastern Ryan clinic

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Background. Specialty pharmacy (SP) provides timely medication delivery to patients and seeks to improve patient adherence through monthly pharmacist medication therapy management (MTM). Patients living with HIV/AIDS have both high cost medications and complex disease states and thus will benefit from SP. We report on the outcome of HIV therapy after 3 years of a pilot SP ina southern inner city RW funded clinic.

Methods. This is a single center retrospective chart review of patients at our clinic who were enrolled in the SP from 6/3/13–5/13/16 for at least 6 months. Baseline demographic characteristics and HIV markers (CD4, viral load) were collected. Outcomes of interest were: change in CD4 count, percent with viral suppression (VS), emergency room (ER) and hospital admission usage, as well as percent of scheduled providers' appointment kept. Each individual had the same follow up time before and after SP initiation. Bivariate analysis compared outcomes preSP and during SP using Chi-square or Fisher exact tests for categorical and Wilcoxon rank-sum test for continuous variables.

Results. During the 3-year period, there were 212 individuals referred to SP, of which 170 participated in the program. There were 92(54%) men, 136(80%) black. The median age was 48.3 years (IQR: 28.5–56.3). The average duration of follow up pre and during SP were 22.1(IQR: 16.5–27) months. In terms of insurance, 69(40%) had Medicare, 22(13%) had Medicaid, 22(13%) had private insurance, 54(32%) received AIDS drug assistance program (ADAP), and 37(21%) had no insurance. Patients' median distance from the clinic was 17.4(IQR: 8.8–25) miles. The respective outcomes before and during SP were: CD4: 350(IQR: 181–551) vs. 413(IQR: 263–611 cells/mL (P < 0.0001), VS in 78 ± 30% vs. 91 ± 20% (P < 0.001). The proportion of patients with emergency room usage or hospital admissions was 68(40%) vs. 49(29%) (P = 0.036). There was no difference in the rate of kept providers' appointment (66.6% (IQR: 53.8–76.8%) vs. 63.8% (50–77%) (P = 0.19). There was no reported death during the follow up period.

Conclusion. This pilot SP program at the RW clinic showed statistically significant impact on CD4, VS, ER and hospital admission usage. Further studies are needed to determine whether SP is beneficial to people living with HIV/AIDS in other settings.

Disclosures. M. Patel, ViV: Scientific Consulting fee

1353. HIV Risk Assessment using Longitudinal Electronic Health Records

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Background. Universal HIV screening programs are costly, labor-intensive, and in practice unable to identify all individuals at risk of HIV infection. Automated risk assessment methods that leverage longitudinal electronic health records (EHRs) could improve predictive models of HIV diagnosis.

Methods. 181 individuals who received care at an academic medical center in New York City prior to a confirmatory HIV diagnosis were included in the study. Assessment methods that leverage longitudinal electronic health records (EHRs) could improve predictive models of HIV diagnosis. Automated risk assessment models that leverage longitudinal EHRs could improve predictive models of HIV diagnosis.

Results. During the 3-year period, there were 212 individuals referred to SP, of which 170 participated in the program. There were 92(54%) men, 136(80%) black. The median age was 48.3 years (IQR: 28.5–56.3). The average duration of follow up pre and during SP were 22.1(IQR: 16.5–27) months. In terms of insurance, 69(40%) had Medicare, 22(13%) had Medicaid, 22(13%) had private insurance, 54(32%) received AIDS drug assistance program (ADAP), and 37(21%) had no insurance. Patients' median distance from the clinic was 17.4(IQR: 8.8–25) miles. The respective outcomes before and during SP were: CD4: 350(IQR: 181–551) vs. 413(IQR: 263–611 cells/mL (P < 0.0001), VS in 78 ± 30% vs. 91 ± 20% (P < 0.001). The proportion of patients with emergency room usage or hospital admissions was 68(40%) vs. 49(29%) (P = 0.036). There was no difference in the rate of kept providers' appointment (66.6% (IQR: 53.8–76.8%) vs. 63.8% (50–77%) (P = 0.19). There was no reported death during the follow up period.

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1357. Mortality and Retention in Care of HIV-Infected Patients According to Year of Admission and Availability of Antiretroviral Drugs in the Chilean National AIDS Program: Fundacion Arriaran 1990–2015

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Background. The HIV epidemic reached Chile in the mid 1980s, as response a national AIDS commission was created, AIDS care centers were organized (Fundacion Arriaran [FA] was the first) and free antiretroviral therapy (ART) was later provided with progressive coverage, complexity and availability over the years.

Objective. Quantity evaluation of mortality, retention and abandonment (LTFU) over 25 years according to culturally relevant and different national programs of the period of access to ART, from no availability to full coverage with current drugs at FA center

Methods. Retrospective analysis of FA updated database of the 5080 adult patients admitted from 1990 to 2014, who were distributed in 4 groups: A: no ART availability (1990–92); B: monoval/dual ART (1993–98); C: early modern ART (HAART) (1999–2007) and D: contemporary HAART (2008–14). Mortality, Retention and LTFU were evaluated at admission, 1, 3, 5 and 10 years intervals from admission and at end of 2015. Mortality was included in period of occurrence; LTFU was permanent absence at cen-
ter of > 6 months during studied period. Local IRB approved the study

Results. Main results shown in Table. Mortality varied from 40% to 2%, and 62% to 7% at 1 year in 5 years, for groups A and D respectively, 72% to 16% at 10 years for groups A and C, respectively. Retention at 5 years were 28%, 32%, 72% and 77% for groups A, B, C and D respectively. LTFU was 10%, 17%, 12% and 10% at 5 years for same groups, respectively. At 12/2015 6%, 19%, 61% and 84% from groups A, B, C and D, respectively, remained retained in care

Table

| Year | M | R | A | M | R | A | M | R | A | M | R | A | Dec 2015 |
|------|---|---|---|---|---|---|---|---|---|---|---|---|-------|
| 1990–92 | 40 | 55 | 5 | 48 | 45 | 7 | 62 | 28 | 10 | 71 | 14 | 14 | 75 | 6 | 15 |
| 1993–98 | 29 | 61 | 9 | 45 | 39 | 14 | 50 | 32 | 17 | 54 | 26 | 19 | 57 | 19 | 20 |
| 1999–2007 | 7 | 84 | 7 | 9 | 78 | 10 | 13 | 72 | 12 | 16* | 63* | 14 | 17 | 61 | 14 |
| 2008–14 | 2 | 91 | 4 | 5 | 83 | 8 | 7* | 77* | 10* | 4 | 84 | 6 | 4 |


disclosures.

1358. Impact of Patient Navigators in Linkage to Care for HIV-Positive Patients in an Urban Emergency Department in Newark, NJ

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Background. Despite CDC recommendations, areas with high HIV prevalence have not implemented routine HIV testing, stating among other concerns, inability to effectively link them to care. We implemented a routine HIV testing program in the Emergency Department (ED) at University Hospital in Newark, NJ that had 46,164 visits from July 2015 to November 2016 and looked at the impact of patient navigators (PN) on linkage to care (LTC) rates.

Methods. This was a retrospective study of all patients newly diagnosed (ND) with HIV with previously positive (PP) but lost to follow-up (LTFU) in select areas of the ED from July 2015 to November 2016. We collected information on demographics, HIV risk factor, and looked at the impact of PN on LTC by comparing months the PN was able to make personal contact compared with months when the PN was unavailable form substantial periods of time.

Results. A total of 9,511 individuals were screened, and 151 (1.6%) had a positive HIV test; 8-died and 2 were incarcerated. Of the remaining 141, 102 (72%) were LTC. The mean age was 49, 57% Male, 77% Black, 14% Hispanic, and 6 White. The reported HIV risk factors were 67% Heterosexual, 9% MSM, 6 IV drug use (IDU) and 18% Other. Of the patients with a positive HIV test, 60 (43%) were ND and 81 (57%) were PP. Only 52% ND patients were LTC, while 88% PP patients were LTC. Black and Hispanic patients tended to be PP (60% of both groups), while White patients tended to be ND (75% of white patients were ND). The risk factors for ND were 44% Heterosexual, 39% MSM, 25% IDU.

Average LTC while the PN was unavailable decreased from 78% to 56%. There were no demographic differences in the LTC group compared with the LTFU group. IDU had the highest rate of being LTFU at 37% followed by MSM and Heterosexual at approximately 13.5% each. The primary reason for LTFU was incorrect contact information in the medical record such as wrong address or phone number. PN would make 3 phone calls, send 2 letters and 1 outreach attempt. If all of those failed, the PN notified the state health department.

Conclusion. PN have a positive impact on LTC even in busy ED settings. Given limitations of staffing a busy ED 24/7, we need to develop strategies to link patients even if the PN is not present. To address this limitation, we plan on looking at the impact of involving medical residents to help with linkage to care after business hours.

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1359. Assessment of personal experiences navigating medical systems and society for the patients of a midwestern HIV clinic

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Background. In the early years of the HIV/AIDS crisis, the debilitating consequences of HIV/AIDS stigma and discrimination became known as part of “the 3rd phase of the epidemic.” Many of these consequences still impact HIV/AIDS care today. In the state of Illinois, the HIV prevalence in Chicago and its collar counties does supersed the prevalence of HIV elsewhere in the state of Illinois, and past HIV reservoirs have utilized mostly urban MSM populations. Unfortunately, although HIV is not an exclusively urban disease, little is known about HIV stigma in smaller communities and lower prevalence contexts.

Methods. Participants were recruited from our local HIV clinic in a county population of 84,000 people. The clinic serves the HIV/AIDS population of Peoria proper as well as the 14 surrounding, more rural counties. Twenty participants were invited for a 1 hour recorded interview speaking of their experiences with HIV stigma. Using a qualitative approach in grounded theory, three researchers independently coded the transcripts and then came to a consensus. Core themes were then summarized.

Results. Sources of stigma included the general community in central Illinois, other outpatient medical clinics, medical testing facilities such as ancillary laboratories, and the LGBT community. Major sources of support included family and loved ones, the HIV medical clinic, and the HIV patient community. Many patients reported HIV education to be assessing, and though facing many social obstacles, ultimately feeling strengthened by adversity. In order to address HIV stigma in the community patients suggested greater networking among HIV infected patients and increased education for the general public.