	SOC	Rapid	t	
	Mean	Mean	(df)	
	(SD)	(SD)		
	n	n		P
Days from diagnosis to first Appt	36.11	12.32	3.56*	0.001**
	–37.61	–11.97	–41	
	35	34		
Days from first Appt to ARV	20.82	7.75	3.28	0.002**
	–17.39	–14.84	–‒64	
	34	32		
Days from ARV to <20	107.48	64.41	2.43*	0.019**
	–81.73	–41.29	–45.84	
	31	17		
Days from first Appt to <20	128.35	70.59	3.03*	0.004**

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

**$P < \alpha = 0.05$

Conclusion.   Preliminary results are comparable to reports from larger studies, suggesting that reduced time to first visit and ARV initiation shortens interval to virologic suppression. Implementing Rapid Entry in a community setting is challenging but feasible, requiring high levels of staff commitment, flexibility, and communication. Efforts in process to further improve Rapid Entry include strategies to engage/retain those infected via injection drug use and shortening time to referral from outside test sites.

Disclosures. J. Cafardi, Gilead: Grant Investigator, Salary.

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

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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 in Connecticut, 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 with patients that were newly diagnosed and utilized the FTL vs. all others. We compared the demographic and outcome data including retention in care, viral suppression (VS) and CD4 differences.

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	29	47	
Age (median [IQR])	50.00 [42.00, 55.00]	31.00 [26.50, 39.50]	<0.001
Sex (%)			0.367
Female	6 (20.7)	5 (10.6)	
Male	23 (79.3)	41 (87.2)	
Race (%)			0.583
Asian/Pacific Islander	0 (0.0)	1 (2.1)	
Black, non-Hispanic	17 (58.6)	23 (48.9)	
Hispanic	4 (13.8)	6 (12.8)	
White, Hispanic	1 (3.4)	0 (0.0)	
Other	0 (0.0)	1 (2.1)	
White, non-Hispanic	7 (24.1)	16 (34.0)	
HIV risk group (%)			0.011
Heterosexual sex	9 (31.0)	12 (25.5)	
Injection drug use	6 (20.7)	1 (2.1)	
Men who have sex with men	12 (41.4)	34 (72.3)	
Time to first HIV clinic visit (median [IQR])	N/A	9.00 [0.00, 19.00]	0.016
Retained in care (≥2 visits in >90 days) (%)	22 (75.9)	43 (91.5)	0.122
Prescribed antiretroviral therapy (%)	18 (62.1)	43 (91.5)	0.005
HIV viral suppression at 1 year (%)	20 (69.0)	37 (78.7)	0.495
Initial CD4 counts at baseline (ave)	340	414	0.334
CD4 count change at d365	+53	+230	0.004

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 Akwatia, Ghana

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Background.   In Ghana, only 65% of HIV-positive adults are linked to HIV care. Stigma, social support and religion influence patients' choice to engage in HIV-related 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. Dominic's Hospital in Akwatia, 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. 77% 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, disclosure and how it can be influenced 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

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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: ≥18-years-old, HIV+, and receiving antiretroviral therapy. Surveys included demographics, sexual/HIV history, AIDS Clinical Trials Group baseline adherence 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 30 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 analysis, depression (OR 1.10; CI 1.05, 1.15) and perceived stress (OR 1.04; CI 1.01, 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