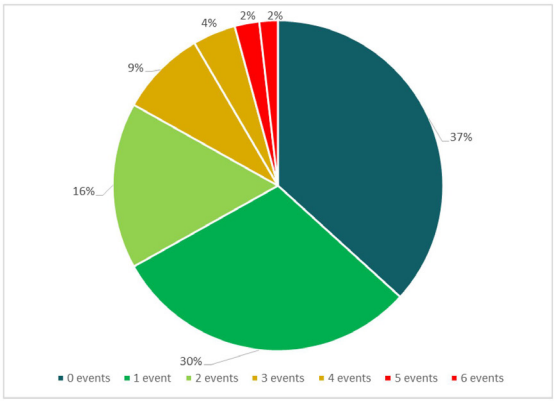

Figure 3: Pie chart showing number of events of disengagement among patients active in care at end of study period

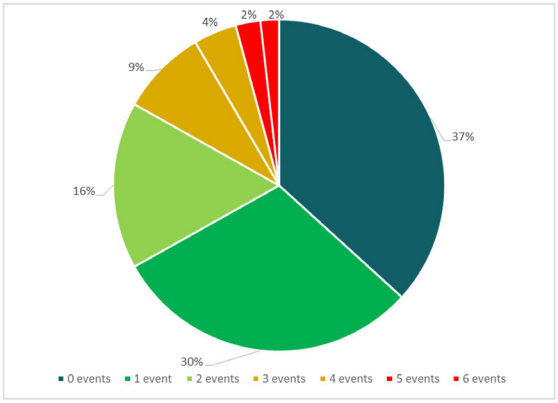

Figure 4: Pie chart showing number of events of disengagement among patients active in care at end of study period

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

1320. HIV Care Continuum Outcomes Among Newly Diagnosed PLWH in Washington, DC

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Friday, October 4, 2019: 12:15 PM

Background. In 2019, the US Administration announced the *Ending the HIV Epidemic* plan to decrease new infections. A key component is the Test and Treat plan to diagnose early, treat rapidly and achieve viral suppression (VS) among persons living with HIV (PLWH). We assessed retention in care (RIC), antiretroviral therapy (ART) initiation and VS among newly diagnosed PLWH in Washington, DC.

Methods. We conducted a cross-sectional analysis using data from the DC Cohort, an observational longitudinal cohort of PLWH in care in 14 clinics in DC. We included participants enrolled from 2011 to 2016 whose HIV diagnosis was within 1 year of enrollment and with at least 12 months follow-up. RIC was defined as ≥2 visits or HIV lab results 90 days apart in the first year of follow-up. ART initiation was defined as being prescribed ART, VS was defined as HIV RNA <200 copies/mL, and both these outcomes were assessed at 2 time points: by 3 and 12 months. Adjusted multivariable logistic regression was used to identify clinical and sociodemographic factors associated with RIC, ART initiation and VS.

Results. Among the 455 newly diagnosed participants (6% of all enrollees), median age was 33 years (IQR 25, 45), 69% were Black, 79% male, 60% MSM. Median duration of HIV at enrollment was 4.9 months (IQR 2.3, 7.7). Median nadir CD4 count was 346 cells/μL (IQR 224, 494). Of the 455, 38% had a history of AIDS, 92% were RIC, 65% initiated ART by 3 months and 17% had VS by 3 months. There were no differences by sex or race for RIC, ART initiation and VS. An AIDS diagnosis at enrollment was associated with RIC (aOR 2.28; 1.01–5.15), ART initiation by 3 months (aOR 2.41; 1.54–3.76), and VS by 12 months (aOR 1.92; 1.06–3.46). Lower nadir CD4 (aOR 0.89 per 50 cell increase; 0.84–0.94) and younger age (aOR 0.747 per 10-year increase; 0.584–0.995) were associated with ART initiation by 12 months.

Conclusion. Although the majority of newly diagnosed PLWH were RIC, fewer started ART or achieved VS. With a large proportion of our sample having an AIDS diagnosis at enrollment, we illustrate the ongoing challenge of late HIV diagnosis in DC. Those with AIDS at diagnosis were more likely to initiate ART within the first 3 months. As same-day ART initiation is scaled up in DC, future research can evaluate if all PLWH, regardless of AIDS status, will achieve this milestone earlier.

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

1321. Trans Females Receiving Gender-Affirming Surgical Referrals are More Likely to Have Durable Virologic Suppression at Whitman-Walker Health, 2008–2017

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Background. Trans females bear a disproportionate burden of HIV infection yet little is known about their HIV care continuum participation. We characterized the care continuum among trans female people with HIV (PWH) at Whitman-Walker Health (WWH) in Washington, DC and explored the impact of gender-affirming care on continuum participation.

Methods. This IRB-approved review from 2008 to 2017 analyzed trans female and nontrans PWH cohorts. Trans females were selected via self-identification and chart review, based on hormone prescription or narrative charting. Chi-square analysis was performed to examine associations between gender identity and demographic factors, comorbidities, and achieving steps in the care continuum. Bivariate analysis using chi-square test of independence and point-biserial correlation was performed between predictor and outcome variables in the care continuum. Multivariate logistic regression analysis was performed to identify predictors of poor outcomes in the care continuum.

Results. We analyzed 219 trans female and 456 nontrans PWH (Figure 1). Trans female PWH were more likely to be Black and/or Hispanic, have unstable housing, and be publically insured when compared with nontrans PWH (Table 1). There was no difference in ART initiation, retention in care (RiC), or durable virologic suppression (DVS) <200 copies/mL based on gender identity (Figure 2). Nontrans PWH had a higher odds of DVS at lower limits of detection (LLOD) than trans female PWH (OR 1.59, 95% CI 1.15–2.20). Hormone prescription did not impact trans female PWH continuum participation (Table 2). Surgical referral was found to impact DVS < 200 (P = 0.036) and DVS < LLOD (P = 0.021), but multivariate modeling could not be performed. Trans female PWH with surgical referrals were more likely to achieve DVS < 200 (OR 3.57, 95% CI 1.02–12.23) and DVS < LLOD (OR 2.85, 95% CI 1.14–7.12).

Conclusion. This novel analysis of gender-affirming care and the HIV care continuum shows trans female PWH were less likely than nontrans to achieve durable VS < LLOD. Trans female PWH who received surgical referrals were 3.5 times more likely to achieve durable VS < 200 and almost three times more likely to achieve durable VS < LLOD. Further research is needed to explore this association between surgical referrals and DVS among trans female PWH.

Figure 1. Cohort Attrition

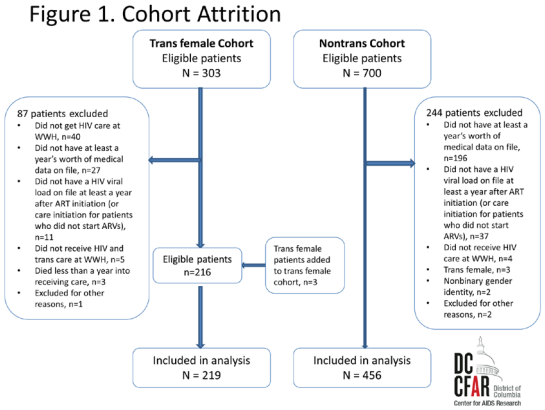

Fig. 2: HIV Care Continuum, WWH, 2008-2017