Results. 22 patients with median age of 74 years old were identified, only three pediatric cases. The average time of acquired influenza was at 13th day of hospitalization. In 77% Influenza A was the only agent detected and 27% had respiratory co-infection. Thirteen (59%) were previously hospitalized in CIU, but only 2 (15%) due to respiratory problems. Nineteen patients (86%) presented comorbidity such as arterial hypertension (59%), chronic kidney disease (18%), and immunosuppression (18%). Half of them had a decapensation, mainly respiratory, associated to influenza infection. The observed lethality was 18%. Among all the influenza HAI, 59% occurred in unvaccinated patients, although 46% of them met criteria for vaccination recommendation.

Conclusion. HAI due to influenza occurred in chronic, older, and unvaccinated patients. Education about HAI’s and continuing high vaccination coverage must be a priority.

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1265. Application of the ALERT Influenza Trigger for Enhanced Prevention Activities
Lisa Yeach, MD, FACP, FSHEA1; Julie Gibbons, BSN, RN2; Katarina Smolka, BS2 and Verna Ramachandran, MD3;1;UnityPoint Health, Des Moines, Iowa, USA;2Regis University, Denver, Colorado
Session: 139. Healthcare Epidemiology: Outbreaks
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Background. Accurate prediction of the onset of increased influenza activity in a healthcare setting can allow for optimal use of enhanced prevention activities. The ALERT (Above Local Elevated Respiratory Illness Threshold) algorithm, described by Reich et al. (2015), utilizes historical weekly case counts of laboratory-confirmed influenza infections to set a trigger point of cases/week that anticipates elevated disease incidence. This can then be used in real-time, during subsequent influenza seasons, for initiation of enhanced prevention, including masking by nonvaccinated healthcare workers.

Methods. Historical data collected from UnityPoint Health-Des Moines (3-hospital, 800-bed system), between 2011 and 2014, was analyzed using the ALERT method (Reich et al. 2015) to set a threshold number of diagnosed influenza cases per week to predict the start of the influenza season. Each following year the threshold was re-analyzed, adding the most recent year's data to the historical data set. Our goal was to capture at least 80% of influenza cases within our "ALERT period," without prolonging the duration of heightened prevention efforts.

Results. For the initial year of real-time application (2015–2016), the threshold was defined as seven cases. In subsequent years, the threshold was 5. Compared with the 3 years prior, use of the ALERT method resulted in more accurate and consistent identification of the influenza season, including anticipating the increase in cases and defining the total duration of the season.

**Influenza Season Metrics**

| Year   | Onset Date of Enhanced Prevention | Total Cases per Season | Percent of Cases Captured | Duration of Alert Period (Weeks) |
|--------|----------------------------------|------------------------|---------------------------|--------------------------------|
| 2012–2013 | N/A November 15, 2012 | 725 | 99% | 22 |
| 2013–2014 | N/A December 30, 2013 | 255 | 77% | 9 |
| 2014–2015 | N/A December 11, 2014 | 773 | 73% | 19 |
| 2015–2016 | ALERT Trigger Initiated | 250 | 87% | 13 |
| 2016–2017 | ALERT Trigger Initiated | 791 | 95% | 17 |
| 2017–2018 | ALERT Trigger Initiated | 1,445 | 98% | 20 |

*As of April 28, 2018.

Conclusion. The ALERT method utilizes health system specific historical data to more precisely define the period of high influenza incidence allowing for focused utilization of enhanced measures to prevent transmission. This results in a safer environment, optimal use of resources and improved employee and patient satisfaction.

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1266. Multifaceted Infection Control Strategies to Control Multidrug-Resistant Acinetobacter baumannii (MDR-AB) in a Adult Intensive Care Unit in a Tertiary Hospital in Eastern Region, Saudi Arabia
Ayman Gammal, American Board of Internal Medicine and Infectious Disease; Infection Prevention and Control, Ministry of National Guard Health Affairs Eastern Region – Al Ahsa, Al Ahsa, Saudi Arabia
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Background. Multidrug-resistant Acinetobacter baumannii (MDR-AB) has emerged globally to a significant pathogen in hospitals. During 2010, our hospital experienced an increase of MDR-AB in Adult intensive care unit (ICU). Our adult ICU is consists of 10 acute care beds. The hospital is a tertiary institution located in Eastern region of Saudi Arabia. Multidisciplinary team was formed to implement and determine the effect of multifaceted strategies in controlling MDR-AB.

Methods. Active surveillance culture (ASC) was initiated to determine the prevalence rate of MDR-AB per 1,000 patient-days (PD). Using ASC, which was done during admission in ICU, after 48 hours of admission and every week for all patients if there is a positive MDR-AB case, acquisition rate of MDR-AB was calculated per 1,000 PD.

Average daily colonization pressure was also monitored. In addition, a multifaceted infection control strategies were carried out. These include hand hygiene, contact isolation, cohorting of patients, Chlorhexidine bath, and environmental cleaning and disinfection. Compliance with hand hygiene was observed using direct observation method. We use the Fluorescent Gel Method for evaluating the thoroughness of disinfection and cleaning for environmental surfaces.

Results. Hand hygiene compliance of HCWs initially was 89%, in 2017 it increased to 98%. Daily Chlorhexidine bath was adopted for all patients in ICU. Initially, the compliance for thoroughness of disinfection and cleaning is 84.6% it was increased to 92% in 2013–2017. Prevalence rate of MDR-AB was 20.7/1,000 PD in 2010, it was decreased by 50% in 2011–2012. In 2017, declined to 0.9/1,000 PD. MDR-AB acquisition rate was 11.8/1,000 PD in 2010, it was decreased by 57% in 2011–2012. In 2017, dropped to 0.6/1,000 PD. Average daily colonization pressure was 0.21 in 2010. In 2011–2012, it was decreased by 31%. In 2017, it was reduced to 0.02. Death rate among MDR-AB patient in 2010 was 25.7%. It was decreased to 14% in 2011–2012. In 2017, an enormous drop to 0% was achieved.

Conclusion. Implementing these multifaceted strategies help in controlling MDR-AB in our hospital. The commitment and adherence of the HCW to all infection control strategies are essential in sustaining low prevalence rate and acquisition rate of MDR-AB.

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1267. Nonventilator Hospital Acquired Pneumonia (NV-HAP) Prevention Initiative in Colombia, Bogotá
Sandra Valderrama, Specialist in Infectious Diseases;1 Claudia Janneth Linares Miranda, NP2; Maria Juliana Soto, MD3; Estefania Mckinley, MD;4 Juan Pablo Morcillo, MD5; Juan Pablo Alarcon, MD6; Angela Patricia Gonzalez, NP7 and Leidy Gamba, Nurse;8 Infectious Diseases, Hospital Universitario San Ignacio, Bogotá, Colombia; Infections Diseases Hospital Universitario San Ignacio, Bogota, Colombia, Pontificia Universidad Javeriana, Bogota, Colombia, Pontificia Universidad Javeriana, Bogotá, Colombia
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Background. Pneumonia is the second most common healthcare-associated infection worldwide. Non ventilator – Hospital Acquired Pneumonia (NV-HAP) affects more people than VAP, has a comparable mortality rate (18.7% vs. 18.9%), and has higher total costs ($156 million vs. $86 million), respectively. The objective of this study was to describe the result of the implementation of a bundle of measures for the prevention of NV-HAP in adult patients in a University Hospital in Colombia.

Methods. Descriptive study in a period of 2 years, a care bundle for NV-HAP was implemented in adult patients in a university hospital that consisted of: (1) identification of patients at risk (patients over 60 years of age, or with altered consciousness, or swallowing disorder, or patients with tracheostomy), (2) marking the patient with a sticker on the head of the bed, and (3) implementation of the following measures: head of the bed elevation to 30°-45°, oral care every 12 hours, chlorhexidine oral rinse decontamination every 12 hours and aspiration of secretions as needed. In the first 6 months, training was carried out for all staff, the monthly adherence to the strategy was measured.

Results. During 2016, 1,045 patients were included, with 10,011 observations, bundle adherence during the first year was 33%. In the second year, 1,400 patients were included, with 13,198 observations, the bundle adherence increased to 90% throughout the hospital. The rate of NV-HAP decreased from 4.2 (96 cases) to 3.4 (89 cases) per 1,000 patient-days, in the second year compared with the previous intervention year.

Conclusion. The strategy of prevention of NV-HAP decreased the cases of nosocomial pneumonia in a university hospital, through the education a high adherence to the strategy was achieved. Studies with a better design should be done to confirm the findings.

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1268. Transmissibility of Candida auris by Type of Inpatient Healthcare Facility
Prabasaj Paul, PhD, MPH1; Kailit Forsberg, MPH2; Snigdha Vallabhaneni, MD, MPH; Shawn R Lockhart, PhD3; Anastasia P. Litvinseva, PhD;3 Janna L. Kerins, VMD, MPH4; Angela S. Tang, MPH5; Oluemini Igeode, MPH6; Patricia M. Barrett, NS5; Kathleen Ross, MPH7; Rachel Slayton, PhD, MPH7 and John A. Jernigan, MD8;1Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, 2Myocytic Diseases Branch, Centers for Disease Control and Prevention, Atlanta, Georgia, 3Centers for Disease Control and Prevention, Atlanta, Georgia, 4Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, 5Illinois Department of Public Health, Chicago, Illinois, 6Infectious Diseases, Detroit Medical Center/Wayne State University, Detroit, Michigan, 7New Jersey Department of Health, Trenton, New Jersey
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Background. Candida auris is a multidrug-resistant yeast causing outbreaks in healthcare settings. Stopping the spread and identifying the possible transmission of healthcare facilities at risk of higher transmission to help targeted implementation of infection control measures. We used data collected during public health investigations to quantify transmissibility of C. auris by type of healthcare facility.

Methods. In two states, 3,159 patient swabs were collected during 96 patient-days at 36 inpatient and intensive care facilities in November 2016.
and April 2018. We estimated facility transmissibility and facility reproduction number (number infected by one indexed patient per day, and per stay, respectively, at the facility) of C. auris based on estimated colonization pressure, a count of newly colonized patients between successive surveys at the same facility, and mean lengths of stay at facilities (estimated from CMS administrative data). The results were summarized by facility transmissibility (ACH), long-term acute care hospital (LTACH), or a ventilator unit at skilled nursing facility (VSNF), and were compared with previous estimates for transmissibility of carbapenem-resistant Enterobacteriaceae (CRE).

**Results.** Swabs were collected from 13 ACHs, 12 LTACHs, and 11 VSNFs. The C. auris facility reproduction number may exceed the critical value of 1 in both ACHs and VSNFs, and may exceed that for CRE in ACHs (table).

**Conclusion.** Transmissibility of C. auris is comparable to that of CRE. The transmissibility within VSNFs emphasizes their potential role as amplifiers in the outbreak. Understanding transmissibility by facility type helps evaluate the potential impact of interventions in various settings.

### Table: Transmissibility of C. auris by Facility Type

| Facility Type | C. auris Reproduction Number (per Day) | CRE Transmissibility* | CRE Reproduction Number† |
|---------------|---------------------------------------|-----------------------|--------------------------|
| ACH           | 0.218 (0.215–0.221)                   | 1.05 (1.04–1.07)      | 0.95 (0.93–1.00)         |
| LTACH         | 0.035 (0.019–0.045)                   | 0.73 (0.40–0.97)      | 0.44 (0.36–0.53)         |
| VSNF          | 0.019 (0.014–0.023)                   | 1.05 (0.70–1.27)      | 1.05 (1.03–1.07)         |

*Previous estimates (Poster 429, SHEA 2018). for comparison.

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1269. HIV Testing in a Large Community Health Center Serving a Multi-cultural Population: A Qualitative Study of Providers

Anthony James, BA; Rodney Thomas, MA; Danielle Marable, MA; Caroline Cubbin, MD; Andrew Tarbox, BA; Sarah Ow, MSW; Kenneth Freedberg, MD, MSc; and Julie Levison, MD, MPH, MPH 1,2,3 Massachusetts General Hospital, Boston, Massachusetts; 1,2 Massachusetts General Hospital Chelsea Health Care Center, Chelsea, Massachusetts; 3 Harvard Medical School, Boston, Massachusetts; 4 Harvard Medical School, Boston, Massachusetts

**Session:** 140. HIV: Diagnosis and Screening

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**Background.** In the United States, 15% of people with HIV (PWU) do not know their serostatus, leading to both individual morbidity and HIV transmission to others. While CDC guidelines recommend HIV screening for all individuals aged 13-64 years, racial and ethnic minorities in the United States continue to present to care with advanced HIV infection.

**Methods.** Our objective was to assess providers’ perspectives on barriers to and facilitators of HIV testing at an urban community health center serving a predominantly racial/ethnic minority population of low socio-economic status. Staff conducted five focus groups from January 2017 to November 2017 with 74 health center staff: 20 adult medicine/primary care providers, 28 community health workers (CHWs), six urgent care physicians, six community health administrators, and 14 behavioral health providers. Each focus group ranged from six to 20 participants.

In addition to exploring participants’ views on HIV testing in this setting, we also explored potential interventions to improve HIV testing. Interviews were digitally recorded. Data were analyzed using a grounded theory approach. We used open coding to develop themes and compared themes among provider groups.

**Results.** The main facilitators of routine HIV testing were clinical training in HIV and CHW’s engaging patients in topics that intersect with HIV risk factors. Providers’ perceptions of key barriers were patients’ cultural perceptions of HIV (e.g. HIV-related stigma), patients’ concerns about test confidentiality, competing medical and social issues, and provider lack of HIV knowledge. All groups agreed that HIV testing should occur through the primary care provider through acknowledgment that patients may be seeking healthcare more frequently through mental health, urgent care, or social services than primary care. Primary care physicians wanted easier mechanisms to identify patients in need of HIV testing and assistance with offering the test to non-English language speaking patients.

**Conclusion.** Specific, focused efforts can lead to improved HIV testing in racial, ethnic minorities in community health centers. Training to improve provider comfort, increasing CHW engagement, and a focus on patients’ cultural beliefs may all have an impact on HIV testing.

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1270. Are HIV-Related Diagnostics Excessively Ordered? A Pilot Intervention Study to Improve Test Use in the Inpatient Setting

Daryush Tabatabai Ad, PharmD; Harminerd Sikand, PharmD, FCSPH, FASHP; PPCP; Eva Sullivan, PharmD; and Nancy Cruvy-Ciamfiono, MD, MPH; 1 Pharmacy, Scripps Mercy Hospital - San Diego, San Diego, California, 2 Pharmacy, Scripps Mercy Hospital, San Diego, California

**Session:** 140. HIV: Diagnosis and Screening

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**Background.** Excessive ordering of HIV-related laboratory tests (CD4 counts, HIV RNA levels, and HIV genotypes) may result in increased healthcare costs, unneeded interventions (e.g., response to low CD4 in acute illness), and patient anxiety. Recent data have evaluated methods to reduce excessive testing in outpatients, but there are limited data in the inpatient setting. The purpose of this study was to evaluate the impact of implementation of a pharmacist-driven intervention protocol based on published guidelines improved utilization of HIV-related diagnostics in the inpatient setting.

**Methods.** A pre-interventional study performed on HIV diagnostics usage over a 1-year period, followed by a 3-month post-interventional study at a large academic medical center to evaluate and improve HIV test ordering. Patients were included if ≥18 years old with suspected or documented HIV infection and CD4 count, HIV RNA level, or HIV genotype ordered. A pharmacist-driven intervention was undertaken in which ordered tests were evaluated and canceled if deemed inappropriate prior to pre-specified criteria based on CDC and DHHS guidelines, and clinicians were provided education on appropriate ordering. Results were tabulated and presented as descriptive statistics, and financial data were calculated based on in-hospital costs.

**Results.** In the pre-intervention arm, 87% (396/441) of total tests ordered did not meet criteria for appropriate ordering (CD4 count, HIV RNA level, and 10 genotypes). These tests resulted in excessive financial burden of $24,600. Post-intervention, 63% (32/51) of HIV-related tests were canceled netting an initial savings of $2,700. Most common cancellation reason was recent outpatient laboratories readily available. Post-intervention, HIV-related testing decreased over time, likely due to the intervention audit and feedback provided to clinicians.

**Conclusion.** A pharmacist-driven intervention reduced the number of unneeded HIV-associated tests by 63% and offered significant cost savings. These data suggest the importance of evaluating HIV-related diagnostic testing in the inpatient setting to improve test usage and reduce excessive healthcare costs.

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