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 naïve 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 resulted 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 1st viral load	17	75	125
Median (IQR) at 1st 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 1st viral load	58.6%	25.8%	15.6%
Time to 2nd viral load	51 (45-117)	55 (36-81)	38 (32-69)
Population size at 2nd viral load	14	37	18
Median (IQR) at 2nd 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 2nd viral load	5.6%	41.0%	53.4%

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

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)

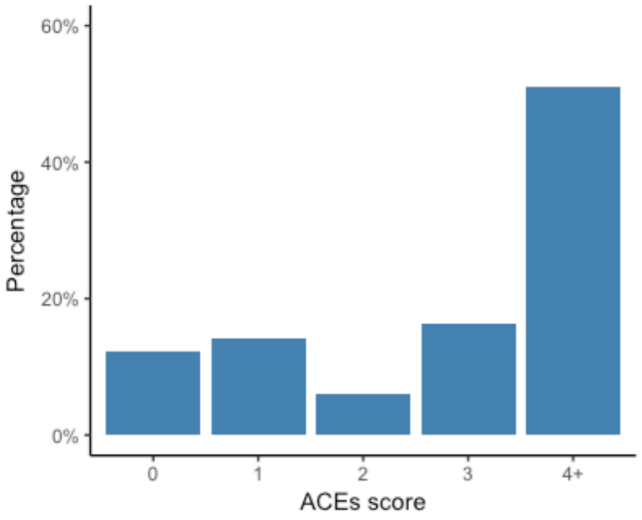
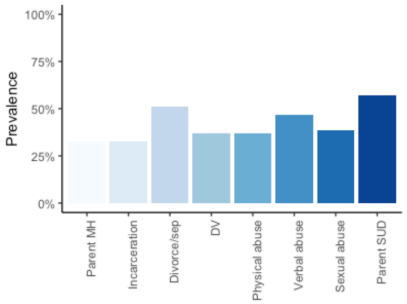


Fig 2. ACEs Prevalence by Experience Type (n=49)



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

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

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

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Background. While Germany has a long tradition in HIV research with many well-established regional cohorts, there was a lack of collaborative efforts toward harmonized data collection and biobanking, both key strategies for efficient translational research projects. Key challenges are heterogeneity of data systems and privacy concepts, of existing study and data collection protocols, and sample collection, storage, and sharing.

Methods. In 2013, we established the Translational Platform HIV (TP-HIV) with support of the German Centre for Infection Research (DZIF) as a collaboration between university hospitals and specialized HIV care centers throughout Germany. After assessing the individual needs of all partner sites, we have taken comprehensive action to create a common platform for collaboration in all research stages. We developed protocols, rules of operation, biobanking strategies, and privacy concepts for all collaborating partner sites. Patients infected with HIV (PLWH) who sign the informed consent for the TP-HIV are pro- and retrospectively included in the cohort.

Results. To date, the TP-HIV infrastructure is implemented at 27 member sites from 11 cities, potentially extending to more than 20,000 patients currently treated for HIV across Germany. Facing the special needs in the German research environment, the TP-HIV established a unique data- and biomaterial collection allowing expedited translational research and reduce project overheads, regulatory burden, and data security regulations for investigators. By active surveillance, rapid access to individual patient groups such as patients with acute HIV infection, TP-HIV is an ideal platform for early phase clinical trials with new drug candidates. Researchers with clinical, biological, epidemiological, and statistical expertise have been brought together within the TP-HIV, which enables an effective translational chain from bench to bedside and back. New collaborations have been established with currently 23 active study protocols.

Conclusion. The TP-HIV has demonstrated to be a powerful tool for generating and testing research hypotheses in PLWH. In the future, we will work to further expand our network and address the pressing needs in the German research environment.

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

1270. Population-Based Estimates of PrEP Access in Oregon, 2012–2016

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Background. PrEP is an important HIV prevention modality. Population-based metrics of PrEP uptake and access are critical to the evaluation of public health efforts to increase PrEP use.

Methods. Using the Oregon All Payers All Claims administrative dataset, we determined the number of unique individuals at least 16 years of age starting PrEP, defined as at least one prescription of >30 days of Truvada, each year from 2012–2016. People with HIV or hepatitis B were excluded. We created two metrics of PrEP access in 2016: the number of individuals starting PrEP per 100K population and the number of individuals with a PrEP prescription in each of the four quarters of 2016 per 100K population (i.e., prevalent users). Using public health surveillance data, we created three metrics of PrEP need in 2016: the number of HIV diagnoses per 100K population; the number early syphilis and gonorrhea diagnoses per 100K population; and the number of acute or chronic hepatitis C diagnoses among patients aged 16–30 years per 100K population. We calculated six metrics of PrEP access-to-need by dividing each of the access measures by the need measures.

Results. The number of individuals with a new PrEP prescription increased from 8 in 2012 to 571 in 2016. Most new PrEP users were men, aged 25–34 years, identified as white, lived in an urban area, had commercial insurance, and had an internal medicine PrEP prescriber. In 2016, there were 17.2 PrEP starts and 9.9 individuals with a PrEP prescription in all four quarters of 2016 per 100K population. There were 6.7 HIV cases, 136.0 early syphilis and gonorrhea cases, and 109.1 acute and chronic hepatitis C cases per 100K population. Per HIV diagnosis, there were 2.6 PrEP starts and 1.5 prevalent users. However, there were 0.13 PrEP starts and 0.07 prevalent users per early syphilis and gonorrhea diagnosis and 0.16 PrEP starts and 0.09 prevalent users per hepatitis C diagnosis. Women, people aged 16–24, people of color, and people in rural areas experienced lower PrEP access-to-need.

Conclusion. Access metrics based on prevalent users (a measure of longer-term adherence to PrEP), STI diagnoses (a measure of HIV acquisition risk), and HCV diagnoses among those less than 30 years of age (a measure of need among people who inject drugs) may provide a more complete assessment of PrEP access-to-need than those based on PrEP starts and HIV diagnoses.

Figure. Number of PrEP starts per year, Oregon, 2011-2016.

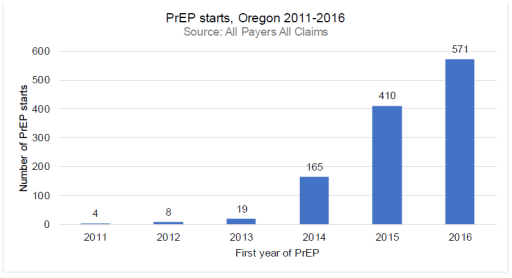

Table. PrEP access to PrEP need by selected characteristics, Oregon, 2016.

	PrEP starts per HIV diagnosis	PrEP starts per STI diagnosis	PrEP starts per HCV diagnosis[a]	Prevalent users per HIV diagnosis	Prevalent users per STI diagnosis	Prevalent users per HCV diagnosis[a]
Overall	2.6	0.13	0.16	1.5	0.07	0.09
Sex/gender						
Men	2.7	0.18	0.28	1.6	0.11	0.17
Women	1.4	0.02	0.02	0.4	0.01	0.01
Age						
16-24	2.1	0.05		0.7	0.02	
25-34	3.4	0.14		1.6	0.06	
35-44	2.3	0.17		1.6	0.11	
45-54	2.2	0.23		1.8	0.19	
55+	1.8	0.25		1.3	0.18	
Race/ethnicity[b]						
Hispanic, anyrace	0.3	0.02	0.12	0.1	0.01	0.03
Non-Hispanic white	0.8	0.04	0.05	0.6	0.03	0.04
Non-Hispanic black	0.7	0.02	0.27	0.3	0.01	0.11
American Indian/Alaskan Native	0.5	0.03	0.05	0	0	0
Asian	0.6	0.06	0.16	0.2	0.02	0.06
Native Hawaiian/Pacific Islander	0	0	0	0	0	0
Region						
Portland metro area	3.5	0.17	0.33	2.1	0.10	0.19
Balance of state	1.2	0.06	0.05	0.6	0.03	0.03

PrEP, pre-exposure prophylaxis; HCV, hepatitis C virus; STI, sexually transmitted infection (includes early syphilis and gonorrhea).

[a]Among people aged 16-30 years.

[b]Based on 27% of sample with complete race/ethnicity data.

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

1271. Pre-Exposure Prophylaxis (PrEP) Awareness and Uptake Between Men Who Have Sex with Men and Men Who Have Sex with Men and Women

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Background. Men who have sex with men are disproportionately impacted by HIV in the United States and may benefit most from pre-exposure prophylaxis (PrEP). However, differences may exist between men who only have sex with men (MSM) and men who have sex with both men and women (MSMW). MSMW may experience more barriers to accessing PrEP and may act as a potential bridge population for transmitting HIV to female sex partners. Differences in PrEP awareness and use between MSM and MSMW are unknown.

Methods. We evaluated all MSM and MSMW presenting to the Rhode Island Sexually Transmitted Diseases (STD) clinic and PrEP clinic from 2013–2017. Demographics and behavioral information were reviewed. Bivariate analyses were performed to present distributions of demographic and behavioral characteristics by sexual behavior. Logistic regression was conducted to explore associations between PrEP awareness/use and sexual behavior. Confounding variables were identified using the directed acyclic graphs (DAGs) and *a priori*.

Results. Of 1,795 male individuals, 84% (1,504) were MSM, and 16% (291) were MSMW. The median age of our study population was 29 (interquartile range [IQR]: 23–42). When compared with MSM, MSMW were more likely to be non-White (33% vs. 28%), uninsured (54% vs.46%), self-report more sexual partners in the past 12 months (median 6 [IQR: 3–9]: vs. 4 [IQR:2–10]), use intranasal cocaine (21% vs. 12%), and engage in selling (6% vs. 2%) or buying sex (12% vs. 4%, all $P < 0.05$). MSMW were also less likely to have a previous HIV test (77% vs. 89%) compared with MSM. MSMW were 59% (adjusted odds ratio [aOR]: 041, 95% confidence interval [CI]: 0.31–0.55) less likely to be aware of PrEP and 17% (aOR: 0.83, 95% CI: 0.41–1.66) less likely to report ever using PrEP after adjusting for age, race/ethnicity, and self-reported HIV risk.

Conclusion. Despite engaging in higher risk behaviors, MSMW were significantly less likely to be aware of or use PrEP compared with MSM. Future PrEP interventions are needed to target this potentially high-risk bridge population.

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

1272. Feasibility and Successful Enrollment in Proof-of-Concept Trials to Assess Safety and Efficacy of a Broadly Neutralizing Monoclonal Antibody, VRC01, to Prevent HIV-1 Acquisitionin in Uninfected Individuals

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