0.27, 0.78). DS was significantly inversely associated with LOVS (OR 0.96; CI 0.92, 0.99) and age (OR 0.97; CI 0.95, 0.998), and positively associated with drug use (OR 3.96; CI 1.53, 10.23). The association between DS and LOVS was maintained after adjusting for age, gender/sexual orientation, race/ethnicity, and drug use.

Conclusion. DS was highly prevalent in this cohort. The unanticipated inverse association between DS and LOVS highlights the complexity of this relationship. Despite this association, the balance of data in this cohort demonstrates an overall negative impact of DS. Further study is needed to understand this surprising finding.

Disclosures. **All authors:** No reported disclosures.

569. Pre-retained: Early Intervention for HIV Patients at High Risk of Becoming Un-retained

AlexandraAbrams-Downey, MD[1]; Christopher Joseph, LMSW, MPH[2]; Rebecca Lindner, MS[2]; Gabriela Rodriguez, MD[1]; Shirish Huprikar, MD[1]; Keith Sigel, MD, PhD[1] and Rachel Chasan, MD[1]; [1]Department of Medicine, Division of Infectious Disease, Icahn School of Medicine at Mount Sinai, New York, New York, [2]Institute for Advanced Medicine at Mount Sinai, New York, New York

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

Background. Poor engagement in HIV care is an established barrier to achieving optimal treatment. Improved engagement is a cornerstone of the national HIV/AIDS strategy and a marker of quality care. However, there is no consensus on strategies for proactive engagement. The objective of this prospective quality improvement pilot project is to demonstrate the effectiveness of early intervention for patients at high risk of becoming un-retained to increase clinic re-engagement and decrease time to re-engagement.

Methods. The Jack Martin Fund Clinic (JMFC) is a New York State Designated AIDS Center within the Institute for Advance Medicine at Mount Sinai in Manhattan. Patients at high risk of becoming un-retained were defined as no PCP follow-up in six months. The investigator arranged an appointment and notified patients to confirm. Re-engagement was defined as PCP follow-up within 90 days of intervention. A chart review was completed to collect demographics, co-morbidities and HIV data for the intervention group ($n = 84$) and a retrospectively identified control group ($n = 126$).

Results. The intervention group achieved a statistically significant outcome of increased re-engagement in care and decreased time to re-engagement. Within the intervention group, 67 of 84 patients (80%) followed-up within 90 days compared with only 65 of 126 patients (52%) in the control ($P < 0.01$). The time to re-engagement after last PCP visit was also significantly decreased in the intervention group. There were no statistically significant differences between the control and intervention groups regarding race/ethnicity, case management involvement, viral load or co-morbidities.

Conclusion. This study demonstrates a low-intensity, high-yield, sustainable intervention that significantly increased re-engagement for HIV patients that are at high risk of becoming un-retained. A unique aspect of this project is the focus on patients who are currently retained, but at risk of falling out of care, as opposed to patients already un-retained. Patients that did not re-engage despite intervention may be at risk for poor retention and earlier care coordination involvement may be considered. Future directions include continuing to follow patients to demonstrate 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 Mashiak, BS[1]; Grace Chan, PhD[2]; David Steffens, MD[1] and Lisa M. Chirch, MD[1]; [1]University of Connecticut School of Medicine, Farmington, Connecticut, [2]Department of Psychiatry, Univeristy of Connecticut School of Medicine, Farmington, Connecticut, [1]Division of Infectious Disease, University of Connecticut School of Medicine, Farmington, Connecticut

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

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.

Methods. A convenience sample of English-speaking, HIV-infected patients was surveyed at UConn Health. The survey included assessments of internal LOC (ILOC), 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 ≥2 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 associated with less 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:

				Social Support		ILOC		ELOC		HIV Stigma	
		N	%	Score	*P*-value	Score	*P*-value	Score	*P*-value	Score	*P*-value
Engaged in care	Yes	27	47	41.7	0.09	8.8	0.09	5.3	0.10	22.9	0.53
	No	31	53	45.5		9.4		4.5		21.6	
Viral suppressed	Yes	36	62	44.8	0.23	9.1	0.64	5.1	0.07	21.9	0.72
	No	22	38	42.0		9.2		4.3		22.7	
CD4 count (cells/μL)	≥350	43	74	43.1	0.38	9.0	0.06	5.0	0.24	21.7	0.40
	<350	15	26	45.4		9.5		4.3		23.7	
Depressed	Yes	21	36	40.4	**0.02**	8.4	**0.02**	5.5	**0.03**	27.3	**<0.01**
	No	37	64	45.6		9.5		4.4		19.3	

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[1,2,3]; Seunghyun Won, PhD[4]; Christie Joya, DO[2]; Robert Deiss, MD[1,4,5]; Ryan Maves, MD, FCCP, FIDSA[5]; Karl Kronmann, MD, MPH[6]; Tahaniyat Lalani, MBBS, MHS[1,4,6]; Christina Schofield, MD FACP, FIDSA[7]; Timothy J. Whitman, DO[8]; Jason Okulicz, MD[9] and Brian Agan, MD[1,4]; [1]Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., Bethesda, Maryland, [2]Infectious Disease, Walter Reed National Military Medical Center, Bethesda, Maryland, [3]Infectious Disease Clinical Research Program, Uniformed Services University of the Health Sciences, Bethesda, Maryland, [4]Infectious Disease Clinical Research Program, Department of Preventive Medicine and Biostatistics, Uniformed Services University of the Health Sciences, Bethesda, Maryland, [5]Infectious Diseases, Naval Medical Center San Diego, San Diego, California, [6]Naval Medical Center Portsmouth, Portsmouth, Virginia, [7]Madigan Army Medical Center, Tacoma, Washington, [8]Walter Reed National Military Medical Center, Bethesda, Maryland, [9]Infectious Disease, San Antonio 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 ^{3}200 copies/mL on two consecutive measurements or one VL of >1,000 c/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 $\log_{10}$ 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	HR (95% CI)
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)
VL at ART (per $\log_{10}$)	1.27 (1.05–1.54)
HIV Dx to AI* (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*	Ref.
Boosted PI	0.36 (0.16–0.77)
InSTI	0.55 (0.35–0.86)
NNRTI	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.