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 acute care hospital (ACH), long-term acute care hospital (LTACH) or 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 |
|----------------------------------------------------|
| **Table:** C. auris reproduction number (per day), transmissibility (per day), and reproduction number (per stay) by facility type. |
| **Facility Type** | **ACH** | **LTACH** | **VSNF** |
| **Transmissibility (per day)** | 0.218 (0.215–0.221) | 0.035 (0.019–0.045) | 0.019 (0.014–0.023) |
| **Reproduction number (per stay)** | 1.05 (1.04–1.07) | 0.73 (0.40–0.97) | 1.05 (0.70–1.27) |
| **Median (IQR)** | 0.50 | 0.61 | 1.61 |
| **95% CI** | 0.30 | - | - |

*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

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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. Study 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 four 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 major facilitators of routine HIV testing were clinical training in HIV/HEIV 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 or a county provider who acknowledged 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 minority communities. 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

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Methods. A pharmacist-driven intervention was undertaken in which ordered tests were evaluated and canceled if deemed inappropriate per pre-specified guidelines on the basis of 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 on in-hospital costs.

Results. In the pre-intervention arm, 87% (356/414) of total tests ordered did not meet criteria for appropriate ordering. After the intervention audit and feedback provided to clinicians, 11% (3/28) of tests were increased over time, likely due to the intervention audit and feedback provided to clinicians.

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

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