screening. Of those tested, only one (1.47%) returned reactive. The remaining 67 screenings returned non-reactive. Applying only 10% of this diagnosis rate to the total number of STI encounters suggests an opportunity to diagnose 47 additional individuals; applying 50% of this rate and the corresponding value is 239 individuals.

Conclusion. These results highlight the need for expanded HIV screening in EDs. Systematic HIV test tracking and follow-up removes this burden from ED providers and enables expanded HIV testing in these settings.

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955. Addressing Gaps and Disparities in HIV testing in the Emergency Department

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Session: P-45. HIV: Epidemiology and Screening

Background. Early diagnosis of HIV is key to improving outcomes for persons living with HIV (PWH). The Emergency Department (ED) is a critical site for PWH to access care. Previous studies in South Carolina (SC) have shown that two-thirds of individuals newly diagnosed with HIV have visited a health care facility a mean 7 times prior to their HIV diagnosis. Over 80% of these visits were to the ED, thus representing missed opportunities. Failure to test results from a multitude of barriers, including avoidance of testing due to a perceived lack of follow up. To address this gap in care we established a rapid HIV engagement team (RHET) that assumes responsibility for post-HIV testing linkage and reporting. The goal of this study is to evaluate the effectiveness of this intervention.

Table 1: Baseline Characteristics

	All (n=4104)	Pre (n=2154)	Post (n=1950)	P-value
Age, mean (years)	31.4	31.7	31.0	NS
Male gender, n (%)	980 (23.9)	489 (22.7)	491 (25.2)	0.09
Race/Ethnicity, n (%)				
White, n (%)	916 (22.3)	554 (25.7)	362 (18.6)	<0.001
Black, n (%)	2885 (70.3)	1462 (67.9)	1423 (73.0)	<0.001
Hispanic, n (%)	196 (4.8)	84 (3.9)	112 (5.7)	<0.001
Other, n (%)	107 (2.6)	54 (2.5)	53 (2.7)	0.61
Reason for ED Visit, n (%)				
STI Related, n (%)	1629 (39.7)	848 (39.4)	781 (40.0)	<0.001
Constitutional Symptoms, n (%)	66 (1.6)	22 (1.0)	44 (2.3)	NS
Other, n (%)	2409 (58.7)	1284 (59.6)	1125 (57.7)	<0.001
Day of the week				NS
Sunday	563 (13.7)	284 (13.2)	279 (14.3)	
Monday	598 (14.6)	325 (15.1)	273 (14.0)	
Tuesday	639 (15.6)	359 (16.7)	280 (14.4)	
Wednesday	590 (14.4)	308 (14.3)	282 (14.5)	
Thursday	589 (14.3)	305 (14.2)	284 (14.6)	
Friday	591 (14.4)	309 (14.3)	282 (14.5)	
Saturday	534 (13.0)	264 (12.3)	270 (13.8)	
STI Testing Obtained, n (%)				
Gonorrhea		1829 (84.9)	1747 (89.6)	0.09
Chlamydia		1783 (82.8)	1729 (88.7)	0.19
Trichomonas		1518 (70.4)	1354 (69.4)	0.21
HSV		38 (1.8)	33 (1.7)	0.003
HIV Testing Obtained, n (%)		131 (6.1)	251 (12.9)	<0.001

NS = not significant
STI = Sexually transmitted infection

Methods. This retrospective cohort study compared HIV testing rates and patterns in Prisma Health EDs from May 2018 through October 2018 (pre-RHET) to 5/2019 through 10/2019 (post-RHET). Included persons were ≥18 years of age and had ICD-10 codes for a sexually transmitted infection (STI), trichomonas, herpes simplex, and gonorrhea (GC) or Chlamydia (CT) NAAT, and/or presented with an initial complaint of a STI. Multivariable logistic regression analysis was utilized to examine impact of RHET implementation on HIV testing in ED.

Results. A total of 4104 individuals were identified, 2154 pre-RHET and 1950 post-RHET. Table 1 displays baseline characteristics for the two groups. Overall, 87% had GC testing; 9% had positive results; 95% had CT testing, 12.6% had positive results. Only 6% were tested for HIV pre-RHET implementation. HIV testing improved to 12% post-PHET implementation (p< 0.001). In the multivariate regression analysis predictors for HIV testing were presenting post-RHET (OR 2.27; 95% CI 1.81 to 2.85), male gender (OR 2.98; 95% CI 2.39 to 3.73), white race (OR 2.27; 95% CI 1.81 to 2.85), and presenting to ED for STI (OR 3.58; 95% CI 2.03 6.33).

Conclusion. HIV testing rates increased post-RHET yet, despite indications for HIV testing, only a small proportion received HIV testing. Further interventions are needed to improve HIV testing in EDs, particularly in women and blacks. The overall HIV testing rate remained low, representing ongoing missed opportunities for early HIV diagnosis.

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956. Delayed HIV diagnosis in Philadelphia

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Session: P-45. HIV: Epidemiology and Screening

Background. Ending the HIV Epidemic (EHE) requires prompt diagnosis and treatment of HIV to reduce transmission. Delayed HIV diagnosis and late entry into care remain challenging. Strategic deployment of testing resources may leverage both targeted and universal testing to accomplish the timely diagnosis of HIV infection.

Methods. We extracted data from the City of Philadelphia's Enhanced HIV/AIDS Reporting System for 3,856 individuals diagnosed with HIV infection in Philadelphia, PA from 2012-2018, to determine characteristics associated with delayed diagnosis, defined as: AIDS diagnosed within 90 days of HIV or date of AIDS diagnosis prior to HIV diagnosis. Independent variables included: time since HIV diagnosis, age category, birth sex, current gender, race/ethnicity, transmission risk, insurance status, and receipt of care from Ryan White medical provider. We used Chi-square and multivariate logistic regression to assess factors associated with delayed diagnosis.

Results. From 2012 to 2018, the number of HIV diagnoses declined from 731 to 422; those with delayed diagnosis declined from 28% to 18%. Age category of 25-34 years comprised the majority of HIV diagnoses N=1402 (36%). The majority were: born male (78%), current gender male (76%), black (69%), MSM (51%), insured (54%), and participating in Ryan White care (71%). In multivariate regression, current gender male, heterosexual transmission, race/ethnicity Asian, American Indian, Alaska Native, or Multi-race, unknown insurance status, and receipt of care from a Ryan White medical provider were 3.7 (95%CI, 1.2-11.4), 1.3 (1.0-1.7), 1.8 (1.2-2.8), 5.9 (4.9-7.1), and 1.4 (1.2-1.7) times as likely to have delayed diagnosis, respectively, after adjustment for time since diagnosis, age category, and birth sex.

Participants' Characteristics and Logistic Regression Results

Variable	HIV (non-AIDS) Col %	AIDS (Concurrent) Col %	Logistic Regression OR (95% CI)	Adjusted Logistic Regression aOR (95% CI)
Time since diagnosis				
<3 Years	1121 (37.3)	265 (31.3)	1.00 (Ref)	1.00 (Ref)
3 – 4 Years	880 (29.3)	231 (27.2)	1.110 (0.912 – 1.353)	0.754 (0.599 – 0.948)
4+ Years	1007 (33.5))	352 (41.5)	**1.479 (1.234 – 1.772)**	0.937 (0.757-1.158)
Age Category:				
18-24	384 (12.8)	37 (4.4)	1.00 (Ref)	1.00 (Ref)
25-34	1202 (40.0)	200 (23.6)	**1.726 (1.193 – 2.496)**	1.415 (0.957 – 2.090)
35-44	593 (19.7)	197 (23.2)	**3.446 (2.371 – 5.008)**	**3.001 (2.000– 4.503)**
45-54	412 (13.7)	207 (24.4)	**5.212 (3.577 – 7.594)**	**4.453 (2.939 – 6.747)**
55-64	327 (10.9)	134 (15.8)	**4.251 (2.870 – 6.295)**	**3.692 (2.382 – 5.722)**
65+	90 (3.0)	73 (8.6)	**8.414 (5.326 – 13.29)**	**7.004 (4.189 – 11.710)**
Birth Sex				
Male	2331 (77.5)	660 (77.8)	1.00 (Ref)	1.00 (Ref)
Female	677 (22.5)	188 (22.2)	0.981 (0.817-1.178)	2.556 (0.821 – 7.955)
Current Gender				
Female	675 (22.4)	183 (21.6)	1.00 (Ref)	1.00 (Ref)
Male	2269 (75.4)	656 (77.4)	1.066 (0.886 – 1.283)	**3.657 (1.178-11.353)**
Transgender	64 (2.1)	9 (1.1)	0.519 (0.253- 1.062)	3.174 (0.870-11.573)
Race/Ethnicity				
Black	2051 (68.2)	589 (69.5)	1.00 (Ref)	1.00 (Ref)
White	400 (13.3)	104 (12.3)	0.905 (0.716 – 1.144)	0.898 (0.685 – 1.176)
Hispanic	469 (15.6)	113 (13.3)	0.839 (0.670 – 1.051)	0.894 (0.696 – 1.150)
Asian/American Indian/Alaska Native/Multi-race	88 (2.9)	42 (4.9)	**1.662 (1.138 – 2.427)**	**1.843 (1.202 – 2.826)**
Transmission Risk				
MSM	1604 (53.3)	361 (42.6)	1.00 (Ref)	1.00 (Ref)
PWID	245 (8.1)	55 (6.5)	0.997 (0.729 – 1.365)	0.748 (0.520 – 1.078)
MSM/PWID	67 (2.2)	11 (1.3)	0.729 (0.382 – 1.394)	0.579 (0.289 – 1.160)
Heterosexual	965 (32.1)	371 (43.9)	**1.708 (1.448 – 2.016)**	**1.324 (1.040 – 1.685)**
No Report Risk	127 (4.2)	50 (5.9)	**1.749 (1.237 – 2.474)**	1.067 (0.710 – 1.603)
Insurance Status				
Yes	1,800 (59.8)	264 (31.1)	1.00 (Ref)	1.00 (Ref)
No	629 (20.9)	88 (10.4)	0.954 (0.737 – 1.234)	1.082 (0.829 – 1.411)
Unknown	580 (19.3)	496 (58.5)	**5.841 (4.897 – 6.966)**	**5.923 (4.918 – 7.135)**
Ryan White Care				
No/Unknown	870 (28.9)	246 (29.0)	1.00 (Ref)	1.00 (Ref)
Yes	2138 (71.1)	602 (71.0)	0.996(0.842– 1.178)	**1.416 (1.166 1.719)**

Conclusion. EHE will only be successful by reaching all people living with HIV and creating opportunities for early diagnosis. Routine opt-out universal screening combined with repeated, targeted testing will allow for identification and early treatment of HIV infection. As a medical care safety net, Ryan White program provides care to a disproportionate number of people with delayed diagnosis of HIV. By diagnosing HIV as early as possible, we may eliminate delayed diagnosis and reduce the risk of AIDS-related events or death.

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957. Efficacy of Using Disease Intervention Specialists (DIS) to Re-engage Out of Care HIV/HCV Co-Infected Persons into HCV Treatment

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