treatment. Collectively, these data demonstrate consistency and reliability of the potential benefit of RBX2660 across an entire clinical program.

Disclosures. **Lindy Bancke, PharmD**, **Rebiotix, a Ferring Company** (Employee) **Xin Su, MD**, **Rebiotix/Ferring** (Employee)

168. Testing, Diagnosis, and Incidence of Sexually Transmitted Infections Among People with Substance Use Disorders in the Veterans Health Administration, 2019

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Session: O-33. STIs and Enteric Infections

Background. People with substance use disorders (SUDs) are at increased risk of acquiring sexually transmitted infections (STIs.) In response to the syndemic of STIs and SUDs, the Department of Health and Human Services' 2020 STI National Strategic Plan called for increased STI testing among people with SUDs and integration of testing and treatment into non-traditional settings. Existing data describing STI testing and incidence rates among people with SUDs are limited to single or regional medical centers. National samples are needed to target interventions. We report on STI testing, test positivity, and incidence rates among people with SUDs who receive medical care in the Veterans Health Administration (VHA).

Methods. We performed a retrospective cohort study of individuals with SUDs who received VHA care in 2018 or 2019. Data were obtained from the Corporate Data Warehouse, a national database that includes data from VHA's electronic medical record. For individuals with alcohol, opioid, cocaine, and/or other stimulant (e.g. methamphetamine) use disorders, we collected demographic data, testing and results for gonorrhea (GC), chlamydia (CT), syphilis, and HIV during 2019. We calculated rates of testing, test positivity, and incidence rates.

Results. Incidence of all four STIs was highest in the other stimulant use disorder group; incidence of syphilis was particularly elevated at 922.4 cases/100K. Veterans with multiple SUDs were three times more likely to be houseless in 2019 than those with a single SUD and had higher incidence of all STIs than those with single SUDs, except for people with other stimulant use disorders. People with alcohol use disorder (AUD) had a higher incidence of GC, CT, and syphilis than those with opioid use disorder despite similar testing rates. Percent positivity for HIV ranged from 0.27% for AUD to 2.0% for other stimulant use disorders.

Table 1. Demographic characteristics of individuals with reported SUD

Variable	Value	People with Alcohol use disorder N=339,516 *n (%)*	People with Cocaine use disorder N=16,537 *n (%)*	People with Opioid use disorder N=33,837 *n (%)*	People with Other stimulant use disorder N=10,408 *n (%)*	People with Single SUD Reported N=400,298 *n (%)*	People with Multiple SUDs Reported N=85,571 *n (%)*
Age at start of CY 2019	*mean (SD)*	55.1 (15.1)	59.3 (10.1)	55.2 (14.7)	49.9 (13.3)	55.2 (14.9)	52.7 (12.9)
Sex	F	21,868 (6.4)	1,145 (6.9)	2,815 (8.3)	1,003 (9.6)	26,831 (6.7)	5,545 (6.5)
	M	317,648 (93.6)	15,392 (93.1)	31,022 (91.7)	9,405 (90.4)	373,467 (93.3)	80,026 (93.5)
Race	Asian American	2,479 (0.7)	45 (0.3)	141 (0.4)	153 (1.5)	2,818 (0.7)	372 (0.4)
	Black	70,558 (20.8)	11,514 (69.6)	4,826 (14.3)	1,166 (11.2)	88,064 (22)	33,427 (39.1)
	Hawaiian/Pacific Islander	3,017 (0.9)	91 (0.6)	216 (0.6)	184 (1.8)	3,508 (0.9)	590 (0.7)
	Native American	3,891 (1.1)	63 (0.4)	303 (0.9)	128 (1.2)	4,385 (1.1)	797 (0.9)
	White	236,467 (69.6)	4,062 (24.6)	26,380 (78)	7,980 (76.7)	274,889 (68.7)	45,921 (53.7)
	Unknown race	19,809 (5.8)	556 (3.4)	1,648 (4.9)	635 (6.1)	22,648 (5.7)	3,450 (4)
	Multiracial	3,295 (1)	206 (1.2)	323 (1)	162 (1.6)	3,986 (1)	1,014 (1.2)
Ethnicity	Hispanic ethnicity	27,217 (8)	830 (5)	1,819 (5.4)	958 (9.2)	30,824 (7.7)	5,964 (7)
Rurality	Urban	231,026 (68)	13,791 (83.4)	23,076 (68.2)	7,253 (69.7)	275,146 (68.7)	66,841 (78.1)
	Rural/Highly Rural	104,415 (30.8)	2,482 (15)	10,326 (30.5)	2,821 (27.1)	120,044 (30)	16,733 (19.6)
	Unknown	4,075 (1.2)	264 (1.6)	435 (1.3)	334 (3.2)	5,108 (1.3)	1,997 (2.3)
Census region	West	69,624 (20.5)	1,650 (10)	7,807 (23.1)	4,586 (44.1)	83,667 (20.9)	15,010 (17.5)
	Midwest	75,910 (22.4)	2,935 (17.7)	6,726 (19.9)	1,784 (17.1)	87,355 (21.8)	17,006 (19.9)
	South	145,542 (42.9)	9,558 (57.8)	13,132 (38.8)	3,346 (32.1)	171,578 (42.9)	38,332 (44.8)
	Northeast	41,847 (12.3)	1,985 (12)	5,651 (16.7)	328 (3.2)	49,811 (12.4)	12,514 (14.6)
	Other	6,593 (1.9)	409 (2.5)	521 (1.5)	364 (3.5)	7,887 (2)	2,709 (3.2)
HIV	People living with HIV in CY 2019	1,833 (0.5)	657 (4)	405 (1.2)	479 (4.6)	3,374 (0.8)	2,243 (2.6)
Living status	Experienced homelessness during FY 2018-19	38,816 (11.4)	4,981 (30.1)	4,144 (12.2)	3,760 (36.1)	51,701 (12.9)	36,943 (43.2)
Mental health diagnoses during CY 2019	Any	233,462 (68.8)	11,087 (67)	23,519 (69.5)	8,247 (79.2)	276,315 (69)	75,432 (88.2)
	Anxiety	98,473 (29)	3,298 (19.9)	10,290 (30.4)	3,451 (33.2)	115,512 (28.9)	34,040 (39.8)
	Bipolar	22,630 (6.7)	1,668 (10.1)	2,387 (7.1)	1,513 (14.5)	28,198 (7)	15,103 (17.6)
	Depression	151,904 (44.7)	6,666 (40.3)	14,209 (42)	4,844 (46.5)	177,623 (44.4)	53,568 (62.6)
	PTSD	126,907 (37.4)	4,475 (27.1)	11,433 (33.8)	3,764 (36.2)	146,579 (36.6)	40,957 (47.9)
	Schizophrenia	9,866 (2.9)	1,705 (10.3)	725 (2.1)	989 (9.5)	13,285 (3.3)	8,239 (9.6)
	Other mental health	33,809 (10)	2,043 (12.4)	3,673 (10.9)	1,716 (16.5)	41,241 (10.3)	19,496 (22.8)

Table 2. STI testing, percent positivity, and case rate by SUD diagnosis in 2019: single and multiple SUDs

STI	SUD reported	N	Percent of pts tested	Percent positivity of testing	Unique pts with new diagnosis *n (%)*	Cases per 100k
Chlamydia	**Alcohol**	339,516	4.4	3.7	633 (0.2)	196.5
	Cocaine	16,537	7.3	2.4	35 (0.2)	211.6
	Opiates	33,837	3.2	2.6	31 (0.1)	91.6
	Other stimulant	10,408	9.7	4.8	63 (0.6)	672.6
	Multiple	85,571	9.8	2.7	264 (0.3)	326
Gonorrhea	**Alcohol**	339,516	4.4	2.1	360 (0.1)	111.9
	Cocaine	16,537	7.3	3.9	58 (0.4)	368.9
	Opiates	33,837	3.2	2.1	25 (0.1)	76.8
	Other stimulant	10,408	9.7	6.3	86 (0.8)	883.9
	Multiple	85,571	9.8	3.7	357 (0.4)	449.9
Syphilis	**Alcohol**	339,516	6.6	0.8	202 (0.1)	60.1
	Cocaine	16,537	11.9	2.1	45 (0.3)	296.3
	Opiates	33,837	6.5	0.5	12 (0)	35.5
	Other stimulant	10,408	12.1	5.6	92 (0.9)	922.4
	Multiple	85,571	19.6	1.2	252 (0.3)	298
HIV*	**Alcohol**	337,793*	12.7	0.27	110 (0.03)	32.6
	Cocaine	15,898*	17.9	0.52	18 (0.1)	113.2
	Opiates	33,441*	11.6	0.41	9 (0.03)	26.9
	Other stimulant	9,966*	18.6	2.0	37 (0.4)	371.3
	Multiple	83,421*	28.0	0.44	93 (0.1)	111.5

*Denominators exclude people who are living with HIV at the start of CY 2019

Conclusion. High incidence of STIs among people with non-cocaine stimulant use disorder indicates a need for comprehensive testing. The data suggests that veterans with AUD would benefit from increased testing. Houselessness and mental health diagnoses were common, and comprehensive STI testing and treatment programs, including an assessment of HIV risk, should be integrated into programs addressing these comorbidities.

Disclosures. **Holly Villamagna, MD**, Nothing to disclose

169. The Resurgence of *Candida auris* in California during the Novel Coronavirus (COVID-19) Pandemic, May 2020–May 2021

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Session: O-34. The Interplay Between COVID and other Infections

Background. In February 2019, California (CA) experienced its first *C. auris* outbreak in Orange County (OC). The CA Department of Public Health (CDPH) and OC with the Centers for Disease Control and Prevention (CDC), mounted a successful containment response; by November 2019, cases were limited to low-level spread in OC long-term acute care hospitals (LTACH).

In May 2020, *C. auris* cases began to surge in OC, followed by extensive spread in six other southern CA local health jurisdictions (LHJ). CDPH with LHJ and CDC, initiated an aggressive, interjurisdictional containment response.

Methods. We carried out response and preventive point prevalence surveys (PPS), onsite infection prevention and control (IPC) assessments, and in-service trainings at outbreak and interconnected hospitals and skilled nursing facilities in six LHJ. Other regional activities included: epidemiologic investigation, contact and discharge tracking and screening; increasing laboratory testing capacity; screening patients admitted to and from LTACH; statewide healthcare facility (HCF) education

and outreach; sending regional outbreak HCF lists to all HCF; and biweekly state-LHJ coordination calls. The Antibiotic Resistance (AR) Lab Network supported testing.

Results. From May 2020—May 2021, we conducted screening at 226 HCF, and identified 1192 cases at 93 HCF, mostly through screening (n=1109, 93%) and at LTACH (n=906, 76%); we identified 113 (10%) cases at ACH, including 35 (31%) in COVID-19-burdened units. Cases peaked in August 2020 (n=93) and February 2021 (n=191) and have since declined, with *C. auris* resurgence mirroring COVID-19 incidence.

We conducted 98 onsite IPC assessments, and identified multiple, improper IPC practices which had been implemented in response to COVID-19, including double-gloving and -gowning, extended use of gowns and gloves outside patient rooms, and cohorting according to COVID-19 status only.

Figure 1. *C. auris* and COVID-19 Cases in California through May 2021, and *C. auris* Cases by Local Health Jurisdiction (LHJ) May 2020–May 2021

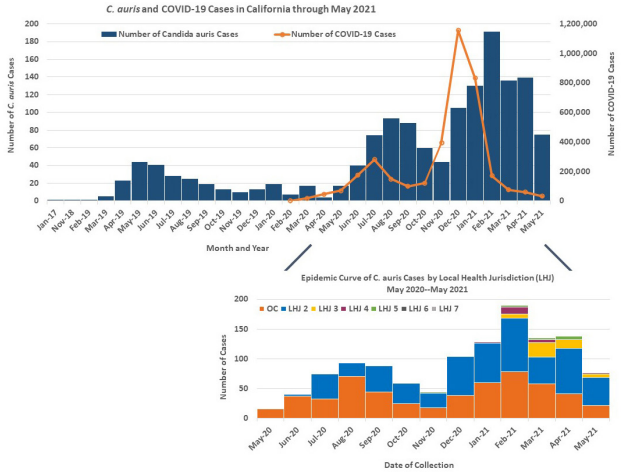

Table 1. By Facility Type: Colonization Testing May 2020–May 2021, and Total Case Counts before and from May 2020

	Colonization Testing (Screening) May 2020 – May 2021			Total Case Counts	
Facility Type	Number of HCF Performing Screening	Number of Colonization Swabs Tested	% Colonization Swabs Tested Positive	Total Cases (%) May 2020–May 2021	Total Cases (%) January 2017–April 2020
ACH	39	1488	7.7%	113 (9.5%)	9 (3.4%)
LTACH	19	9025	10.2%	906 (76.0%)	161 (61.7%)
SNF	82	4888	3.4%	19 (1.6%)	7 (2.7%)
vSNF	70	1675	1.3%	152 (12.8%)	82 (31.4%)
Other	16	45	2.2%	2 (0.2%)	2 (0.8%)
TOTAL	226	17,121	7.1%	1192	261

ACH=acute care hospital; LTACH=long-term ACH; SNF=skilled nursing facility; vSNF=ventilator-equipped SNF; HCF=healthcare facility

Table 2. COVID-19-related Infection Control Practices Affecting C. auris Spread, and Associated Public Health Recommendations

Observations of Infection Control Practices Related to COVID-19	Public Health Recommendations
Cohorting patients on COVID-19 status only	Cohort considering all communicable disease (CD) status.
Improper personal protective equipment (PPE) use (e.g., double-gowning, -gloving)	Address healthcare personnel (HCP) concerns; perform competency-based training on proper PPE use.
Inadequate environmental cleaning and related auditing	Address HCP safety concerns (including adequate PPE); educate on proper contact time; ensure routine monitoring of daily and terminal cleaning/disinfection.
Implementation of crisis capacity strategies during perceived PPE shortages (i.e., reuse, extended use of gowns/gloves, including in hallways)	Do not reuse gowns/gloves; only implement crisis capacity strategies after requesting supplies through the emergency coordination center, and exhausting all contingency capacity strategies; if extending use of gowns/gloves, only do so when all CD status known and for patients with the same CD status housed in the same room.

Conclusion. The *C. auris* resurgence in CA was likely a result of COVID-19-related practices and conditions. An aggressive, coordinated, interjurisdictional *C. auris* containment response, including proactive prevention activities at HCF interconnected with outbreak HCF, can help mitigate spread of *C. auris* and potentially other novel AR pathogens.

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

170. Reduction in Bloodborne Pathogen Splash Exposures After Implementation of Universal Masking and Eye Protection for COVID-19

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Session: O-34. The Interplay Between COVID and other Infections

Background. While splashes to the eyes, nose and mouth can often be prevented through appropriate personal protective equipment (PPE) use, they continue to occur frequently when PPE is not used consistently. Due to the COVID-19 pandemic, we implemented universal masking and eye protection for all healthcare personnel (HCP) performing direct patient care and observed a subsequent decline in bloodborne pathogen (BBP) splash exposures.

Methods. Our healthcare system, employing >12,000 healthcare personnel (HCP), implemented universal masking in April 2020 and eye protection in June 2020. We required HCP to mask at all times, and use a face shield, safety glasses or goggles when providing direct patient care. Occupational Safety tracked all BBP exposures due to splashes to the eyes, nose, mouth and/or face, and compared exposures during 2020 to those in 2019. We estimated costs, including patient and HCP testing, related to splash exposures, as well as the additional cost of PPE incurred.

Results. In 2019, HCP reported 90 splashes, of which 57 (63%) were to the eyes. In 2020, splashes decreased by 54% to 47 (36 [77%] to eyes). In both years, nurses were the most commonly affected HCP type (62% and 72%, respectively, of all exposures). Physicians (including residents) had the greatest decrease in 2020 (10 vs. 1 splash exposures [90%]), while nurses had a 39% decrease (56 vs. 34 exposures). Nearly all of the most common scenarios leading to splash exposures declined in 2020 (Table). We estimated the cost of each BBP exposure as $2,940; this equates to a savings of $123,228. During 2020, we purchased 65,650 face shields, safety glasses and goggles (compared to 5303 similar items in 2019), for an additional cost of $238,440.

Specific activities identified as leading to bloodborne pathogen splash exposures, 2019 vs. 2020.

Activity	2019 Splash Reports N = 90	2020 Splash Reports N = 47	Difference (%)
Direct patient care, including positioning	13	10	-23%
Discontinuing IVs	10	4	-60%
Handling uncooperative patient	9	12	33%
During disposal of needles/supplies	7	2	-71%
Inserting IV/site care/dressing change	7	1	-86%
Flushing, irrigating tubes/lines/drains	5	3	-40%
Emptying urine/drain collection device	4	3	-25%
Performing fingerstick glucose	3	0	-100%
Inserting/discontinuing nasogastric tube	3	1	-67%
Procedures	24	10	-58%
Assisting with surgery/invasive procedure	9	3	-67%
Blood draws/injections	5	2	-60%
Wound care	5	0	-100%
Inserting/removing urinary device	3	1	-67%
Other procedures*	2	4	100%
All other	5	1	-80%

*Included performing CPR, suctioning, vaginal exams.

Conclusion. We observed a significant decline in splash-related BBP exposures after implementing universal masking and eye protection for the COVID-19 pandemic. While cost savings were not observed, we were unable to incorporate the avoided pain and emotional trauma for the patient, exposed HCP, and coworkers. This unintended but positive consequence of the COVID-19 pandemic exemplifies the need for broader use of PPE, particularly masks and eyewear, for all patient care scenarios where splashes may occur.

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

171. The Impact of COVID-19 on Healthcare-Associated Infections

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For the CDC Prevention Epicenters Program

Session: O-34. The Interplay Between COVID and other Infections

Background. The profound changes wrought by COVID-19 on routine hospital operations may have influenced performance on hospital measures, including healthcare-associated infections (HAIs).

Objective. Evaluate the association between COVID-19 surges and HAI or cluster rates

Methods. **Design:** Prospective cohort study

Setting. 148 HCA Healthcare-affiliated hospitals, 3/1/2020-9/30/2020, and a subset of hospitals with microbiology and cluster data through 12/31/2020

Patients. All inpatients

Measurements. We evaluated the association between COVID-19 surges and HAIs, hospital-onset pathogens, and cluster rates using negative binomial mixed models. To account for local variation in COVID-19 pandemic surge timing, we included the number of discharges with a laboratory-confirmed COVID-19 diagnosis per staffed bed per month at each hospital.

Results. Central line-associated blood stream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia increased as COVID-19 burden increased ($P \leq 0.001$