mortality and other relevant outcomes among HIV patients from developing countries is paramount for benchmarking purposes. This study aimed to evaluate the mortality of patients with HIV/AIDS admitted to the ICU during the years 1999 to 2015.

Methods. An observational retrospective study was conducted based on episodes of patients admitted to the ICU of the Fundación Valle del Lili from December 1998 to October 2015. The Cochran-Armitage test was used to evaluate the trend of HIV mortality by 4-year periods, considering sex and age groups (<50 vs. >50 years). The Z test compared the mortality between HIV patients with non-HIV patients in the ICU; also it compared the mortality in HIV patients by sex and age group.

Results. A total of 53,798 episodes of ICU admissions were analyzed, 0.76% (414) were HIV patients, and of this 78.5% were men. Twenty-three percent were over 50 years old. Overall mortality in the ICU was 9.13%, and the mortality in HIV patients was 22.03%, which was higher when compared with a non-HIV group (9%, $P < 0.001$). Mortality due to HIV had a statistically significant decreasing trend ($P < 0.001$), going from 40% between 1999 and 2003 to 18.04% between 2012–2015, this trend was observed among men with HIV ($P < 0.001$) starting with 43. 5% and ending at 20%, but among women the decreasing trend was not statistically significant ($P = 0.62$). Mortality for HIV decreased, in the <50 years group: it went from 38. 3% to 18. 6% ($P = 0.0003$). Furthermore, in patients 50 years and older group mortality went from 50% to 17.9% ($P = 0.025$). During period 2008–2011, patients 50 years and older had more mortality compared with <50 years group ($P = 0.019$), but there were no differences by sex in any period.

Conclusion. This study found a statistically significant trend for mortality decrease over a 16-year period among HIV patients admitted to an ICU from a developing country.
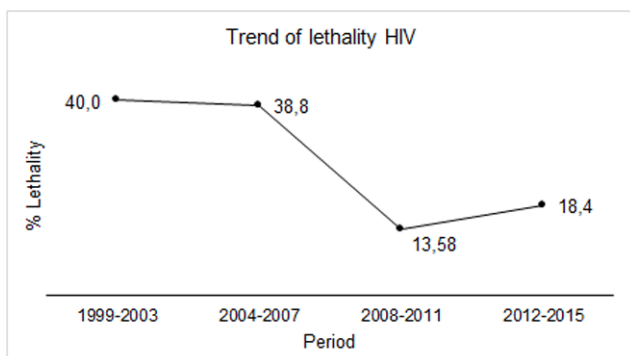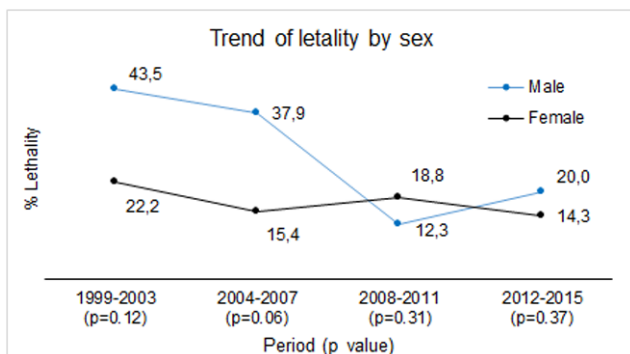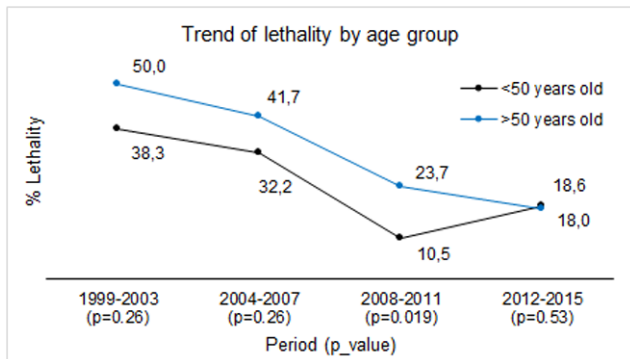
Disclosures. All authors: No reported disclosures.

1296. Should HIV Disclosure at ED Based on Preliminary Results?
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Background. It is recommended that all adults presenting to Emergency Departments (ED) be offered opt out testing for HIV. There is evidence that detection of HIV infection, disclosure of infected status to the patient, and enrollment into HIV care are best accomplished during the ED visit. Any delay results in loss of patients. Among critical variables are capacities to conduct screening and confirmatory testing during the time the patient is a resident in the ED. We report on a facility where HIV screening is performed during ED patient dwell times but confirmatory results follow in ≥24h. The conundrum is whether patients found HIV positive by a screening test should be informed of the positive screening finding before confirmatory results are in hand.

Methods. Data obtained from a routine opt-out HIV screening program for the interval June 2017 to March 2019 conducted at the ED in Houston, Texas were evaluated. Patients between 18–65 years with Glasgow Score >9 were eligible for testing. HIV fourth-generation ADVIA Centaur™ Ag/Ab COMBO (Siemens) was used for screening. Positives screening tests were followed by Gennius™ HIV1/HIV2 confirmatory test.

Results. 12,040 HIV fourth-generation tests were performed; 232 (1.9%) were positive; the specificity of the screening testing was 98.2%. Twenty-two (9.5%) of screening test positive individuals were found HIV false positive (Ag/Ab positive and Gennius negative). The population had a mean age of 43.8 years (21–64), was predominantly female (63.6%) and white (40.9%). Further testing was completed for 14 of the 22 patients with false-positive screening tests. 13 had negative tests for HIV RNA and 1 had a second HIV Ag/Ab test with negative findings. 8 (36.3%) screening test false-positive patients could not be located after their departure from the ED.

Conclusion. If patients were disclosed of their HIV-positive status because of the screening test result, approximately 10% of these individuals would have been incorrectly categorized generating significant personal and social disruption while waiting for the confirmatory result.

Disclosures. All authors: No reported disclosures.

1297. Examining the Successes and Challenges of Implementing HIV Testing Clinical Decision Support in the Emergency Department
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Background. In 2016, MetroHealth System (MHS) launched the FOCUS (Frontlines of Communities in the United States) project to routinize HIV testing in the emergency department (ED). Before 2016, clinical decision support (CDS) for HIV testing was not in place, nor was there a policy to support the importance of opt-out, nontargeted screening. The purpose of this study was to outline the progress of HIV testing after the integration of CDS, as well as describe the implementation challenges, and how certain events impacted HIV testing.

Methods. HIV testing data from MHS EDs were collected from October 1, 2015 to March 31, 2019 and graphed into a run chart. The dataset was mapped with the following events: project start date, ED testing begins (without CDS), CDS implementation, the staffing of the ED Testing Coordinator (EDTC), and optimization of CDS (Figure 1). To determine whether observed variation in the dataset is due to random or special cause variation, these run chart rules were applied: Run, Shift (Figure 2), and Trend.

Results. There were 42 data points and 4 runs. With 42 points, the lower limit of runs was 16 and the upper limit of runs was 28. This signals that one or more special cause variations were present. A total of three distinct shifts were observed indicating special cause variation. The run chart did not include any downward or upward trends. Testing increased as much as 3971% (7 tests in October 2015 vs. 285 tests in March 2018).

Conclusion. HIV testing increased from 7 tests to 86 tests (Shift 1). This coincided with establishment of an ED testing policy in April 2016. Testing increased to 266 tests in October 2016 (Shift 2). This directly related to implementation of CDS in the ED. December 2017 displayed the lowest testing with 117 tests. This was due to lack of policy awareness, and to the rarely-visited location of the HIV screening tool during the triage process. Staff was re-educated and the HIV screening tool was moved to a more visible location. This resulted in 227 tests in February 2018, and was followed by the highest testing month with 285 tests (Shift 3). Continued challenges prohibit sustained upward trends in ED testing. A control chart may be the appropriate next step to identify new control limits