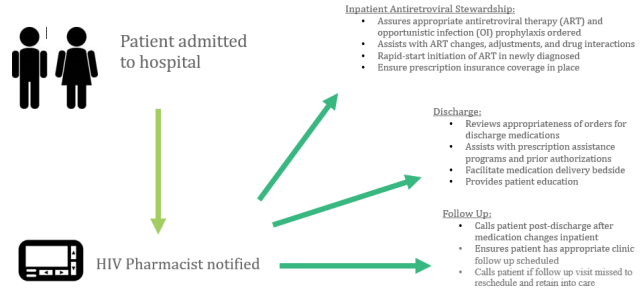
of this program, rapid-start initiation of antiretroviral therapy (ART) was not implemented prior to discharge. The purpose of this study was to evaluate the impact of a pharmacist-driven antiretroviral stewardship and transitions of care service in persons living with HIV/AIDS (PLWHA).

Methods. This was a retrospective pre- and post-analysis of PLWHA hospitalized at University of Illinois Hospital (UIH). Patients included were adults following at UIH outpatient clinics for HIV care admitted to UIH for acute care. Data were collected between April 19, 2017 and October 19, 2017 for the pre-implementation phase, and between July 1, 2018 and December 31, 2018 for the post-implementation phase. The post-implementation phase included an HIV-trained clinical pharmacist (Figure 1). Primary and secondary endpoints included follow-up rates at UIH outpatient HIV clinics, 30-day readmission rates, and access to medications at hospital discharge. Statistical analysis included descriptive statistics and Fisher's Exact test.

Results. A total of 119 patients were included in the analysis, 66 in the pre-implementation phase and 53 in the post-implementation phase. Patients included were mostly black males with median age of 48. In the pre-implementation phase 50 out of 65 (77%) patients attended follow-up visits for HIV care at UIH outpatient clinics, vs. 42 out of 47 (89%) patients in the post-implementation phase ($P = 0.1329$). Thirty-day readmission occurred in 17 of 62 (27%) patients in the pre-implementation phase vs. 5 of 52 (10%) of patients in the post-implementation phase ($P = 0.0183$). During the post-implementation phase, the HIV pharmacist secured access of ART and opportunistic infection medications prior to discharge for 22 patients (42%), 2 of which were new diagnoses.

Conclusion. A pharmacist-led antiretroviral stewardship and TOC program led to a decrease in 30-day readmission rates in PLWHA. Although not significant, the HIV-pharmacist led to higher rates of clinic follow-up. Finally, the HIV-pharmacist helped secure access to ART and initiate rapid-start therapy in newly diagnosed patients prior to leaving the hospital.

Figure 1. Role of the HIV-Pharmacist



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

1310. The Impact of Recent Incarceration on Post-Release HIV Linkage to Care and Risk-Taking Behaviors in the Setting of Enhanced Linkage to Care Policies in Florida

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Background. The United States has the largest incarcerated population in the world with 6.61 million adults in 2016.[1] While incarceration is a known risk factor for difficulties in linkage to care[2–3] and adverse health outcomes[4–6], little is published on post-release incarcerated persons living with HIV (PLWH) in Florida.

Methods. Data were acquired from the Florida Cohort, an ongoing, longitudinal, cross-sectional study of PLWH recruited across HIV clinics in the state of Florida, from 2014 to 2018. Chi-square and multiple regression analyses correlated recent incarceration (within last 12 months) with demographics, HIV care adherence, perceived barriers to care, and self-reported high-risk behaviors.

Results. Of 936 participants, 6.4% ($n = 60$) reported recent incarceration within the last 12 months. Those recently incarcerated were more likely to report missing at least one appointment in the last 6 months (46.7% vs. 22.2%; $P < 0.0001$), to have an excessively long travel time (>60 minutes) to a HIV provider (34.5% vs. 16.6%, $P = 0.002$; OR 2.66 [95% CI: 1.20–5.92]), and to lack reliable transportation (70% vs. 47.5%, $P = 0.0007$; OR 1.70 [95% CI: 0.82–3.52]) Those not recently incarcerated reported having completed a high school education (OR: 0.69 [95% CI: 0.5–0.97]) and stated they "never missed an appointment" (OR: 0.42 [95% CI: 0.22–0.81]). Recently incarcerated PLWH also had higher occurrence of high-risk behaviors such as receiving (40.4% vs. 8.7%; $P = 0.001$) or providing (30.4% vs. 10.4%; $P = 0.000$) money or drugs for sex, having used IV drugs (15% vs. 4%; $P = 0.001$), and not using condoms during exchange of drugs for sex (OR: 9.43 [95% CI: 3.78–23.52]).

Conclusion. Recently incarcerated PLWH continue to have significant geographical and logistical barriers to care and self-report more high-risk behaviors than nonincarcerated peers. Enhanced case management and telehealth services may be useful in linkage to care when PLWH transition from correctional to community healthcare systems in the Florida setting.

Table 1. Demographics of Incarcerated vs Non-incarcerated Persons Living with HIV (PLWH) in Central Florida.

	Incarceration?		
	Yes N=60	No N=876	p-value
Gender			
Male	48 (81.4)	553 (63.6)	**0.0271**
Female	10 (17.0)	298 (34.3)	
Transgender	1 (1.7)	16 (1.8)	
Other	0 (0.0)	2 (0.2)	
Ethnicity			0.1713
Hispanic	8 (13.3)	181 (20.7)	
Non-Hispanic	52 (86.7)	695 (79.3)	
Race			0.2416
White	19 (31.7)	277 (31.7)	
Black	36 (60.0)	510 (58.4)	
Native American	2 (3.3)	4 (0.5)	
Asian	0 (0.0)	5 (0.6)	
Multi Race	1 (1.7)	42 (4.8)	
Other	2 (3.3)	36 (4.1)	
US born?			0.0861
No	5 (8.3)	146 (16.8)	
Yes	55 (91.7)	724 (83.2)	
Marital status			0.9348
Married	3 (5.0)	71 (8.1)	
Divorced	8 (13.3)	138 (15.8)	
Widowed	3 (5.0)	37 (4.2)	
Separated	4 (6.7)	55 (6.3)	
Single/never married	36 (60.0)	473 (54.2)	
Living with partner	6 (10.0)	99 (11.3)	
Sex preference			0.2739
Heterosexual	34 (58.6)	436 (51.8)	
Homosexual	15 (25.9)	310 (36.8)	
Bisexual	8 (13.8)	82 (9.7)	
Other	1 (1.7)	14 (1.7)	
Taking HIV meds currently			0.4936
No	7 (12.1)	83 (9.6)	
Yes	51 (87.9)	785 (90.4)	
Believes HIV meds have positive effect			0.3840
Not at all	4 (7.8)	56 (7.3)	
Somewhat	12 (23.5)	128 (16.6)	
Very positive	35 (68.6)	586 (76.1)	

	Incarceration?		
	Yes N=60	No N=876	p-value
Has HIV Healthcare in Place			0.8249
No	5 (8.3)	87 (10.1)	
Yes	55 (91.7)	776 (89.9)	
HIV missed appointments			**<0.0001**
No	32 (53.3)	672 (77.8)	
Yes	28 (46.7)	192 (22.2)	
HIV case manager			0.7767
No	8 (14.6)	130 (16.0)	
Yes	47 (85.5)	683 (84.0)	
Primary Care Provider (PCP)			0.5507
No PCP	13 (22.4)	164 (19.3)	
Different from HIV Provider	18 (31.0)	227 (26.7)	
Same as HIV Provider	27 (46.6)	458 (54.0)	
Refused treatment?			0.5626
Never	51 (86.4)	769 (89.6)	
Once	6 (10.2)	58 (6.8)	
Twice	1 (1.7)	19 (2.2)	
Three more	1 (1.7)	12 (1.4)	
Transportation			**0.0007**
No car	42 (70.0)	416 (47.5)	
Having car	18 (30.0)	460 (52.5)	
Completed High School, mean	2.7 (0.9)	3.2 (1.2)	**0.0001**
Time to Acquiring HIV Care, median (in months)	1 (1 – 7)	2 (1 – 5)	**0.0074**
HIV meds directed			**0.0118**
Never	1 (2.0)	12 (1.6)	
Rarely	1 (2.0)	13 (1.7)	
Sometimes	2 (3.9)	15 (1.9)	
Usually	7 (13.7)	26 (3.4)	
Almost always	13 (25.5)	174 (22.5)	
Always	27 (52.9)	533 (69.0)	
HIV provider distance			**0.0024**
<30 min	20 (34.5)	395 (45.7)	
30 – 60 min	18 (31.0)	326 (37.7)	
>60 min	20 (34.5)	143 (16.6)	
Adherence to Anti-Retroviral Therapy (ART)			0.3549
No	35 (58.3)	457 (52.2)	
Yes	25 (41.7)	419 (47.8)	

	Incarceration?		
	Yes N=60	No N=876	p-value
Sexual Experience Uninvited			0.0942
Never	44 (74.6)	717 (83.9)	
Once	4 (6.8)	46 (5.4)	
Twice	2 (3.4)	35 (4.1)	
Three or more	9 (15.3)	57 (6.7)	
Sexual Experience with Bad Person			0.0817
Never	42 (71.2)	708 (82.6)	
Once	10 (17.0)	75 (8.8)	
Twice	2 (3.4)	31 (3.6)	
Three or more	5 (8.5)	43 (5.0)	
IV drug use			**0.0002**
No	42 (71.2)	715 (86.8)	
Yes but in past 12 months	9 (15.3)	34 (4.1)	
Yes but not in past 12 months	8 (13.6)	75 (9.1)	
Anal or Vaginal Sex Number, median	1 (0 – 7)	1 (0 – 8)	0.0725
Anal or Vaginal Sex Number with condom, median	0 (0 – 6)	0 (0 – 7)	0.1414
Sex partner with HIV positive			0.5445
No	23 (48.9)	379 (56.0)	
Yes but condom always	12 (25.5)	132 (19.5)	
Yes but not condom always	12 (25.5)	166 (24.5)	
Sex partner with HIV status unknown			0.4054
No	31 (68.9)	460 (69.2)	
Yes but condom always	6 (13.3)	125 (18.8)	
Yes but not condom always	8 (17.8)	80 (12.0)	
Sex partner received drugs			**<0.0001**
No	28 (59.6)	611 (91.3)	
Yes but condom always	9 (19.2)	35 (5.2)	
Yes but not condom always	10 (21.3)	23 (3.4)	
Sex partner provided drugs			**<0.0001**
No	32 (69.6)	602 (89.6)	
Yes but condom always	6 (13.0)	39 (5.8)	
Yes but not condom always	8 (17.4)	31 (4.6)	
Diagnosed with Sexually Transmitted Disease			0.7198
No	50 (83.3)	745 (85.1)	
Yes	10 (16.7)	131 (15.0)	

Table 2. Odds Ratio Estimates for Incarcerated Persons Living with HIV (PLWH) compared to non-incarcerated PLWH.

Event	Odds Ratio (95% Confidence Intervals)
Never Missed Appointment with HIV provider	**0.42 (0.22-0.81)**
Lack of transportation	1.70 (0.82-3.52)
"30-60 minutes" distance from HIV provider	0.87 (0.38-1.95)
">60 minutes" distance from HIV provider	**2.66 (1.20-5.92)**
Received illicit drugs from partners and using condoms	**3.67 (1.51-8.95)**
Received illicit drugs from partners and not using condoms	**9.43 (3.78-23.52)**
Completed high school education	**0.69 (0.50-0.97)**

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

1311. Ryan White HIV Care Continuum Model Doubled the Rate of Community HIV Viral Suppression for Newly Diagnosed Patients: A 10-Year Review

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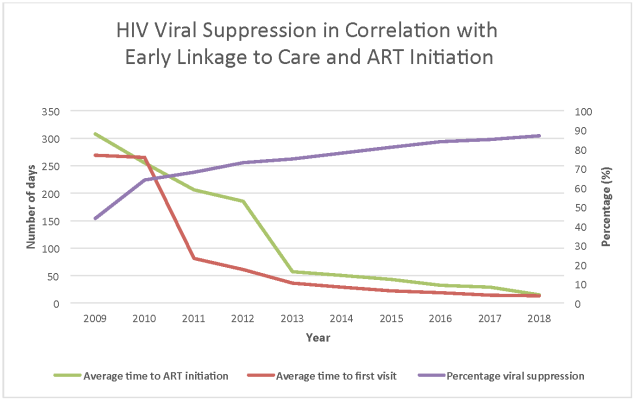
Background. It is estimated that 1,295 per 100,000 are people living with HIV (PLWH) in New Haven, which is the second highest rate of HIV prevalence in Connecticut. Since 2009, New Haven has established the Ryan White (RW) HIV Care Continuum. The main goals of HIV care are early linkage to care, ART initiation, and HIV viral suppression. This study is designed to understand the trends and outcomes in newly diagnosed PLWH in New Haven County.

Methods. This study is a retrospective medical record review of all newly diagnosed RW eligible PLWH from January 1, 2009 to December 31, 2018. The data were collected in REDCap database and included demographics, HIV risk factor, presence of mental health and/or substance abuse disorder, date of diagnosis, date of initial visit, and ART initiation. Health outcomes such as AIDS at diagnosis and rate of viral suppression were evaluated. The data were then analyzed to show the trends over 10 years.

Results. From January 1, 2009 to December 31, 2018 there were 420 newly diagnosed RW PLWH. Sixty-seven percent of those were male, 56% were non-white, 47% self-identified as Men who have Sex with Men (MSM), and 41% were heterosexual. Twenty-nine percent had AIDS-defining condition at the time of the diagnosis. Thirty-four percent of the 420 patients had a mental health and/or substance use disorder; 53% of those were MSM and 51% were non-white. Over the 10-year period, it was noted that the duration between date of HIV diagnosis and linkage to care as well as ART initiation decreased. This decline was associated with a substantial increase in viral suppression. The average time between the dates of HIV diagnosis and initial visit decreased from 269 days in 2009 to 13 days in 2018. Moreover, the average time between the dates of diagnosis and ART initiation dropped from 308 days in 2009 to 15 days in 2018. The 1-year HIV viral suppression rate subsequently doubled from 44% in 2009 to 87% in 2018 ($P < 0.01$).

Conclusion. The Ryan White HIV Care Continuum Model with emphasis on early linkage to care and ART initiation can have a significant impact on HIV viral suppression at a community level for newly diagnosed patients. Another important observation in this study was the alarming high rate of AIDS at diagnosis, which highlights the need for universal HIV testing, and early diagnosis.



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

1312. Increasing Care Engagement Amongst People Living with HIV Through a Text Messaging Intervention at a Tertiary Center

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Background. HIV has transitioned from an acute illness to a chronic disease due to potent antiretroviral therapy (ART). People living with HIV (PLWH) must be highly compliant which is difficult due to multiple barriers. The HIV care continuum was developed as a series of steps that PLWH take in their treatment cascade. At our HIV clinic, 90% of the patients are virally suppressed (viral load <200 copies/mL). Although this is higher than the national average, PLWH who are not virally suppressed and not retained in care carry the highest risk of transmission. We have several resources to engage patients, but text messaging has not been utilized for at-risk patients at the clinic or at the academic center.

Methods. The aim is to demonstrate that a pilot study of a text messaging-based intervention will increase the proportion of PLWH along the care continuum. The pre-intervention data consists of the clinic population with a viral load ≥200 copies/mL between July 1, 2017 and June 30, 2018. After chart review, eligible patients were consented to receive weekly text messages with content regarding appointment and medication reminders, and motivational messages. In the consented group, effectiveness of the intervention will be measured by tracking their appointments, viral loads, and ART prescriptions.

Results. After chart review, 80 patients were eligible, and 18 patients were consented for the intervention. In the eligible group, the average length of care is 8 years (range 0 to 26) and average number of years since initial ART prescription is 6.8 (range 0 to 20). The average viral load is 27,372 copies/mL. Amongst the consented group ($n = 18$), compared with the pre-intervention, there was a 6% increase in those who made an appointment, 33% increase in those who kept an appointment, 50% increase in those who had a viral load <200, and 62% increase in those who had ART dispensed post-intervention.

Conclusion. The intervention group is small due to difficulties in consenting this vulnerable population. This is an observational study that demonstrated the impact of text messaging a high-risk population with minimal harm that not only improved the local HIV care continuum, but also addressed the barriers to care. The next steps are to determine how this method can link other at-risk patients to care at a large HIV clinic at a tertiary center.