compared with 15.4 % for Chicago overall. In 2016 X-TLC screened 91,865 persons for HIV, and 65.2 % of those tested were women. There were 193 new diagnosis and 32.1 % (62) were women, 85.7 % AA. In comparison, in 2015 there were 139 women with a new HIV diagnosis for all of Chicago. Women newly diagnosed were less likely to be linked to care (adjusted odds ratio, aOR, 0.54, 0.35–0.85). Linkage was lower for women diagnosed at CHCs (84.6 % vs. 76.3 %, P = 0.02). Most CHCs did not have on site HIV providers. At our site, however, women linked to care were more likely to be retained in care (aOR 0.58, 0.43–0.78). We also conduct targeted outreach testing, partner services (PS) testing, and social network strategy (SNS) testing, but women are not identified by these programs (16/171 tested women, 8 new diagnoses were men for PS; 507 tested, 471 men and 36 trans-gender women, 38 new positives, 0 cis-gender women for SNS).

Conclusion. More women than men were offered and/or accept HIV screening in healthcare settings. The proportion of seropositive women identified was higher than the national average. X-TLC is reaching a large proportional of AA women with HIV unaware of their status. Other testing strategies will rarely identify cis-gender women with HIV infection. Gender differences in linkage to and retention in care will require strategies targeted at women.

Disclosures. **J. P. Ridgway**, Gilead FOCUS: Grant Investigator, Grant recipient; **N. Glick**, Gilead FOCUS: Grant Investigator, Grant recipient; **D. Pitrak**, Gilead Sciences FOCUS: Grant Investigator, Grant recipient

1378. Making a Big Impact on Expanding HIV Inpatient Testing with a Small EHR Modification

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Session: 155. HIV Testing
Friday, October 6, 2017: 12:30 PM

Background. The CDC estimates over 1.2 million Americans are living with HIV and, of those, approximately 14% are unaware of their HIV-positive status. Since 2014, most hospitals adopted some form of Electronic Health Records (EHR) and the Centers for Medicare & Medicaid Services extended Medicare coverage for annual HIV screenings. Despite these developments, there has been limited progress in expanding HIV testing in inpatient settings. The present study was conducted at Jersey City Medical Center (JCMC) in an effort to expand HIV testing by implementing EHR modification in the form of testing prompts.

Methods. This study began on January 1, 2016 at JCMC, a teaching hospital that passed all lab work orders through an EHR system. The number of daily orders for HIV screenings was recorded for 145 consecutive days before EHR modification (*n = 145*) to establish baseline data.

EHR modification occurred on the 146th day of the study (May 25, 2016). This modification featured testing prompts displaying CDC guidelines for screening patients over the age of 18 for HIV whenever a physician ordered lab work for admitted patients. Orders for HIV screenings on this transitional date were excluded from analysis.

After EHR modification was completed, the number of daily orders for HIV screenings was recorded for an additional 145 consecutive days (*n = 145*) for comparison. Testing data was available for all 145 consecutive days before and 145 consecutive days after EHR modification.

Results. Since the beginning of this study—before testing prompts were implemented—JCMC inpatient units ordered an average of 8.53 (*SD*=3.25) HIV screenings per day. The average number of daily orders for HIV screenings increased twofold after EHR modification (*M*=17.39, *SD*=4.26), $t(288) = 19.90$, $P < .001$. JCMC identified 86 HIV-positive and linked over 90% of these patients to care.

Conclusion. Conventional HIV screening methods in the inpatient setting might not be sufficient at detecting most HIV-positive cases. By implementing testing prompts in its EHR system to encourage increased testing for HIV, Jersey City Medical Center was able to increase the number of individuals aware of their HIV status and link them to care as needed.

Disclosures. **T. Nguyen**, Gilead FOCUS: Employee, Grant recipient

1379. Can an HIVSmart! App-optimized Self-Testing Strategy be Operationalized in Canada?

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Background. Although HIV self-tests are recommended by the WHO, they are not yet approved in Canada. Service delivery gaps such as linkages to counseling and care remain unachieved by offering self-tests without adequate support. In this first Canadian study, we evaluated the feasibility of operationalizing an innovative HIVSmart! app-optimized oral HIV self-testing strategy in men who have sex with men (MSM), presenting at a large sexual health clinic in Montreal.

Methods. Between July 2016 to February 2017, participants were offered the OraQuick In-Home HIV Test, and a tablet installed with the HIVSmart! app, at a private office in the clinic to simulate an unsupervised home environment. With the HIVSmart! app, participants independently performed and interpreted self-tests, and were linked to in-person post-test counseling and care. Self-test results were confirmed by laboratory tests (p24, Western Blot, RNA as needed).

Results. The mean age of the 451 participants was 34 years (18–73); 85% were well educated (beyond high school, *n* = 371/438); 53% (230/438) were frequent testers (past 6 months), and 13% were on PrEP (52/451). 99% (417/422) of participants found the HIVSmart! app helpful in guiding them through the self-testing procedure; 93% (418/451) of participants interpreted their tests accurately; and 94% (395/419) stated they would recommend the app-optimized self-testing strategy to their partners. Feasibility (completion rate of self-testing) was 93% (419/451), and acceptability of the strategy was high at 99% (451/458). All HIV self-test negative participants (448/451, 100%) were counseled following the self-test. Three participants self-tested positive, were confirmed HIV positive (0.7% prevalence), and were rapidly linked to care with a physician.

Conclusion. The HIVSmart! app-optimized strategy was feasible, and highly accepted by an educated, frequently testing, urban MSM population of Montréal. With the app, participants were able to interpret their test results accurately and were rapidly linked to care. Innovations like HIVSmart! which engage, aid, and facilitate linkages to care, can be adapted to suit the needs of many populations in Canada and internationally, maximizing global impact through reverse innovation.

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

1380. A Randomized Trial of Bictegravir or Dolutegravir with Emtricitabine and Tenofovir Alafenamide (F/TAF) Followed by Open Label Switch to Bictegravir/F/TAF Fixed Dose Combination

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Session: 156. HIV: Antiretroviral Therapy
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Background. Integrase strand transfer inhibitors (INSTIs) are widely recommended for initial HIV-1 treatment. Bictegravir (BIC, B) is a novel, once-daily INSTI with potent antiviral activity being developed in coformulation with emtricitabine and tenofovir alafenamide (F/TAF).

Methods. In this Phase 2 study, treatment naïve, HIV-infected adults were randomized 2:1 to receive blinded treatment with BIC or dolutegravir (DTG) coadministered with open label F/TAF (200/25 mg). After all participants completed 48 weeks, they were unblinded and switched to a single fixed-dose combination tablet of B/F/TAF 50/200/25 mg. The proportion of participants with HIV-1 RNA <50 copies/mL (c/mL) was assessed at Week (W) 24 and W48 of the blinded phase and 12 weeks after switching to open label B/F/TAF (W72).

Results. Of 98 participants enrolled in the blinded treatment phase, 65 were randomized to BIC+F/TAF and 33 to DTG+F/TAF. Most were male, had asymptomatic HIV infection, with median HIV-1 RNA 4.4–4.5 $\log_{10}$ c/mL. The proportion of subjects with HIV-1 RNA <50 c/mL at W24 was 97% for the BIC arm and 94% for the DTG arm, and at W48 was 97% and 91%, respectively (Table). All 92 participants who completed the blinded phase were switched to B/F/TAF at W60. At W72 or 12 weeks after switching to open-label B/F/TAF, 99% (91/92) maintained HIV-1 RNA <50 c/mL (98% prior BIC arm [*N* = 62]; 100% prior DTG arm [*N* = 30]) and one individual withdrew prior to the analysis. No viral resistance was detected in participants treated with BIC. No participants discontinued open label B/F/TAF due to an adverse event, there were no treatment-related serious adverse events and no deaths. One individual on BIC previously discontinued due to an adverse event of urticaria following the W24 visit.

Conclusion. All participants switched from DTG+F/TAF to open-label B/F/TAF maintained virologic suppression, with none discontinuing due to adverse events. During 72 weeks of follow-up, no treatment-emergent resistance to any components was detected in participants taking B/F/TAF. B/F/TAF demonstrated durable virologic suppression in naïve patients through W72 and was safe and effective after switching from DTG + F/TAF, further study in treatment naïve and experienced populations is warranted.

Table.

	Week 24[a]		Week 48[b]		Week 72	
N (%)	BIC + F/TAF (n=65)	DTG + F/TAF (n=33)	BIC + F/TAF (n=65)	DTG + F/TAF (n=33)	B/F/TAF from BIC + F/TAF (n=62)	B/F/TAF from DTG + F/TAF (n=30)
HIV-1 RNA < 50 copies/mL	63 (97)	31 (94)	63 (97)	30 (91)	61 (98)	30 (100)
HIV-1 RNA ≥ 50 copies/mL	2 (3)	2 (6)	1 (2)	2 (6)	0	0
HIV-1 RNA ≥ 50 copies/mL in the analysis window	1 (2)	1 (3)	0	1 (3)	0	0
Discontinued study drug due to lack of efficacy	0	0	0	0	0	0
Discontinued study drug due to other reason[c] and last HIV-1 RNA ≥ 50 copies/mL	1 (2)	1 (3)	1 (2)	1 (3)	0	0
No virologic data in the analysis window	0	0	1 (2)	1 (3)	1(2)	0

a Difference in percentages (BIC+F/TAF vs DTG+F/TAF) at Week 24: 2.9% (-8.5% to 14.2%); p=0.50
b Difference in percentages (BIC+F/TAF vs DTG+F/TAF) at Week 48: 6.4% (-6.0% to 18.8%); p=0.17
c Other reasons include subjects who discontinued study drug due to investigator's discretion, withdraw consent, lost to follow-up, noncompliance with study drug, protocol violation, pregnancy, and study termination by sponsor.

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1381. No Emergent Resistance in HIV-1 Infected Virologically-Suppressed Subjects Who Switched to R/F/TAF

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Session: 156. HIV: Antiretroviral Therapy
Friday, October 6, 2017: 12:30 PM

Background. GS-US-366-1216 and GS-US-366-1160 are randomized, double-blind, phase 3b studies evaluating the safety and efficacy of switching to rilpivirine/emtricitabine/tenofovir alafenamide (R/F/TAF) from R/F/tenofovir disoproxil fumarate (TDF) or efavirenz (EFV)/F/TDF, respectively, in HIV-1-infected virologically-suppressed subjects. At Week 48, switching to R/F/TAF was non-inferior to staying on R/F/TDF (94% vs. 94%, respectively) or EFV/F/TDF (90% vs. 92%) for HIV-1 RNA <50 c/mL (virologic success) by FDA snapshot analysis. Here, we present integrated resistance analyses of these two studies through Week 48.

Methods. Historical genotypes were collected when available. Subjects in the resistance analysis population (subjects with HIV-1 RNA ≥400 c/mL at virologic failure, discontinuation, or Week 48) had genotypic/phenotypic analyses at failure for protease and reverse transcriptase (RT; PhenoSense GT, Monogram). Subjects with post-baseline resistance mutations detected had their baseline proviral DNA analyzed retrospectively (GenoSure Archive, Monogram).

Results. Of the 1504 randomized and treated subjects, resistance development was analyzed for 7 subjects (0.9%; 7/754) on R/F/TAF, 1 subject (0.3%; 1/313) on R/F/TDF, and 2 subjects (0.5%; 2/437) on EFV/F/TDF. No R/F/TAF (0%) or R/F/TDF (0%) subjects developed primary NNRTI or NRTI resistance mutations. One EFV/F/TDF subject (0.2%; 1/437) developed primary NNRTI and NRTI resistance mutations (NNRTI: Y188L; NRTI: M184V). Three subjects on R/F/TAF had virologic rebound with mutations also detected at baseline by proviral DNA analysis. Historical genotypes were available for 527 subjects; virologic success rates were high among subjects with pre-existing mutations (Table 1).

Table 1. Virologic success rates of subjects with mutations by historical genotype.

	Subjects with success/subjects with mutation (%)		
RT mutation	R/F/TAF	R/F/TDF	EFV/F/TDF
K101E	1/1 (100%)	0	0
K103N	10/11[a] (91%)	6/7[a] (86%)	1/1 (100%)
E138A/K	2/3[a] (67%)	2/2 (100%)	0
M184V	1/2[a] (50%)	1/1 (100%)	0

[a]1 subject discontinued prior to Week 48 with HIV-1 RNA <50 c/mL.

Conclusion. No emergent resistance to any of the components of R/F/TAF was detected through 48 weeks after switching. Virologic success rates were high among subjects with pre-existing mutations.

Disclosures. **D. Porter**, Gilead Sciences, Inc.: Employee and Shareholder, Salary; **R. Kulkarni**, Gilead Sciences, Inc.: Employee and Shareholder, Salary; **H. Cao**, Gilead Sciences, Inc.: Employee and Shareholder, Salary; **D. Sengupta**, Gilead Sciences Inc.: Employee and Shareholder, Salary; **K. White**, Gilead Sciences, Inc.: Employee and Shareholder, Salary

1382. Sword 1 and 2: Subgroup Analysis of 48 Week Results by Age, Race and Gender

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Background. Switching to the 2-drug regimen (2DR) of DTG+RPV was proven non-inferior to continuing a suppressive PI-, INI- or NNRTI- based current antiretroviral regimen (CAR) at Week 48. This analysis evaluated the efficacy and safety of switching from CAR to DTG+RPV by age, race and gender subgroups.

Methods. Two identically designed, open-label, multicenter, global, phase III, non-inferiority studies compared the efficacy and safety of switching from a 3 or 4-drug CAR to DTG + RPV once daily in HIV-1-infected adults, with HIV-1 RNA<50 c/mL. Primary endpoint was proportion of patients with VL<50 c/mL at Wk48 using FDA Snapshot. Additional analysis were performed to summarize efficacy base on age, race and gender subgroups for each individual study and pooled.

Results. 1024 patients were randomized and exposed (DTG+RPV 513; CAR 511), across both studies. Treatment arms were well matched for demographic and baseline characteristics. Median age across both arms was 43.4 years, with 29% and 28% ≥ 50 years in DTG+RPV and CAR, respectively. 23% and 21% were female while 18% and 22% were non-white for DTG+RPV and CAR. For the pooled studies and for SWORD-1 and SWORD-2 individually, switching to DTG+RPV was non-inferior to CAR at Wk48. Similar response rates were observed in the DTG+RPV arm compared with CAR across subgroups (Table 1). More AEs were reported in the DTG+/RPV arm across all subgroups except Asian race; no unexpected AEs were identified for either drug.

Table 1. Proportion of patients with HIV-1 RNA <50 c/mL at Week 48 (snapshot): pooled SWORD studies population

	DTG/RPV, *N* = 513, *n*/*N* (%)	CAR, *N* = 511, *n*/*N* (%)
Overall	486/513 (95)	486/511 (95)
Age		
<50 years	350/366 (96)	348/369 (94)
≥50 years	136/147 (93)	137/142 (96)
Gender		
Male	375/393 (95)	387/403 (96)
Female	111/120 (93)	98/108 (91)
Race		
White	395/421 (94)	378/398 (95)
African heritage	36/37 (97)	44/47 (94)
Other	17/17 (100)	14/16 (88)
Asian	38/38 (100)	49/50 (98)

Conclusion. Switch to a novel, once daily 2DR of DTG+RPV in patients with a suppressed viral load, was an effective and well tolerated treatment option across age, race, and gender subgroups which were consistent with overall results.

Disclosures. **S. Walmsley**, Merck: Board Member, Consultant, Grant Investigator, Investigator, Scientific Advisor and Speaker's Bureau, Consulting fee, Grant recipient, Research grant and Speaker honorarium; ViiV Healthcare: Board Member, Consultant, Grant Investigator, Investigator, Scientific Advisor and Speaker's Bureau, Consulting fee, Grant recipient, Research grant and Speaker honorarium; Gilead Sciences: Board Member, Consultant, Grant Investigator, Investigator, Scientific Advisor and Speaker's Bureau, Consulting fee, Grant recipient, Research grant and Speaker honorarium; GSK: Board Member, Consultant, Grant Investigator, Investigator, Scientific Advisor and Speaker's Bureau, Consulting fee, Grant recipient, Research grant and Speaker honorarium; Janssen: Board Member, Consultant, Grant Investigator, Investigator, Scientific Advisor and Speaker's Bureau, Grant recipient, Research grant and Speaker honorarium; BMS: Grant Investigator, Investigator, Scientific Advisor and Speaker's Bureau, Consulting fee, Grant recipient, Research grant and Speaker honorarium; **G. Richmond**, Viiv Healthcare: Investigator, Research support; **F. Bredeek**, ViiV Healthcare: Investigator and Scientific Advisor, Consulting fee and Research support; **M. Ramgopal**, viiv: Investigator, Consulting fee; **C. C. Hung**, Gilead Sciences: Board Member and Speaker's Bureau, Consulting fee and Speaker honorarium; ViiV: Board Member and Investigator, Consulting fee and Research support; Abbvie: Board Member and Investigator, Consulting fee and Research grant; Bristol-Myers Squibb: Investigator, Research support; Jassen: Board Member and Investigator, Consulting fee and Research support; **E. Blair**, ViiV Healthcare: Employee and Shareholder, Salary; **L. Kahl**, ViiV Healthcare: Employee and Shareholder, Salary; **M. Underwood**, ViiV Healthcare: Employee, Salary; **K. Angelis**, GlaxoSmithKline: Employee, Salary; **K. Vandermeulen**, Jansen: Employee, Salary; **B. Wynne**, ViiV Healthcare: Employee, Salary; **M. Aboud**, ViiV Healthcare: Employee, Salary

1383. Efficacy and Safety of Tenofovir Alafenamide vs. Tenofovir Disoproxil Fumarate in HIV-infected, Virologically Suppressed Black and Non-Blacks Adults Through Week 96: Subgroup Analysis of a Randomized Switch Study

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