toxicity, drug-to-drug interactions, and noncompliance. The objectives of this study were to describe clinical characteristics and treatment history of currently treated HIV-1 patients in commercial and Medicare Advantage health plans in the United States.

Methods. A retrospective cohort study of adults (≥18 years) with ≥1 ARV pharmacy claim from January 1, 2012 to March 31, 2017 and ≥1 pre-HIV policy claim with the Community Health Plan, a claims-based database was used to identify users of treatment (LOT), including the most recent LOT (LOT0) and previous LOTs dating back to January 1, 2007. Subjects were continuously enrolled 12 months prior to the start of LOT0 (baseline) and comorbidities assessed. Treatment-naïve subjects were defined as having no current baseline ART during baseline, ≥1 LOT were defined as treatment-experienced. Study variables were summarized descriptively and results were stratified by treatment status, insurance type, and age groups.

Results. There were 18,699 eligible subjects, of whom 27% were treatment naïve. Average age was 47 years (±12), 84% were male, 51% Caucasian, and 82% had commercial insurance. Common baseline comorbidities among subjects were hyperlipidemia (41%), cardiovascular disease (41%), hypertension (34%), and depression (17%). Most comorbidities increased with age except for depression and anxiety, which were mostly constant across age groups. Among all subjects, the average cumulative proportion of days covered with an ARV was 85%. Average total pills per day, ARV and non-ARV, increased with age corresponding with Medicare subjects having 9.2 and commercial subjects having 3.7 pills per day.

Conclusions. The study results provided the insight to give improved life expectancy for patients with HIV, management of comorbidities and overall medication burden has become increasingly complex. HIV treatment guidelines suggest streamlined ARV regimens may be considered as patient complexity evolves over time to decrease disease burden taking into account co-morbidities, drug-drug interactions, and total pill burden.

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589. Assessment of an Antiretroviral Therapy Policy in Patients with Human Immunodeficiency Virus at a Large Academic Medical Center Elizabeth Barber, PharmD1; Kady Phe, PharmD2; Hannah Palmer Russo, PharmD1 and Mayar Al Mobaraj, MD, MBA, CAQ, FACP3; CHI St. Luke’s Health – Baylor St. Luke’s Medical Center, Houston, Texas, Department of Medicine, Section of Infectious Diseases, Baylor College of Medicine, Houston, Texas
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Background. Accurate medication reconciliation upon hospital admission is crucial for patients with human immunodeficiency virus (HIV) to ensure continuation of appropriate antiretroviral therapy (ART). An ART policy was implemented at our institution which restricted ART ordering to infectious diseases (ID) pharmacy resident and an ID clinical specialist. The ASP intervention included adult patients with HIV who received one or more doses of ART prior to implementation of the HIV medication restriction policy on the appropriate-ness of ART re-ordering upon admission.

Methods. This was a single-center, retrospective chart review conducted from July 1, 2014 to June 30, 2017 post intervention. The purpose of this study was to evaluate the effectiveness of the HIV medication restriction policy on the appropriate-ness of ART re-ordering upon admission. The post-intervention group included adult patients with HIV who received one or more doses of ART prior to implementation of the HIV medication restriction policy. The post-intervention group included adult patients with HIV who received one or more doses of ART after implementation of the exclusion criteria. Exclusion criteria included patients who were initiated ART for hepatitis B infection or prophylaxis, HIV post-exposure prophylaxis, or patients receiving a first dose of ART for occupational exposure. Home ART medication regimen and inpatient ART medication regimen were evaluated. The primary endpoint was to compare the rate of appropriate medication reconciliation, before and after implementation of the HIV medication restriction policy. The secondary endpoint was to compare the time to restart of ART following admission.

Results. A total of 151 patients were included in this study. Appropriate medication reconciliation increased from 76% to 100% after implementation of the policy (P = 0.0014). However, the mean time to re-initiation of ART increased from 7.9 hours to 14.5 hours after implementation of the policy (P = 0.001). ART regimens were restarted within 24 hours of admission in 96.7% of the pre-HIV policy group vs. 84% in the post-HIV policy group (P = 0.02).

Conclusion. The mean time to re-initiation of ART increased after implementation of the HIV policy. However, restriction of ART ordering to infectious diseases physicians significantly increased the rate of appropriate medication reconciliation for patients with HIV. In light of these results, a procedure will be established to ensure the timely re-initiation of ART.

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590. Tackling HIV/AIDS in Brooklyn New York Within a Network of Federally Qualified Health Centers Neil King, MD1; Finn Chacko, MPH1; Isha Huyon, MD1; Tiffany Yi Shan Lee, MD1; Anum Aamir, MD1; Marilyn Chacko, DO1; and Isaac Dakpis, MD1; 1Family Health Center, Family Health Centers at NYU Langone Health, Brooklyn, New York, 2Clinical Research, NYU Langone Hospital-Brooklyn, Brooklyn, New York, 3Internal Medicine, Family Health Centers at NYU Langone Health, Brooklyn, New York
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Background. As of June 30, 2016, 122,945 New Yorkers had been diagnosed and were known to be living with HIV/AIDS. The Family Health Centers at NYU Langone (FHC) has for the past 27 years continued to build an evolving network of services which aim to tackle the epidemic through the principles of hot-spotting, elevating cultural competency, and applying the continuum of care model for the communities we serve.

Methods. FHC’s network covers a service area of six NYC Community Districts in Brooklyn. Utilizing best practices, FHC has built a network which addresses the cascade of care through EMR embedded screening, education on cultural competencies in the LGBTQI+ community, dedicated health navigators, and a comprehensive panel of providers to deal with biopsychosocial factors that prohibit access to healthcare delivery. Utilizing automated referral pathways within the EMR along with a daily review of all testing results performed within the network, care coordination teams and dedicated case managers are able to identify patients. Dedicated case management teams are then assigned to locate patients and link patients to treatment and assist in overcoming care access barriers.

Results. Within the FHC catchment area the incidence of new HIV infections was heavily concentrated among poor populations. Among the FHC patient population, minority races comprised 79.3% of the PIWHAs, with 58% of the population having the risk factor of MSM activity. For those patients who fall under >20% below Federal poverty level, New York’s HIV/AIDS death rate is at 74%. Despite national and regional efforts, patients served are disproportionately impacted by HIV with fewer than 12% of all high risk PLHWA having access. The network covers 114 ZIP Codes, 62% of which are majority minority. The FHC is the only network which aims to tackle the epidemic through the principles of hot-spotting, elevating cultural competency, and applying the continuum of care model for the communities we serve.

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591. Impact of an Antimicrobial Stewardship (ASP) Initiative Evaluating Antiretroviral Regimens for HIV Positive Patients KwaBena Nimarko, PharmD2; Aiman Bandali, PharmD, AAHIVP1; Tiffany Bia, PharmD, BCPS, AAHIVP2; Hannah Zambrano, PharmD1; 1Pharmacy, Hahnemann University Hospital, Philadelphia, Pennsylvania, 2Hahnemann University Hospitals, Philadelphia, Pennsylvania
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Background. Advancements in the development of antiretrovirals (ARVs) have led to HIV-related morbidity and mortality and improved patient adherence. Despite the simplicity of current ARV regimens, medication errors still frequently occur. This study evaluated the impact of an antimicrobial stewardship (ASP) team in identifying and reducing ARV medication errors.

Methods. A retrospective study was conducted to evaluate ARV medication errors pre- and post-implementation of an ASP initiative in HIV-positive patients admitted between July 1, 2016 and December 2017. The ASP team consisted of a PGY2 infectious diseases (ID) pharmacy resident and an ID clinical specialist. The ASP intervention included patients upon admission. The primary endpoint was to assess the number of drug-drug interactions, drug-to-drug interactions, and noncompliance. The following endpoints were assessed: incidence of errors, classification of errors, and the number of errors detected/corrected.

Results. Three hundred and fifty-six patients were included in the analysis; 153 patients in the pre-intervention group and 203 patients in the post-intervention group. A total of 243 errors were identified in 175 patients; 119 errors (n = 78) in the pre-intervention group and 124 (n = 97) in the post-intervention group. The overall number of errors was significantly stratified by classification (42/243; 17%), drug-drug interaction (159/243; 66%), and completeness of regimen (42/243; 17%). Drug–drug interactions involving integrae inhibitors and cations were the most frequently occurring medication error in both cohorts. There was a statistically significant difference in errors detected, and subsequently corrected in the pre-intervention group compared with the post-intervention group (12/119 vs. 85/124, P < 0.001). Of the 39 errors that were missed by the ASP team, six were not detected, 12 occurred post-review, and 21 were not accepted by the primary team.

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592. Determining the Impact of an Antiretroviral Stewardship Team on the Care of HIV-Infected Patients Ambedded to an Academic Research Institution Ashley DePuy, PharmD2; Rafik Samuel, MD, FIDSA1; and David Koren, PharmD3; 1Department of Pharmacy, Temple University Hospital, Philadelphia, Pennsylvania, 2Section of Infectious Diseases, Lewis Katz School of Medicine at Temple University, Philadelphia, Pennsylvania
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Background. The American Society of Health-System Pharmacists and The American Academy of HIV Medicine have established guidelines on the pharmacist’s role in the care of HIV-infected patients. However, continuous review throughout the hospital course at discharge, as well as education of all practitioners, is critical to preventing propagation of errors.
involvement in HIV care. Despite expanding roles, there is a paucity of data regarding the impact of collaboration amongst physicians and physicians on inpatient antiretroviral management. We evaluated the effects of an antiretroviral stewardship team, comprised of an HIV specialized pharmacist, Infectious Disease physician, and associated learners on reducing inpatient antiretroviral-related errors.

**Results.** Two hundred ninety-seven admissions were evaluated of which 15 were excluded due to treatment for Hepatitis B and PEP. Forty-eight percent of included admissions (134/282) had at least one intervention made, with 196 interventions made in total. The following variables were assessed to identify predisposing risk factors for errors: non-institutional outpatient provider (OR 1.908 [95% CI 1.136–3.143]; P = 0.014), admission to the intensive care unit (OR 3.836 [95% CI 1.192–12.340]; P = 0.024), change in GFR (OR 3.332 [95% CI 1.144–9.710]; P = 0.027), CD4 count <200 cells/mm³ (OR 1.196 [95% CI 1.015–3.617]; P = 0.045), and multi-tablet inpatient regimens (OR 2.501 [95% CI 1.614–4.121]; P = 0.090). Cost savings from interventions were estimated to be $137,040.

**Conclusion.** Interprofessional antiretroviral stewardship teams optimize patient care and provide cost savings. Patients at highest risk for errors include those with non-institutional outpatient providers, admission to the intensive care unit, changes in GFR, and CD4 counts <200 cells/mm³.

593. A Nationwide Assessment of Predictive Factors for Proportion of Continuity of Care Resources for HIV-Positive Detainees in ICE Health Service Corps-Staffed Facilities, 2015 and 2017

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**Background.** Continuity of care (CoC) is paramount to the successful management of patients with human immunodeficiency virus (HIV), and is uniquely challenging when patients are mobile. Over the past several years Immediate Detention Center Customs Enforcement Health Service Corps (IHSC) has increased training and education for providers regarding the provision of CoC. The objective of this study was to evaluate the impact of these efforts by assessing provision of and factors associated with CoC counseling to HIV-infected detainees in 2015 as compared with 2017.

**Methods.** This retrospective analysis reviewed electronic health records of detainees with confirmed HIV infection detained at any of the 21 IHSC-staffed nationwide facilities between January–December 2015 and January–August 2017. Using SAS software V.9.3, odds ratios, 95% CI, chi-square, univariate and multiple logistic regression analyses were utilized to assess and compare relationships between independent variables and CoC for 2015 and 2017.

**Results.** Five hundred and eight HIV-infected detainees were identified; they were predominately male (88.4%), born in Mexico (37%), generally had CD4 counts <200 (86.2%) and had an established diagnosis of HIV prior to entering custody (94.1%). Among all primary variables assessed for predictive association to CoC, female gender and infectious disease (ID) consultation were statistically significant (P = 0.0058, 0.0085, respectively). After adjusting for all other variables, women were 1.5 times (95% CI 1.015–2.278) more likely to receive CoC counseling to HIV-infected detainees in 2015 compared with 2017.

**Conclusion.** Discussing CoC with ICE detainees is imperative given their increased risk for treatment interruption. Our results emphasize that (i) CoC discussion should happen early in custody stay as most detainees have left our care system before having CoC counseling; and (ii) CoC counseling to HIV-infected detainees in 2015 as compared with 2017.

594. The Prevention and Management of HIV: Online Education as a Tool to Improve Knowledge and Confidence Among HIV/ID Specialists

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**Background.** To optimize care for patients at risk for HIV infection and individu-
als living with HIV, healthcare providers (HCPs) must not only remain current in answering patients' questions about new ARV agents and regimens and 90% of HIV/ID specialists indicated a commitment to incorporate one or more changes into practice.

**Conclusion.** Participation in this online education consisting of segmented video interviews on new clinical data significantly improved ID specialists' knowledge and confidence with regard to key advances in HIV prevention, treatment, and the management of HIV/HCV coinfection. These findings highlight the positive impact of well-designed online education.

595. Changes in Ryan White Clinic Referral Patterns Among HIV-Infected Patients Following Implementation of the Affordable Care Act

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**Background.** The Affordable Care Act (ACA) enacted on March 23, 2010 may have subsequently affected referral patterns for persons living with HIV (PLWH). The ACA permits states to provide Medicaid for individuals at or below 138% of the federal poverty line with federal funding for 3 years after enactment. Following the Kentucky Medicaid expansion in September 2013, the uninsured rate fell from 14.3% (~616,000) in 2013 to 6% (~261,000) in 2015 (USDC, 2016). As of June 2016 the total number of diagnosed PLWH in Kentucky was 9,928 (CHFS, 2016).

This study evaluated the impact of the ACA on referrals to care for PLWH. The University of Kentucky Bluegrass Care Clinic (UK BCC) is a federally funded Ryan White HIV/AIDS clinic that serves 63 counties in central and eastern Kentucky.

**Methods.** This study examined 1,022 newly enrolled patients between March 24, 2010 and June 8, 2017 to observe changes in referral patterns at the UK BCC. Referral type was categorized into one of twelve groups (referral by self, outpatient clinic, hospital, OB/GYN, community organization, UK BCC, transfer, health department, and unknown). Unknown observations were removed from the data analysis.

**Results.** Of the 1,022 intake records, 127 had an unknown referral source (12.4%). Between the periods 2010–2013 (Pre-ACA) there was an 18% decrease in referrals from Health Departments between pre- and post-ACA (29.8% vs. 12.0%). In addition, there was a 13.0% increase in transfer care to the UK BCC (16.1% vs. 29.3%). There was an overall significant difference in referral care patterns between the two time periods (P < 0.001) when considering all referral groups.

**Conclusion.** The decrease in referral of patient from Health Departments may indicate that PLWH have more access to screening and referrals to clinic care through primary care providers with Medicaid expansion. Further, the increase in patients who transfer from pre-existing care to the Ryan White clinic suggest that the expansion of PLWH using Medicare and Medicaid may have resulted in additional eligibility for other