Rapid – 45.84 n 0 (0.0) N/A 3.28 – 41 23 (48.9) 9 (31.0) 6 (20.7) 20 (69.0) 12.32 4 (13.8) 29 0.002** (SD) 12 (41.4) Pn – 43 (91.5) 70.59 18 (62.1) +230 414 0 (0.0) (df) 0.004** 41 (87.2) – +53 3.03* – 14.84 49x44

566. Earlier Linkage and ART Initiation Via Fast Track Referral System for New HIV Patients Leads to Stronger Engagement and Better Outcomes

Michael Virata, MD,1 Carlo Conia, BA,1 and Patrick Cadaby, MD1,2

1Medicine, Yale University, New Haven, Connecticut, 2Economics, University of Pennsylvania, Philadelphia, Pennsylvania and 3Division of Infectious Diseases, Department of Internal Medicine, Yale New Haven Hospital, New Haven, Connecticut

Session: 61. HIV: Linkage to Care and Viral Suppression in the Care Cascade

Background. To reach the 90-90-90 target goals for HIV care, clinical service requires a coordinated strategy to overcome barriers that prevent patients’ sustained wellbeing. Earlier initiation of antiretroviral therapy (ART) improves desired outcomes yet it can be a difficult task. With the help the Early Intervention Service (EIS) from our local Health Department, our academic clinic implemented a Fast-Track Linkage (FTL) and ART process for clients new to HIV care by providing services within 10 days of diagnosis. The aim of our study was to compare this new system with the standard of care (SOC).

Methods. We retrospectively reviewed the medical records of all new patients who were referred for HIV care at this single academic center from 2014 to 2016. Only patients not on ART at the initial visit were included. We divided them into two groups. One group was referred via the FTL system (see Table 1). Our analysis did not identify any significant barrier to care. FTL patients were significantly younger. Retention, ART, VS and CD4 recovery were better in the group that was treated earlier.

RESULTS. Forty-seven were referred via the FTL system (see Table 1). Our analysis did not identify any significant barrier to care. FTL patients were significantly younger. Retention, ART, VS and CD4 recovery were better in the group that was treated earlier.

Table 1:

| SOC | FTL | P |
|-----|-----|---|
| n   | η   | τ  |
| 29  | 47  | 0.002** |

Adjusted df used because assumption of homogeneity of variance was violated.

**P < 0.05

Conclusion. Implementation of FTL systems that include EIS can lead to successful and sustained high rates of VS and improved CD4 recovery. Larger scale initiatives could prove to be highly beneficial from a public health perspective.

Disclosures. All authors: No reported disclosures.

567. Stigma, Secrecy and Spirituality: An Exploratory Study of How Sociocultural Practices and Perceptions Influence Care Engagement Among HIV-Positive Adults in Akwai, Ghana

Kelsey Brown, Undergraduate Student1; Teresa Deatley, MPH1; Gloria Mensah, Undergraduate Student2; Nialah Tucker, Undergraduate Student1; Timothy Flanigan, MD, FIDSA1 and Maite Alfonso Romero, MD2; Brown University, Providence, Rhode Island, 1Brown University, 02912, Rhode Island, 2Tougalo College, Tougaloo, Mississippi, 3Department of Infectious Diseases, The Miriam Hospital, Providence, Rhode Island, 4St. Dominici’s Hospital, Akwai, Ghana

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Background. In Ghana, only 65% of HIV-positive adults are linked to HIV care. Stigmatization, social support and religiosity and disclosure are among the factors that influence engagement in HIV care. This exploratory study examines the relationship between demographic characteristics, perceived stigma, religious service attendance, and participants’ adherence to HIV-related appointments. The authors sought to identify characteristics that differed among HIV-positive adults who experienced default in attendance of their HIV clinic appointments compared with those with continuous attendance.

Methods. An exploratory study was conducted from June 2017 to July 2017 at St. Dominici’s Hospital in Akwai, Ghana. Structured interviews and medical record reviews were used to collect data on the sociocultural characteristics and appointment adherence of 153 adult HIV-positive participants. Adherence was classified as continuous or noncontinuous. Continuous adherence was defined as attending all scheduled HIV-related appointments over a 6-month period. Only univariate analysis was used to identify characteristics associated with continuous adherence.

RESULTS. The mean age was 53, 75% of the participants were female, and 92% identified as Christian. HIV care adherence was continuous among 73% of participants. Seventy-three percent of participants attended religious services more than once per week even though 58% of participants perceived HIV-related stigma from their religious congregation. Seventy-seven percent of participants reported hiding their HIV status from others. The only statistically significant difference between the continuous and noncontinuous groups was with respect to hiding their HIV status from others (P = 0.054, 90% CI).

Conclusion. The sample size (n = 153) limits the ability to generalize the differences identified between outcome groups. Another limitation is that this study did not examine stigma or disclosure among individuals who had not enrolled in the clinic. Further research is needed to determine whether HIV status concealment can be used as an indicator for patients at higher risk of noncontinuous care engagement. A better understanding of HIV-related stigma and disclosure and its influence can be identified by religious communities and supportive interventions is needed.

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568. The Impact of Disclosure Stigma on Virologic Outcomes in People Living with HIV

Michelle Mathieu, MD,1 Laurie Gleason, BA,2 Thakman Sunil, PhD, MPH1; Norys A. Casta-Pena, MD1; Camille Spears, MD, MPH1; Christopher Smith, MD2; John Michael Flores, MD2 and Barbara S. Taylor, MD, MS1; 1Department of Internal Medicine, Division of Infectious Diseases, University of Texas Health at San Antonio, San Antonio, Texas, 2Institute for Health Disparities Research, University of Texas at San Antonio, San Antonio, Texas, 3Infectious Disease Gonzaba Medical Group, San Antonio, Texas, 4Long School of Medicine, UT Health at San Antonio, San Antonio, Texas, 5Internal Medicine and Pediatrics, University of Illinois at Chicago, Chicago, Illinois

Session: 61. HIV: Linkage to Care and Viral Suppression in the Care Cascade

Background. HIV-related stigma is a leading barrier to engagement in HIV care and successful treatment. Disclosure Stigma (DS), the fear of disclosing one’s serostatus, is associated with poor adherence and retention in care, but its association with clinical indicators of HIV treatment is not well established. The purpose of this study was to determine the influence of DS on virologic suppression, and our hypothesis was that DS would be associated with lack of virologic suppression.

Methods. This cross-sectional study was performed between May 2015 and February 2016, at the largest publicly funded HIV clinic in South Texas. A survey was administered to consecutively recruited participants at routine follow-up who were: 218-years-old, HIV+, and receiving antiretroviral therapy. Surveys included demographics, sexual/HIV history, AIDS Clinical Trials Group baseline questionnaire, and a validated HIV-stigma scale. Clinical data were obtained from medical records. The primary predictor was DS: the sum of 10 items ranked 0–4, with maximum score of 40 indicating highest stigma. The primary outcome was lack of virologic suppression (LOVS): most recent HIV-1 RNA>20 copies/mL. Bivariate analyses were conducted to examine: (i) predictors of DS and (ii) predictors of LOVS. Multivariate logistic regression models examined the relationship between DS and LOVS.

RESULTS. For 275 participants, median DS score was 18.5 (IQR 13, 23). In bivariate analyses, DS was significantly associated with DS (OR 1.10, 95% CI 1.01, 1.18) and perceived DS (OR 1.04, 95% CI 1.00, 1.08) were significantly associated with increased DS. However, dissatisfaction with help received by friends/family was associated with reduced odds of DS (OR 0.46; CI
were associated with better outcomes despite being associated with more depression, compared with their younger peers. Low social support, higher ELOC, and lower ILOC impact with respect to study outcomes.

Conclusion. Engagement in care was to determine how social factors such as LOC affect patients’ progression through the care continuum in the Aging HIV-Infected Population. Patients that did not re-engage despite intervention may be at risk for poor retention and earlier care coordination intervention may be considered. Future directions include continuing to follow patients to demonstrate the effectiveness of long-term effects of early intervention and re-engagement on rates of retention.

Disclosures. All authors: No reported disclosures.

570. The Effects of Locus of Control, Social Support, and Stigma on the HIV Care Continuum in the Aging HIV-Infected Population

Christopher Mashiah, BS1; Grace Chan, PhD2; David Steifens, MD3 and Lisa M. Church, MD1; University of Connecticut School of Medicine, Farmington, Connecticut, 1Department of Psychiatry, University of Connecticut School of Medicine, Farmington, Connecticut, 2Division of Infectious Disease, University of Connecticut School of Medicine, Farmington, Connecticut.

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Background. Locus of control (LOC), or how one perceives one's control over a situation, can affect health outcomes, including outcomes of HIV care. Our research goal was to determine how social factors such as LOC affect patients' progression through the HIV care continuum, focusing on the experiences of older HIV-infected individuals. A convenience sample of English-speaking HIV-infected patients was surveyed at UConn Health. The survey included assessments of internal locus (LOC), external LOC (ELOC), social support, depression, HIV stigma, and, and Ryan White (RW) funding status. Outcome measures marking progress through the care continuum, including appointment history, HIV viral load, and CD4 count, were obtained from chart review. Engagement in care was defined as attendance at ≥5 appointments and no missed appointment in the previous year.

Results. A total of 58 subjects were enrolled from June to November 2016. The mean age was 52.4 years (range 24–84), 78% were ≥50 years old, 57% were male, and 47% received RW funding. Table 1 shows associations between study outcomes and social support, LOC and HIV stigma. Among older subjects, engagement in care was inversely associated with LOC and HIV stigma. Among younger subjects, engagement in care was associated with social support and LOC but not with HIV stigma. Among all subjects, engagement in care was associated with social support (P = 0.04). Among subjects with significant depressive symptoms, lower ILOC was associated with engagement in care (P < 0.001) and CD4 counts ≥350 (P = 0.01). Neither patient age nor RW funding status had significant impact with respect to study outcomes.

Conclusion. Older HIV-infected patients had similar study outcomes compared with their younger peers. Low social support, higher ELOC, and lower ILOC were associated with better outcomes despite being associated with more depression, possibly due to increased reliance on health professionals. These measures could be useful to screen for patients who are less likely to remain in the HIV care continuum.

Table 1:

| Characteristics          | HR (95% CI) |
|--------------------------|-------------|
| Race                     |             |
| African-American         | 0.78 (0.54–1.13) |
| Caucasian                | 0.70 (0.44–1.11) |
| Hispanic/other           |             |
| Age (per 10-year)        | 0.63 (0.50–0.79) |
| Virologic load (log 10)  | 1.27 (1.05–1.54) |
| HIV Dx to A* (per 5-year) | 1.25 (0.99–1.57) |
| Use of antiretrovirals before ART | 1.95 (1.19–3.21) |
| CD4 count (per 100-cell) | 0.93 (0.87–1.00) |
| ART regimen              |             |
| Boosted PI               | 0.36 (0.16–0.77) |
| InSI                    | 0.55 (0.35–0.86) |
| INNFI                   | 1.35 (0.79–2.29) |
| Other combinations       |             |
| Adherence >90% vs. <90%  | 0.28 (0.20–0.41) |

*Time-updated covariate.

Disclosures. All authors: No reported disclosures.

571. In a Well-Characterized Cohort with Universal Access to Care and Medications Racial Disparities in HIV Virologic Outcomes Are No Longer Observed

Anuradha Ganesan, MD, MPH, MPH2; Seunghyun Won, PhD3; Christie Joya, DO2; Robert Deiss, MD2; Ryan Maves, MD, FCCP FIDSA4; Karl Kronmann, MD, MPH5; Tahaniyat Lalani, MBBS, MHS5; Christina Schofield, MD FACP FIDSA5; Timothy J. Whitman, DO5; Jason Okulicz, MD5 and Brian Agan, MD5, 6; 1Henry M. Jackson Foundation for the Advancement of Medicine, Inc., Bethesda, Maryland, 2Infectious Disease, Walter Reed National Military Medical Center, Bethesda, Maryland, 3Infectious Disease Clinical Research Program, Uniformed Services University of the Health Sciences, Bethesda, Maryland, 4Infectious Disease Clinical Research Program, Department of Preventive Medicine and Biostatistics, Uniformed Services University of the Health Sciences, Bethesda, Maryland, 5Infectious Diseases, Naval Medical Center San Diego, San Diego, California, 6Naval Medical Center Portsmouth, Portsmouth, Virginia, 7Madigan Army Medical Center, Tacoma, Washington, 8Walter Reed National Military Medical Center, Fort Sam Houston, Texas

Session: 61. HIV: Linkage to Care and Viral Suppression in the Care Cascade Thursday, October 4, 2018: 12:30 PM

Background. HIV-infected African-Americans (AA) are more likely to experience virologic failure (VF) compared with other ethnic groups. Decreased access to healthcare has been postulated as a potential cause. Using data from the US Military Natural History Study (NHS), we examined the effects of race on VF. The NHS is a longitudinal cohort comprised of Department of Defense (DoD) beneficiaries with unrestricted access to healthcare.

Methods. We included NHS participants who contributed follow-up after 2001. Demographic characteristics, antiretroviral therapy (ART) history, and serial viral loads (VL) were obtained from the database. Pharmacy records were used to calculate adherence. VF was defined as a VL of ≥500 copies/mL on two consecutive measurements or one VL of ≥1,000 copies/mL. A Cox model with time-updated covariates was used to examine the association between race and VF.

Results. A total of 1,521 subjects contributed follow-up after 2001 (41% AA; 95% male). Median age, CD4 count and VL at ART initiation (AI) were 31.6 years [IQR 26–39], 367 cells/µL [IQR 271–489] and 4.6 log, copies/mL [IQR 4.0–5.0], respectively. Subjects were followed for a median of 4.8 years [IQR 2.7–7.9], and 13.2% (n = 201) met criteria for VF. Most subjects initiated ART with a non-nucleoside reverse transcriptase inhibitor (NNRTI) (64%), integrase strand transferase inhibitor (INSTI) (15%) or a boosted protease inhibitor (PI) (14%)–based regimen. Results of the adjusted Cox model are in the table below.

Conclusion. In the NHS, in recent years, AA and Caucasians have similar responses to ART. NNRTI and INSTI use was protective, reinforcing that simpler medications with fewer adverse effects improve outcomes. Unrestricted access to care and modernization of ART should help narrow the disparities observed in virologic outcomes.

Characteristics

| Race          | Ref. |
|---------------|------|
| African-American | 0.78 (0.54–1.13) |
| Caucasian      | 0.70 (0.44–1.11) |
| Hispanic/other |      |
| Age (per 10-year) | 0.63 (0.50–0.79) |
| Virologic load (log 10) | 1.27 (1.05–1.54) |
| HIV Dx to A* (per 5-year) | 1.25 (0.99–1.57) |
| Use of antiretrovirals before ART | 1.95 (1.19–3.21) |
| CD4 count (per 100-cell) | 0.93 (0.87–1.00) |

*Time-updated covariate.