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1906. Hospitalization Rates Among Persons With HIV Who Gained Medicaid or Private Insurance in 2014

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Session: 225. Clinical Practice Issues: HIV, Sepsis, QI, Diagnosis
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Background. The Ryan White Program (RWP), which provides safety net outpatient healthcare coverage to thousands of low-income persons with HIV (PWH), does not pay for inpatient care. Many PWH who relied on RWP transitioned to either Medicaid or private insurance (private) with the Affordable Care Act in 2014. It is unknown whether such transitions affected hospitalization rates.

Methods. We included patients from three HIV Research Network sites (two in Medicaid expansion states, one in a nonexpansion state) who relied solely on RWP in 2013. Patients either stayed in RWP through 2015, or changed to Medicaid or private in 2014. 2015 hospitalization rate ratios were modeled using negative binomial regression, adjusting for demographics, CD4 count, HIV viral load (VL), clinic site, and number of 2013 hospitalizations.

Results. Our sample of 1,634 patients was 73% male, 46% Black, 36% Hispanic; median age was 45 years (IQR 37,52) and median CD4 count 526 cells/μL (356, 716); 85% had a VL ≤400 copies/mL. Ninety-five patients were hospitalized in 2015. Unadjusted hospitalization rates (per 100 person years) were 8.4, 21.3, and 7.4 in 2013 and 6.3, 20.2, and 3.7 in 2015 for those who remained in RWP, switched to Medicaid, or switched to private, respectively. Switching to Medicaid or private was not associated with 2015 hospitalization rates (IRR 1.26 (95% CI 0.71–2.23) and 0.48 (0.18–1.28), table). Older age, CD4 <200, VL >400, and number of 2013 hospitalizations were associated with higher rates.

Conclusion. Among PWH relying on RWP in 2013, changing to either Medicaid or private insurance was not associated with a change in hospitalization rate. Among PWH, gaining inpatient coverage does not appear to increase inpatient utilization.

Incidence Rate Ratios for Hospitalization, 2015 (n = 1634)

Characteristic	IRR	95% CI
Insurance in 2015		
RWP	–	
Private	0.48	0.18–1.28
Medicaid	1.26	0.71–2.23
Gender		
Female	–	
Male or transgender	0.86	0.47–1.58
Race		
White or other	–	
Black	1.19	0.62–2.27
Hispanic	0.83	0.40–1.72
Age		
18–34	–	
35–44	0.91	0.45–1.83
45–54	1.51	0.75–3.07
55–64	2.18	1.08–4.41
Risk factor		
Heterosexual or other	–	
IVDU	1.77	0.68–4.60
MSM	1.68	0.92–3.05
CD4 count		
<200	5.0	2.60–9.61
200–499	1.26	0.71–2.22
≥500	–	
VL ≤400	0.55	0.32–0.94
No. of hospitalizations, 2013	1.97	1.44–2.68

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1907. Barriers at the Last Hurdle: Implementing Advance Care Planning for People Living with HIV

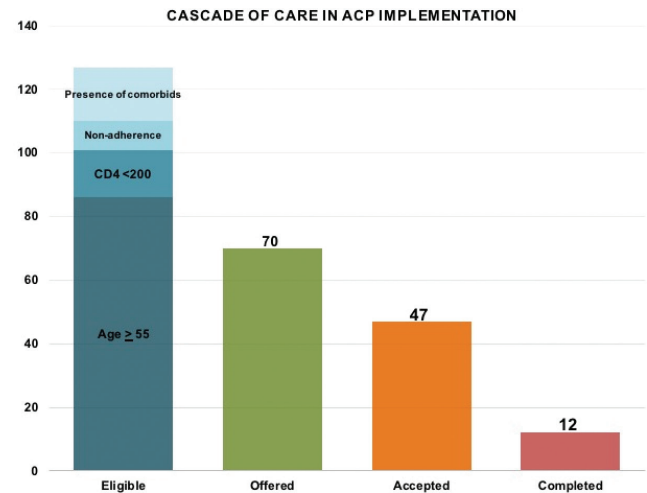
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Background. Advance care planning (ACP) is an increasingly relevant clinical practice as the HIV epidemic ages. In addition to a “graying” cohort of stable people living with HIV (PLHIV), late presentations predominate among newly-diagnosed older people in Singapore. Despite the availability of antiretroviral therapy (ART), prognosis remains guarded in these late presenters and PLHIV with poor adherence for whom ACP is more urgently needed. We sought to evaluate ACP implementation using a cascade-of-care model and determine barriers to its completion among PLHIV receiving care in an HIV specialty clinic.

Methods. Eligible PLHIV were identified during multidisciplinary meetings of the National University Hospital's HIV care team from January 2016 to December 2017. Eligibility was based on any of the following: age ≥55; current CD4 <200; ART nonadherence; or comorbidities potentially contributing to reduced life expectancy. ACP was offered to eligible PLHIV by their primary HIV doctor. If accepted, trained ACP facilitators continued the process of communication between PLHIV, doctors and loved ones. The process was completed with documentation of an agreed plan for future medical decisions, incorporating patient's personal beliefs and goals, and with a nominated healthcare spokesperson.

Results. Among 432 PLHIV screened, 127 (29.4%) were eligible for ACP. Of these, 70 (55.1%) were offered, 47 (37.0%) accepted, and 12 (9.4%) completed ACP. Majority (38, 80.9%) who accepted ACP were ≥55 years old. Most were male (43, 91.4%) and of Chinese ethnicity (72%). We found no significant differences between those who were offered, accepted and completed ACP.



Barriers were examined via root cause analysis. Social stigma surrounding death (cultural beliefs) and HIV (isolation, fear of disclosure, lack of a potential spokesperson) were the major patient-centered barriers to ACP. Time constraint was the main healthcare provider-centered factor.

Conclusion. Fewer than 10% of eligible PLHIV completed ACP. Interventions to address barriers along the cascade are urgently needed to ensure that the increased life expectancy of PLHIV translates into increased opportunities for ACP. All healthcare providers should dedicate time, address stigma and correct misconceptions by incorporating ACP discussions into the routine care of PLHIV.

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1908. Development of an Electronic Health Record Generated Alert for Prophylaxis Against Pneumocystis Jirovecii Pneumonia in the Setting of High-Dose Steroids

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