Therefore there is a need to better understand the characteristics, staging of the disease, and response to treatment in older HIV-infected adults, in order to provide an effective treatment and prevention approach.

Methods. A retrospective medical record review of all newly diagnosed HIV-infected patients was conducted at a single academic center HIV ambulatory clinic from January 1, 2007 to December 31, 2015. Patients age group, viral load, stage, and response to antiretroviral treatment (ART) measured by HIV viral suppression at 12 weeks (HIV RNA <50 copies), and change in CD4 count were collected. Bivariate analysis was conducted comparing two groups of HIV-infected patients: younger group (age <50 years) and older group (age 50 years and older).

Results. From 2010 to 2015, 130 newly diagnosed HIV patients were enrolled in the clinic. Thirty-one (23.8%) were 50 years or older and of those 12 (38.7%) were 60 years and older. Older patients group were more likely to have AIDS defining illness at the time of diagnosis, compared with the younger group [19 (61.3%) vs. 25 (29.3%), respectively]. Of those eight (42%) were older than 60 years. Compared with the younger group, the majority of the HIV-infected patients in the older group who were on ART (61.5%) did not achieve HIV viral suppression at 12 weeks. However, both groups accomplished immune reconstitution with an increase in CD4 cell count in older and younger groups (mean CD4 count = 132 and 200 cell/µl, respectively).

More than 80% of patients in both groups were on an integrase inhibitor ART-based regimen.

Conclusion. HIV-infected patients 50 years and older are more likely to present late to care, and to have a delay in HIV viral suppression compared with younger patient group. These findings are alarming and require emphasize on early HIV diagnosis. More data are required to understand the immune response to ART.

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576. Disparities in Virologic Control for People Living with HIV (PLWH) Receiving Care at a Large, Urban, Safety-Net Clinic
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Background. The National HIV/AIDS Strategy highlights reduction of HIV-related disparities as a key goal. Despite universal access to therapy in the United States, the CDC estimates that only 58% of PLWH have achieved virologic suppression. We carried out a recent analysis of virologic suppression, examining for associated factors for PLWH receiving care at one of the nation's largest, urban, safety-net clinics in order to identify ongoing outcome disparities.

Methods. Ruth M. Rothstein CORE Center, Cook County Health and Hospital System's large, urban, safety-net HIV clinic cares for nearly 5,000 PLWH in the Chicago area. We report rates of virologic suppression for PLWH who attended at least one primary care visit between March 31, 2017 and April 1, 2018. We assessed for associations between key demographic characteristics, inclusive of zip code of residence, and virologic suppression (VL < 200 copies/mL).

Results. A total of 4,660 patients attended at least one visit primary care visit at CORE between March 31, 2017 and April 1, 2018. Patients demographics, age group, viral load, stage, and response to antiretroviral treatment measured by HIV viral suppression at 12 weeks (HIV RNA <50 copies) and change in CD4 count were collected. Bivariate analysis was conducted comparing two groups of HIV-infected patients: younger group (age <50 years) and older group (age 50 years and older).

Conclusion. Disparities in virologic suppression persist in younger and African-American PLWH who attended care at Chicago's largest, safety-net HIV clinic, with our data highlighting particular geographic areas of need. Structural interventions and quality improvement initiatives, at the health system and regional level, must continue to focus on improving outcomes for PLWH who fall into these demographic categories.

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577. Barriers to Transitions of Care in the Detroit Young HIV Population
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Background. One of the issues faced by clinics which care for young adults infected with HIV is a disruption to treatment during the transition from pediatric to adult care. There have been no studies performed in this area for this population to cure decreased rates of transmission and favorable health outcomes for the patients. The purpose of this study was to characterize the out of care transitioning patient population from pediatric to adult HIV care in an academic HIV clinic in Detroit, Michigan.

Methods. We assessed barriers to transition for youth with HIV who had not met the requirements for successful transition to the adult HIV clinic (three appointments). Patient barriers were assessed through telephone calls with three questions assessing their reasons for not coming to the adult clinic conducted by adult medical staff and by a pediatric social worker.

Results. One hundred and four youth were identified as transitioning youth. Of those, 13 were excluded due to relocation. Thirty-two (30.7%) patients did not successfully transition and 19 (18%) were accessible through telephone/text for interview. Demographic data for the 32 patients was collected and the predictors of disengagement were identified which included transportation (22.2, n = 10) and work (8.9, n = 4). There were no statistically significant differences in the measured variables of race, HIV mode of acquisition, housing status, or employment status between those who did and did not successfully transition. In regards to reasons for missed appointments, there were eight reasons given to the adult medical staff, but the pediatric social worker was able to elicit, a much broader range of answers, 13.

Conclusion. We found that lack of phone access, transportation and work play a key role in patients transitioning to the adult clinic; however, we initially expected more socioeconomic factors to impair the transition process. In looking at the mismatched reasons for missed appointments given to the adult clinic and the pediatric social worker, it appears that the pediatric social worker could elicit a greater the variety of reasons for missed appointments. Moving forward, more pediatric social work support for the transitioning process may be beneficial.

Figure 1. Reasons for Missed Appointments Given to Pediatric Social Worker.
9% or coverage by the state's ADAP program (13% vs. 2%; P < 0.001 for insurance differences); "true" vs. "virtual" LTC patients more often received Ryan White case management services (69% vs. 15%, P < 0.001). More "virtual" vs. "true" LTC patients have subsequently returned to care (47% vs. 33%, P = 0.03). Active insurance most strongly associated with subsequent return to care on logistic regression.

Conclusion. We found that LTC patients who had ongoing lab monitoring during their gap in medical visits were more likely to have private insurance or ADAP coverage, while being less likely to have received Ryan White case management services. Prospectively identifying LTC patients more likely to have favorable outcomes may free up re-engagement resources for use with higher need patients.

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579. Acceptability of Home-Based Medical Assessment to Facilitate Re-engagement of HIV-Positive Out-of-Care Persons into Clinical Care, New York City
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Background. For people living with HIV (PLWH), retention in care and anti-retroviral treatment improve individual health and curb further HIV transmission. Since 2007, New York City Health Department Disease Intervention Specialists (DIS) make contact attempts to re-engage PLWH presumed to be out-of-care (OOC) because they lack HIV registry report of viral load or CD4 cell count ≥9 months from selection date. Each year, 28–50% of OOC-PLWH refuse assistance from DIS to re-engage in HIV care. In 2017, we assessed the interest of OOC-PLWH in a medical home visit to facilitate their re-engagement in HIV care. Home visits could help DIS circumvent barriers to care re-engagement: privacy issues, impaired mobility and chronic health conditions, and by providing discreet and accessible medical care.

Methods. From January to December 2017, DIS interviewed 847 OOC-PLWH and administered a questionnaire to ascertain their interest in a home visit to evaluate their general and HIV-related health status (e.g., physical and HIV evaluation, health education, sexually transmitted diseases [STD] and hepatitis C [HCV] screening).

Results. Of the 847 OOC-PLWH interviewed, 111 (13%) were interested in home visits. The majority of participants were male (69%), non-Hispanic black (60%) and had a median age of 47 years at intervention (range: 19–88). Thirty-eight percent were men who had sex with men. Higher proportions of those interested accepted care appointments (93% vs. 73%) and kept a clinic appointment (78% vs. 61%). Compared with non-Hispanic blacks, Hispanics were less likely to be interested in home visits (aOR: 0.59, 95% CI 0.36–0.96). Compared with persons who accepted an HIV care appointment, persons who did not were significantly more likely to express interest in home visits (aOR: 4.18, 95% CI 1.62–10.78). Those expressing general interest had specific interest in assessments for HIV-related blood tests (85%), medication (84%) or education (78%), as well as general health evaluation and screening for HCV (68%) or STD (64%).

Conclusion. Our assessment suggests that medical home visits could improve re-engagement rates among OOC-PLWH. Lower interest among Hispanic patients suggests that future efforts should be sensitive to community needs and concerns.

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580. Key Factors for Treatment Changes Within 1 Year After Starting ART in the German ClinSurv Cohort: Between 2005 and 2014
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Background. Initiation of combined antiretroviral therapy (cART) has markedly increased survival and quality of life in HIV-infected patients. With the advent of new treatment options, including an increasing number of single-tablets, the durability of intensified and effective, many patients living with HIV benefit with reduced ART pill burden and longer life expectancy. As this patient population ages, the prevalence of comorbidities increases the likelihood of polypharmacy. This study assessed if comorbidities and their associated polypharmacy affect the success of HIV management in our patients.

Methods. A retrospective analysis of patients living with HIV receiving care at an urban clinic in New Jersey was performed. Eligible patients were ≥18 years old, had ≥2 visits in 2017 with laboratory data ≥24 weeks apart. These patients were divided into three arms: those without any comorbidity conditions, a single comorbidity, and patients with multiple comorbidities. The primary endpoints were to determine the effect of comorbidity conditions and polypharmacy on viral suppression (defined as HIV RNA <20 copies/mL). Secondary assessments accounted for the impact of age and race/ethnicity on HIV management.

Results. There were 318 patients included in the analysis: 156 with multiple comorbidities, 76 with one, and 86 without any. Most patients were male (58%) and the median age was 49 years old. The population was 52% Black, 32% Hispanic, and 15% White. Most patients (72%) had undetectable virus, and 92% had a CD4 count >200 cells/mm³. Patients with multiple comorbidities were more likely to be virologically suppressed than patients with one comorbidity (80% vs. 59%, P = 0.0014) and those without (80% vs. 67%, P = 0.0413), despite having a higher pill burden per day (7.0 vs. 3.7 vs. 2.2, P = 0.0001). Although age was not an independent predictor of viral suppression, patients with multiple comorbidities were older (55 yo) than those with one comorbidity (48 yo) and without any (41 yo) (both P < 0.0001). Hypertension (39%), diabetes mellitus (16%), dyslipidemia (31%), and psychiatric disorders (14%) were the most common comorbidities. Patients with hypertension were more likely to be virologically suppressed than those without (80% vs. 67%, P = 0.0229).

Conclusion. Patients with multiple comorbidities and a greater daily pill burden at our clinic were more likely to achieve virologic suppression. Multiple comorbidities and polypharmacy were not major drivers of virologic failure in our clinic cohort.