

Methods. We calculated the contribution to the community VL for 3 HIV-positive groups from January 1, 2016 to September 1, 2018; (1) AHI (p24 antigen-positive, negative or indeterminate supplemental antibody testing), (2) new diagnoses (ND), and (3) existing diagnoses (ED). Persons who were AHI or ND were ART naive at first VL. The contribution of each group to community VL was calculated at the first and second VL assays. Group contributions were characterized as (1) percentage of the total HIV-positive population, and (2) group contribution to community VL.

Results. 217 persons tested positive for HIV and had an initial VL, and 69 persons linked to our program had a second VL. Time intervals between first and second VL measurements were similar between groups (Kruskal-Wallis $P = 0.55$). Initial VL medians were significantly different by group (Kruskal-Wallis $P < 0.001$), partly due to the large number of ED in care and virally suppressed (< 200 copies/mL) at first VL ($n = 82$). AHI contributed the fewest persons to the HIV-positive population (7.8%), but contributed the most to first VL (58.6%). ART reduced VL for all groups. The median time from diagnosis to treatment for AHI was 5.5 days (IQR 4–21). Due to both natural decay and ART, AHI contributed the least to total VL load at second assay (5.6%). Using previously published data on treated and untreated VL decay, a delay in ART of 15 days would result in an estimated VL of 17,721 copies/mL (95% confidence interval (537– 53,576) vs. the estimated VL with ART, 131 copies/mL (95% CI 5–294), a 135-fold increase in AHI VL.

Conclusion. Patients with AHI are small proportion of our cohort compared with ND and ED, but account for the greatest portion of our community VL. These data quantifies the benefit of rapid initiation of ART for AHI to reduce community VL, a priority for prevention efforts.

	Acute	New	Existing
Population size at 1 st viral load	17	75	125
Median (IQR) at 1 st viral load	1,813,400 (781,752 - 5,000,000)	61,967 (23,404 - 159,834)	0 (0-3009)
Total viral load by group	46,593,104	20,522,663	12,418,361
% of each group population	7.8%	34.6%	57.6%
% of total 1 st viral load	58.6%	25.8%	15.6%
Time to 2 nd viral load	51 (45-117)	55 (36-81)	38 (32-69)
Population size at 2 nd viral load	14	37	18
Median (IQR) at 2 nd viral load	68 (20 - 372)	52 (20 -302)	20 (20-151)
Total viral load by group	72,788	533,221	694,039
% of total population	20.3%	53.6%	26.1%
% of total 2 nd viral load	5.6%	41.0%	53.4%

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1268. Clinic Screening for Adverse Childhood Experiences among Persons with HIV: A Pilot Project

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Background. Childhood trauma has long-lasting implications for adult health as prior work in the general population linked ≥ 4 adverse childhood experiences (ACEs) to multiple negative health outcomes in adulthood. History of childhood trauma is prevalent in people living with HIV (PLWH); however, screening for history of childhood trauma is not routinely performed in HIV clinical care.

Methods. We conducted a single-center, cross-sectional quality improvement pilot project to (1) define the prevalence of ACEs in PLWH engaged in care and (2) improve linkage with mental health resources. We hypothesized the prevalence of ≥ 4 ACEs in PLWH would be $> 21\%$, the prevalence previously reported in the local, general population. Patients were approached in the course of routine clinical care at an urban, academic HIV outpatient clinic between October 2018 and April 2019 and offered screening for ACEs, depression, and post-traumatic stress disorder (PTSD) using previously validated tools.

Results. Forty-nine patients completed the screening. Median age was 48 years [IQR: 37–55]; 69% were male and 53% were gay or bisexual. Most patients identified as black/African American (75%) and white (12%). Median ACEs score was 4 [IQR 1–6], with 51% (95% CI: 36–66%) reporting ≥ 4 ACEs (Figure 1), and most common ACE being guardian substance abuse (57%) (Figure 2). When compared with men, women had a higher median ACEs score (5 vs. 3, $P = 0.04$), history of childhood sexual abuse (67% vs. 26%, $P < 0.001$), parent incarceration (53% vs. 24%, $P = 0.04$), and parental divorce or separation (73% vs. 41%, $P = 0.04$). Patients with ≥ 4 ACEs were more likely to have positive PTSD screens (56% vs. 21%, $P = 0.02$), moderate depression or greater (37% vs. 11%, $P = 0.002$), and were more likely to accept on-site mental health referral after screening (36% vs. 8%, $P = 0.04$). Acceptability of screening was deemed “very good” by patients, with median acceptability score 5 [IQR: 4–5] on a 5-point scale.

Conclusion. Over half of HIV+ patients screened in our clinic reported ≥ 4 ACEs, more than twice the prevalence of the general population. ACEs screening facilitated linkage of patients with high ACEs scores to mental healthcare. These results highlight the potential value of routine ACEs screening to enhance delivery of trauma-informed HIV primary care.

Fig 1. ACEs Prevalence by Score (n=49)

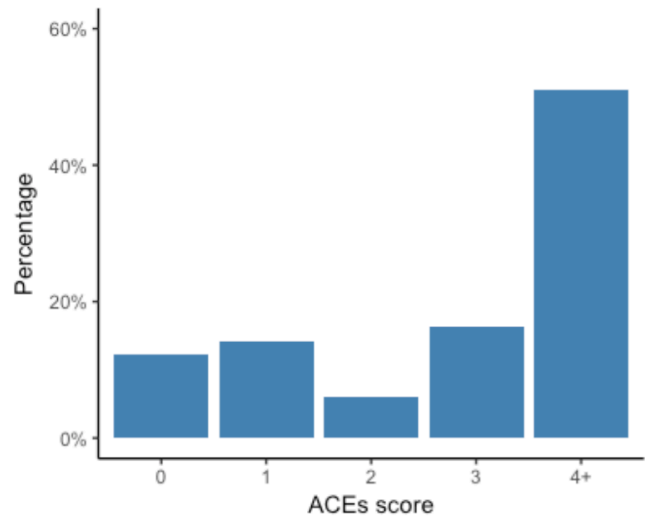
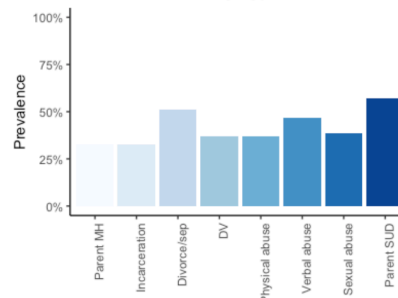


Fig 2. ACEs Prevalence by Experience Type (n=49)



Parent MH = parent mental illness. DV = household domestic violence. Parent SUD = parent alcohol or drug abuse

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1269. Cohort Profile: The Translational Platform HIV (TP-HIV), a Multicenter Cohort Project in Germany

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