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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 a 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 evolution of mortality, retention and abandonment (LTFU) over 25 years according to different periods within the national program 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: mono/duo ART (1993–98); C: early modern ART (HAART, 1999–2007) and D: contemporary HAART (2008–14). Mortality, Retention and LTFU were evaluated at 1, 3, 5 and 10 years interval from admission and at end of 2015.

Mortality was included in period of occurrence; LTFU was permanent absence at center 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 and 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% for each group, respectively. At 12/2015 6%, 19%, 61% and 84% for groups A, B, C and D, respectively, remained retained in care.

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1358. Assessing Sources of Racial Disparities in Mortality, Retention and Abandonment to Care in the Context of an 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 third 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 supersede the prevalence of HIV elsewhere in the state of Illinois, and past HIV research has 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 84,800 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, two 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 assuring, 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.

Conclusions. This study showed the marked reduction in mortality and increase in retention of HIV patients coming to expanded access to therapy although LTFU remains a problem. The objective of the study is to evaluate the impact of SDH on racial disparities on time to LTC for newly diagnosed HIV infected individuals in South Carolina (SC).

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Methods. Data was obtained from the SC enhanced HIV/AIDS Reporting System. Analysis includes individuals diagnosed with HIV in SC in 2009–2011. LTC was calculated as the time from HIV diagnosis to first CD4 or VL test. Early LTC was defined as within 30 days. Late LTC was >30 to 365 days. Individuals not LTC by 365 days were considered to have never been linked to care (NLTC). Censit tract data was used to determine SHD (poverty, education, income, and unemployment) based on residence at the time of HIV diagnosis. Descriptive analysis was performed on data from newly infected individuals. Factors potentially associated with late LTC and NLTC including patient demographics, behavioral risk, residence at diagnosis and SDH were investigated.

Results. From 2009–2011, 2151 individuals were newly diagnosed with HIV. Of these 264 (7.6%), 76 (3.5%) were LTC early, 283 (13.2%) were LTC late and 230 (10.7%) were NLTC. NLTC was associated with male gender, lower initial CD4 count, and earlier stage of HIV at time of diagnoses (P <0.01). In multivariable analysis early stage HIV status at HIV diagnosis (aOR: 1.82; 95% CI 1.3, 2.5) and living in census tracts with lower income (aOR:0.65; 95% CI 0.44, 0.97) were associated with late LTC. Male gender (aOR 2.66; 95% CI 1.49, 4.76) unknown HIV risk group (aOR 2.03; 95% CI 1.11, 2.74) and early HIV stage at diagnosis (aOR 4.59; 95% CI 2.33, 9.04) are associated with NLTC.

Conclusion. In SC, almost ¾ of newly diagnosed HIV infected individuals from 2009–2011 were LTC late or NLTC. SDH were not associated with late LTC or NLTC. Living in a low income census tract was associated with a lower risk for late LTC, possible because of access to Ryan White Services. Male gender and earlier HIV stage were factors with greater association with late LTC and NLTC.

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1359. 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 or 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 for 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.

In the PN 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, and 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 34% each. Gregory Supinski, MD2, 'University of Illinois College of Medicine, Peoria, Illinois, 'Pediatrics, University of Illinois College of Medicine, Peoria, Illinois, 'Medicine & Microbiology, University of Illinois, Peoria, Illinois

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Conclusion. HIV stigma is still a distressing social force to HIV infected patients in the heart of Illinois. Though medical management of HIV has advanced significantly in recent years, the stigma that accompanies a diagnosis of HIV infection remains to be effectively addressed in a comprehensive and conscientious manner. Our study points to the need for tailored interventions in outpatient medical settings, as well as throughout the general community in central Illinois.

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1360. Predictors of Viral Load Suppression in HIV-infected Patient in Rural Eastern North Carolina.
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Background. Virologic suppression (VLS) has been shown to improve clinical outcomes and prevent disease transmission in Human Immunodeficiency Virus (HIV) infected patients. However, only 30% of those living with HIV in the United States (US) are currently VLS. HIV incidence and prevalence are increasing rapidly in the rural Southeastern region of the US and models to predict VLS in this population are needed.

Methods. We conducted a retrospective chart review of patients 18 years or older, who were newly diagnosed with HIV and receiving care at our Ryan White funded clinic between September 2014 and September 2016. We collected demographic information, comorbid conditions, clinic appointment data, and laboratory values. VLS suppression was defined as an HIV viral load <200 copies/ml at 3 months. Pearson Chi square analysis was done using SPSS to evaluate the association between these variables and VLS.

Results. A total of 183 patients were included in the study, 42 (23%) females, 39 (21%) white, 41 (22%) less than 25 years of age, 65 (36%) uninsured and 102 (56%) men who have sex with men. The majority 139 (76%) of patients lived below the 150% federal poverty limit. During 3 months follow up 113/183 (61%) were VLS. There were no statistically significant associations between age, gender, ethnicity, presence of mental health and substance abuse disorders, housing stability, education or poverty level, and VLS. 60/104 (56%) of those who were insured achieved VLS compared with 48/65 (73%) of those who were uninsured (P = 0.033).

Conclusion. VLS was achieved in 61% of the HIV infected patients in eastern North Carolina. Patients without insurance had a statistically significantly higher rate of VLS as compared with those with insurance. It is noteworthy that patients who were uninsured received ambulatory medical and support services as well as medication assistance through Ryan White funding. Future prospective studies are needed to further evaluate the association between insurance status and VLS in federally funded clinics.

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1361. Factors Associated with Elevated HIV RNA Levels in HIV-Infected Individuals
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Background. Virologic suppression is necessary to reduce the risk of complications from HIV infection and to prevent transmission to other individuals. Understanding factors associated with elevated HIV RNA levels in HIV-infected individuals could lead to interventions to improve engagement in care.

Methods. This retrospective, observational study assessed HIV-infected individuals engaged in care in an urban HIV clinic between April 1, 2015 and March 31, 2016. The electronic medical record was reviewed for demographic and HIV-related factors for all individuals with elevated HIV RNA PCR ≥200 copies/ml (EVL) during the study period. Demographic data were compared with individuals with decreased HIV RNA PCR (DVL) <200 copies/ml. Patients with recent HIV diagnosis within 6 months of EVL were excluded due to the possibility of insufficient time to achieve viral suppression after engagement in care. Statistical analysis including Student T-test was used to determine whether travel distance, travel time, and crime rate were associated with retention or viral suppression.

Results. 780 patients were included in the study. Of these 273 (35%) were CR, 392 (50%) were EVL, and 115 (15%) were LTFU. Figure 1 shows maps with geocoded data. Median distance from clinic was 3.6 [2.1–5.6] miles among those CR, 3.9 [2.5–6.0] miles among those EVL, and 3.9 [2.6–6.2] miles among those LTFU. Median travel time by CTA was 37.2 [31.8–53] mins for CR, 42.9 [33–51] mins for EVL, and 42.9 [33–59.1] mins for LTFU; by car was 15.9 [9.6–33] mins for CR, 17.1 [11.8–24.6] mins for IR, and 17.5 [12.2–24.1] mins for EVL. Crime rate was similar across all retention groups. Though no associations were statistically significant at P < 0.05, there was a trend toward shorter distance (P = 0.07) and shorter car travel time (P = 0.06) among CR vs. IR. There was also a trend toward lower neighborhood crime rates among those VS vs. those not VS (P = 0.07).

Conclusion. Retention in care was not impacted by residing in high crime neighborhoods in Chicago. PLWHA who lived farther from HIV clinic and had longer travel time showed a trend toward being more likely to be IR in care vs. CR, but there was no such association for VS. Travel time may impact patient likelihood to attend HIV care appointments, but not necessarily adherence to ART.

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1362. Travel time to Clinic but not Neighborhood Crime Rate is associated with Retention in Care among HIV-positive Patients
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Background. Retention in HIV care can be impacted by structural factors such as crime, poverty, and clinic accessibility. We aimed to determine whether crime rate, travel time, or travel distance to clinic were associated with retention in care or viral suppression (VS) among people living with HIV (PLWH) at the largest provider of HIV care on the South Side of Chicago.

Methods. Using publicly available data in the Chicago Open Data Portal, we geocoded patient home addresses and clinic location. We measured distance from patient home to clinic, and travel time from patient home to clinic using car and Chicago Transit Authority (CTA) public transportation. We further measured crime rate within a two block radius of the public transportation route to clinic. Retention was defined as ≥2 visits, 90 days apart within 12 months, and patients were classified into 3 groups: continuously retained (CR), intermittently retained (IR), or lost to follow-up (LTFU), i.e., no visit in the last 12 months. Kruskal–Wallis rank-sum with Dunns pairwise test was used to determine whether travel time, travel distance, and crime rate were associated with retention or viral suppression.

Results. 780 patients were included in the study. Of these 273 (35%) were CR, 392 (50%) were EVL, and 115 (15%) were LTFU. Figure 1 shows maps with geocoded data. Median distance from clinic was 3.6 [2.1–5.6] miles among those CR, 3.9 [2.5–6.0] miles among those EVL, and 3.9 [2.6–6.2] miles among those LTFU. Median travel time by CTA was 37.2 [31.8–53] mins for CR, 42.9 [33–51] mins for EVL, and 42.9 [33–59.1] mins for LTFU; by car was 15.9 [9.6–33] mins for CR, 17.1 [11.8–24.6] mins for IR, and 17.5 [12.2–24.1] mins for EVL. Crime rate was similar across all retention groups. Though no associations were statistically significant at P < 0.05, there was a trend toward shorter distance (P = 0.07) and shorter car travel time (P = 0.06) among CR vs. IR. There was also a trend toward lower neighborhood crime rates among those VS vs. those not VS (P = 0.07).

Conclusion. Retention in care was not impacted by residing in high crime neighborhoods in Chicago. PLWHA who lived farther from HIV clinic and had longer travel time showed a trend toward being more likely to be IR in care vs. CR, but there was no such association for VS. Travel time may impact patient likelihood to attend HIV care appointments, but not necessarily adherence to ART.