

**Background.** Key to improved HIV outcomes is early diagnosis, linkage to care (LTC), retention in care (RIC) and viral load (VL) suppression. As treatment for HIV has become more effective, the gap in racial disparities has widened for LTC, RIC and VL. Social determinants of health (SDH) are conditions such as poverty level, income, education, employment that are responsible for most health inequities. SDH are drivers of disparities in HIV prevalence. The objective of this 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).

**Methods.** Data was obtained from the SC enhanced HIV/AIDS Reporting System. Analysis includes individuals diagnosed with HIV in SC from 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). Census 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 1636 (76.1%) were LTC early, 285 (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 HIV stage 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) are 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 ¼ 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 greatest association with late LTC and NLTC.

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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.** Quantify evolution of mortality, retention and abandonment (LTFU) over 25 years according to qualitatively different periods in 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/dual 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 year intervals 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% 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

		Mortality (M) Retention (R) and Abandonment (Ab) in %																			
		Year 1				Year 3				Year 5				Year 10				Dec 2015			
		M	R	Ab	M	R	Ab	M	R	Ab	M	R	Ab	M	R	Ab	M	R	Ab		
A	n																				
330	No ARV available (1990–92)	40	55	5	48	45	7	62	28	10	71	14	14	75	6	15					
B	n																				
882	Pre HAART therapy (1993–98)	29	61	9	45	39	14	50	32	17	54	26	19	57	19	20					
C	n																				
1690	Early HAART (1999–2007)	7	84	7	9	78	10	13	72	12	16*	63*	14*	17	61	14					
D	n																				
2178	Contemporary HAART (2008–14)	2	91	4	5	83	8	7*	77*	10*				4	84	6					

Mortality, retention and abandonment according to periods of admission and at end of 2015, in %.

\*Calculated with proportion of patients completing that period. Transfers: 0–8% for each period. Data not in table.

**Conclusion.** This study showed the marked reduction in mortality and increase in retention of HIV patients concomitant to expanded access to therapy although LTFU remains a problem.

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**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 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.

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, 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 23% 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 patients of a midwestern Ryan White funded 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 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 184,000 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, 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.