and April 2018. We estimated facility transmissibility and facility reproduction number (number infected by one index colonized 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 type and for acute care hospital (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 |
|-----------------------------------------------|
| **C. auris reproduction number (per stay)** | **CRE transmissibility** | **CRE reproduction** |
| **Facility Type** | **Day (Median, IQR)** | **Day (Mean, IQR)** | **95% CI** |
| ACH | 0.219 (0.215–0.221) | 1.05 (1.04–1.07) | 0.50 |
| LTACH | 0.035 (0.019–0.045) | 0.73 (0.40–0.97) | 0.61 |
| VSNF | 0.019 (0.014–0.023) | 0.50 (0.70–1.27) | – |

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

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

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

**Methodology.** We conducted five focus groups from January 2017 to November 2017 with 74 health care providers (CHWs), six urgent care physicians, six community health administrators, and four community health nurses to develop themes and compared themes among provider groups.

**Results.** 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, transcribed, and analyzed. All authors: No reported disclosures.

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

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

**Background.** 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 implementation of a pharmacist-driven intervention protocol based on published guidelines, which were developed based on a computer-assisted self-interview. The final data were weighted according to the 2011 Hong Kong census and factors identified through logistic regression.

**Results.** Among 881 participants, 81.6% reported having sex before, among whom, 18.5% (137) had ever taken HIV tests. The main reasons for the 75.5% of participants not taking HIV testing were they do not think they are at risk of HIV infection (59.1%) or think they are very healthy (29.4%). The main places for HIV testing among the sexually experienced residents, factors associated with HIV testing include marital status and number of sexual partners. Compared with single participants, those cohabiting, married, or with marital history were about seven times more likely to be tested (OR 8.57, 95% CI 2.23–20.31). Those who had >1 sexual partners were about twice as likely to be tested (aOR = 1.84, 95% CI 1.05–3.25). Other factors such as condom use, sexual orientation, anal sex behaviors or sexually transmitted infections history were not associated with HIV testing.

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Background. One in seven people living with HIV in the United States are una-ware of their status. Approximately 11,380 annual HIV infections (30.2%) are caused by this subset of individuals (CDC, 2017). In addition, acute HIV infections have nearly tripled since 2011, with many states seeing a dramatic increase in incidence among younger people outside the birth cohort (CDC, 2017). Because many individu-als still use emergency departments (EDs) for their healthcare needs, these institutions play an increasingly important role in screening patients for HIV and HCV and linking them to medical services. Routine, opt-out testing initiatives are particularly effective at identifying new cases of HIV and HCV that could have otherwise been missed by a risk-based approach to screening.

Methods. In early May 2017, physicians and advanced practice nurses from Sutter Health’s Alta Bates Summit Medical Center (ABSMC) and a nearby outpatient HIV clinic implemented a routine HIV and HCV screening program at the hospital’s large, two-campus ED system in Oakland, CA. ED medical directors created a Nursing Standard Based Procedure (NSP) to allow registered nurses (RNs) to integrate both blood tests using an automated, best practice authority (BPA) screen in the elec-tronic health record (EHR) of any patient who met CDC-defined age criteria for testing. Results. Of the 6,315 patients screened for HIV between May 1 and 2017 and March 31, 2017, 43 (0.2%) were tested positive. Twelve (27%) of the 21 patients found to have a new HIV diagnosis also had symptomatic, acute HIV infection (AHI). All 12 patients with AHI initiated anti-retroviral therapy (ART) within five to 96 hours of their preliminary positive test result. Of the 5,820 patients screened for HCV, 423 (7.3%) were anti-HCV positive, while 185 (3.2%) patients had chronic infection. Thirty-nine percent of chronic HCV cases were among younger patients born before 1965. All patients with HIV or chronic HCV were referred to medical care at East Bay Advanced Care (EBAC).

Conclusion. An automated, routine HIV-HCV testing program integrated into standard nursing workflow at a community ED resulted in the timely screening, diag-nosis, and treatment of many patients with acute HIV, and identified a high prevalence of chronic HCV infections among younger patients.

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1273. Routine Opt-out HIV Screening and Detection of HIV Infection Among Emergency Department Patients

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Background. The Southeastern United States bears a disproportionate burden of HIV, with nearly half of all HIV cases and new cases. The Centers for Disease Control and Prevention released routine opt-out testing recommendations in 2006. Our emergency department collaborated with our infectious diseases clinic (ECU-ID) to implement suggested guidelines among adults since March 2017.

Methods. Our primary aim was to implement routine, opt-out HIV testing in the Vidant Medical Center Emergency Department (ED) for patients between 18 and 65 years of age who have blood work completed, and have not had a test documented in the electronic medical record (EMR) in the last year. A secondary aim was to suc-cessfully link HIV-positive patients to care at ECU-ID or preferred clinic. Methods defined for a program of care that included developing nurses and ED staff to opt-out patients, integrating testing into normal ED workflow, utilizing the existing EMR to prompt testing, and hiring a linkage coordinator to initiate post-test counseling and linkage-to-care.

Results. Since March 2, 2017, a total of 7,109 HIV tests were performed; an average of 592 monthly tests conducted compared with a previous average of 10 test stats. Testing increased 5,820% compared with 2015. Of the 21 HIV-positive patients found, 16 were newly diagnosed. Among those newly diagnosed, 14 (87.5%) were linked to care; and among the five known positives, two (40%) were linked to independently enrolled persons could not be linked included incarceration, refusal to link to care, and re-location.

Conclusion. Joined with the implementation of a routinized ED HIV testing pro-gram, a seamless process was developed to link persons found to be positive in the ED to care services, thereby, establishing evidence-based plans include expanding testing to adolescents and utilizing similar methods to inte-grate Hepatitis C testing.

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1274. Universal HIV and HCV Screening in San Diego Emergency Departments: Implications for Other Settings With a High Density of Free of Charge HIV Testing Programmes

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Background. While HIV and HCV testing targeted to high-risk groups results in substantially higher proportions of HIV diagnoses, universal HIV and HCV screening in EDs was not shown to be effective. We hypothesized that screening positive ED patients could be linked to care. Methods. In July 2017, electronic medical record (EMR) based universal opt-out HIV screening (Architect HIV antibody [Ab]/HIV p24 antigen detection) for persons aged 13-64 years (excluding persons known HIV + or reporting an HIV test within the last 12 months) was implemented in our EDs. The EMR algorithm also identified HIV+ individuals who had been out of care for >12 months. In March 2018, EMR based universal HCV screening for birth cohort was added in both EDs.

Results. Over a period of 9 months 7,303 HIV tests were conducted, resulting in 21 (0.3%) new HIV cases. Among these, 21 were successfully linked to care. In five individuals without HIV infection Architect gave a false-positive result (specificity 99.93%). In addition, the EMR algorithm identified 38 out of care HIV+ individuals of which 21 were successfully re-linked to care. During the 1-month HCV birth cohort screening period, 424 HCV Ab tests were performed, of which 106 (25%) resulted positive. At the time being 78% of those seropositive individuals had HCV RNA testing, of which 36 (53%) resulted positive (3.7% of all participants).

Conclusion. In San Diego, a setting with a high density of free of charge HIV screening, we can detect new infections, and expedite linkages to care and treatment.

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1275. Will an App-Optimized HIV Self-testing Strategy Work for South Africans?

Results From a Large Cohort Study

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Background. HIV self-testing (HIVST) offers a potential for expanded test access; challenges remain in operationalizing randomized linked and referrals to care. We investigated if an app-optimized personalized HIVST strategy improved referrals, detected new infections and expedited linkages to care and treatment.

Methods. In an ongoing cohort study (n = 2,000) based in South Africa, from November 2016 to January 2018, 1,000 participants to self-test at community township based clinics, we offered a choice of the following strategies: (a) unsupervised HIVST, (b) supervised HIVST. We also observed participants opting for conventional HIV testing (ConvHIV) in geographically separated clinics. We observed outcomes (i.e., linkage initiation, referrals, disease detection) and compared it between the two (HIVST vs. ConvHIV) for the same duration.

Results. Of 2,000 participants, 1,000 (50%) chose unsupervised HIVST, 401 (40.1%) on supervised HIVST; compared with 1,000 participants opting for conventional HIV testing (ConvHIV) at 91.6%. With an app-optimized HIVST strategy, linkages to care were operationalized in total 21 newly diagnosed individuals were linked to care. Identification of HIV+ out of care individuals yielded in an equivalent number of individuals re-linked to care. The rate of newly diagnosed HCV infections exceeded the rate of newly diagnosed HIV infections by 3-fold outlining the importance of screening for HCV in the ED.

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