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.