

involvement in HIV care. Despite expanding roles, there is a paucity of data regarding the impact of collaboration amongst pharmacists 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.

Methods. In this single-centered retrospective cohort study, electronic medical records of adult patients with an antiretroviral ordered between July 1, 2017 and December 31, 2017 were evaluated for the following outcome measures: number of interventions made, number of admissions with errors, predisposing risk factors for errors, and cost savings from interventions. Categorical data were expressed as a total (percent), continuous data were expressed as a median [interquartile range], and predisposing risk factors were analyzed by a multivariate logistic regression. Cost savings were estimated by the documentation system Clinical Measures[®].

Results. Two hundred ninety-seven admissions were evaluated of which 15 were excluded due to treatment for Hepatitis B and PrEP. 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 1.890 [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 regimen (OR 1.768 [95% CI 0.916–3.412]; $P = 0.090$). 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.

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593. A Nationwide Assessment of Predictive Factors for Provision 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 Immigration and 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) after adjusting for all other variables. Compared with all other detainees, our sample was in custody twice as long (61 days vs. 31 days, $P < 0.001$). In 2015 and 2017, 91% of detainees received ART during custody, and CoC prior to release nearly doubled from 29.4% in 2015 to 59.6% in 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 within two months of entry, (ii) providers should be aware of possible bias during counseling and offer the same level of CoC discussion regardless of gender or clinical parameters. Questions prompting and reminding providers to have CoC discussions should be included in HIV-specific templates during the initial health assessment.

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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 acquisition and individuals living with HIV, healthcare providers (HCPs) must not only remain current with the data, but critically evaluate the clinical implications of such.

Methods. A CME/CE/CPE-certified, 60-minute, video-based activity was developed to increase knowledge of the latest clinical-trial and real-world data for the

prevention and treatment of HIV. The activity posted online on March 26, 2018 and featured four experts. Segmented into three sequentially linked presentations, each presentation featured a moderator and panelist who summarized the latest data and evaluated potential clinical implications with regard to, HIV prevention strategies, including PrEP; Existing and emerging HIV ARV regimens; and the management of HIV/HCV coinfection.

Educational effectiveness was assessed with a repeated-pairs pre-/post-assessment study design, in which each individual served as his/her own control. Responses to three multiple-choice, knowledge questions and one self-efficacy confidence question were analyzed. A chi-squared test assessed changes pre- to post-assessment. P -value < 0.05 is statistically significant. Effect sizes were evaluated using Cramer's V (<0.05 modest; 0.06–0.15 noticeable effect; 0.16–0.26 considerable effect; >0.26 extensive effect). Data were collected through April 25, 2017.

Results. 4,485 HCPs, including 954 physicians have participated in the activity. Data from HIV/ID specialists ($n = 50$) who answered all pre-/post-assessment questions during the study period were analyzed. Significant improvements were observed overall ($P = 0.0039$; $V = 0.166$) and in several specific areas of assessment (figure). Following activity participation, 22% of ID specialists indicated increased confidence 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.

Assessment of Educational Effectiveness			
Area of Assessment	% relative improvement (% of ID specialists selecting the correct response at pre- vs post-assessment)	P -value for change	Cramer's V for the magnitude of the change
Real-world data for the impact of PrEP on different patient populations	67% improvement (42% vs 70%)	$P = .005$	$V = .231$ (Considerable)
The ARV composition of newly approved ART regimens	45% improvement (40% vs 58%)	$P = .018$	$V = .183$ (Considerable)
Efficacy of DAA-based HCV regimens among HIV/HCV coinfecting patients	11% improvement (38% vs 42%)	$P = NS$	$V = .040$ (Modest)

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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 nine 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 period 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 ($P < 0.0001$) 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 loss of eligibility from other