Results. Among 32,575 treated and same number of untreated persons in the final dataset, median age was 58 years, 27% were Black race, and 96% were male. The incidence rate for CVD events/1,000 person-years (95% CI) among the treated was 19.10 (17.79, 20.50) vs. 32.37 (30.51, 34.33) among the untreated (P < 0.001). Treatment with a DAA regimen (vs. PEG/RBV; HR [95% CI] 0.68 [0.53, 0.88]) and achieving SVR (HR [95% CI] 0.76 [0.63, 0.93]) were associated with a lower risk of incidence CVD events. Kaplan-Meier curves demonstrated that untreated persons had a shorter CVD event-free survival during 30 months of follow-up compared with the treated persons. (figure; log-rank P < 0.001)

Conclusion. HCV treatment is associated with a reduction in incident CVD events. Directly acting antiviral regimens (vs. PEG/RBV) and attainment of SVR (vs. no SVR) are associated with a lower risk of incident CVD events.

Table. Factors associated with a diagnosis of incident cardiovascular disease event (multivariable Cox regression analysis) among those who were treated.

| Factor                      | HR 95% CI          |
|-----------------------------|--------------------|
| Age per 10 year increase    | 1.72, 1.50, 1.99   |
| Race                        |                    |
| Black                       | 1.21, 1.01, 1.46   |
| Hispanic                    | 0.74, 0.48, 1.13   |
| Others/unknown              | 1.01, 0.79, 1.29   |
| Male sex (vs. female)       | 1.04, 0.66, 1.66   |
| Smoking                     |                    |
| Never (vs. smoker)          | 1                  |
| Former                      | 0.87, 0.68, 1.11   |
| Current                     | 1.34, 1.08, 1.66   |
| Body mass index, > 30 kg/m² (vs. <=30) | 1.38, 1.17, 1.62 |
| Dyslipidemia                |                    |
| Optimal levels (vs. 0)      |                    |
| Borderline or High          | 0.79, 0.65, 0.96   |
| Liver fibrosis              |                    |
| FIB-4 < 1.25 (vs. 1.25)     |                    |
| FIB-4 1.26 - 3.25           | 0.80, 0.65, 1.09   |
| FIB-4 > 3.25                | 0.80, 0.65, 1.09   |
| Chronic kidney disease (CKD stage) | 1                |
| eGFR >= 90 (vs. <90)        |                    |
| CKD 2                       | 1.20, 1.02, 1.43   |
| CKD 3                       | 1.93, 1.36, 2.75   |
| CKD 4-5                     | 5.54, 2.59, 11.85  |
| Treatment with a DAA regimen (vs. PEG+RBV) | 0.68, 0.53, 0.88 |
| SVR (vs. no SVR)            | 0.76, 0.63, 0.92   |

Figure. Kaplan-Meier curves demonstrating CVD free survival among treated vs. untreated and those with SVR vs. no SVR.

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931. Telemedicine for the Treatment of Hepatitis C: A Systematic Review and Meta-Analysis
David De Gijsel, MD, MSc; Blake Kruger, BS; Dena Hakim, BS; and Sarah Moore, BA, Infectious Disease, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire and The Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, New Hampshire
Session: 114. Hepatitis C: Epidemiology and Elimination
Friday, October 5, 2018: 8:45 AM

Background. Hepatitis C (HCV) is a curable cause of liver disease, typically treated by specialists. Access to specialists is limited in rural areas. Telemedicine between generalists and specialists could yield outcomes comparable with care provided by specialists in face-to-face (FTF) encounters. To assess the effectiveness of HCV treatment through telemedicine compared with usual care, as measured by sustained virologic response (SVR).

Methods. We searched MEDLINE, the Cochrane Library, ClinicalTrials.gov, the Database of Abstracts of Reviews of Effects, and Excerpta Medica Database from inception to March 2018. We included Randomized Controlled Trials (RCTs) and cohort studies comparing telemedicine in rural settings to FTF encounters with specialists in treating HCV. Studies reported cure as measured by SVR. We did not apply any exclusion criteria. At least 2 independent researchers used PREISMA guidelines to extract data. We used a modified Newcastle-Ottawa Scale and the Cochrane Collaboration Tool for Assessing Risk of Bias to assess observational studies and RCTs. We used a random-effects model to calculate pooled odds ratios (OR). The primary outcome was clinical cure. Cure was defined as SVR at 12 weeks after completion of treatment.

Results. Of 1,211 potentially eligible studies, 10 studies, representing 43,117 subjects, met inclusion criteria. Pooled analysis showed no difference in the odds of achieving SVR when comparing telemedicine to FTF specialist care (OR 1.01 [95% CI 0.78–1.30]). This result was robust across sensitivity analyses, including restriction to patients who completed treatment (OR 0.78 [95% CI 0.43–1.39]), restriction to studies excluding outliers, and exclusion of abstracts. There was significant heterogeneity [P = 0.003, I² = 64].

Conclusion. In rural areas with limited access to specialists, care provided by telemedicine-supported generalists is as effective as FTF specialist care in achieving cure of HCV. Telemedicine is a viable option to expand access to HCV care in rural settings.

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932. Universal Hepatitis C Virus Screening in a Tennessee Tertiary Care Emergency Department
Cody A. Chastain, MD; Jakea Johnson, MPH; Karen Miller, RN, MPA, CHFN; Teni Moore, RSN, RN, CCRN; Amanda Lake, RSN, RN, CEN; Autumn Zuckerman, PharmD, BCPS, AAHIVP, CSP; Jin H. Han, MD, MSc; and Wesley H. Self, MD, MPH; 1Division of Infectious Diseases, Department of Medicine, Vanderbilt University School of Medicine, Nashville, Tennessee, 2Department of Emergency Medicine, Vanderbilt University Medical Center, Nashville, Tennessee, and 3Vanderbilt Specialty Pharmacy, Vanderbilt University Medical Center, Nashville, Tennessee
Session: 114. Hepatitis C: Epidemiology and Elimination
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Background. Despite hepatitis C virus (HCV) age cohort and risk factor screening recommendations, many at-risk individuals remain undiagnosed. Current screening practices may not adequately capture those at high risk for infection, especially in regions with increasing injection drug use (IDU). Universal HCV screening in a Tennessee tertiary care emergency department (ED) was introduced to help define regional epidemiology and to improve diagnosis and linkage to care.

Methods. This screening program was implemented in the Vanderbilt University Medical Center ED. Adult patients who underwent phlebotomy for clinical purposes were offered HCV screening. Samples were initially tested for HCV antibodies; if positive, samples were reflexed for HCV RNA testing. Patients with positive HCV RNA tests (i.e., active HCV infection) were notified, counseled, and offered linkage to care.

Results. A total of 11,637 screening tests were performed between April 1, 2017 and March 31, 2018, with 1,008 (8.7%) HCV antibody positive and 488 (4.2%) RNA positive. Of note, 81 (0.7%) were HCV antibody positive but RNA testing could not be performed due to insufficient sample volume. Several notable populations had high rates of HCV (Table 1). Importantly, 3.9% of people not born between 1945 and 1965 were HCV RNA positive, and they were the majority (63.5%) of patients with active HCV (Table 2). A minority (31.6%) of those with active HCV had a known history of IDU (Table 2).

Conclusion. HCV is common among patients presenting for emergency care at a Tennessee tertiary care ED. Universal screening identified many infections that would have been missed using age cohort and risk factors alone. ED HCV screening may be a useful method to augment guideline-based testing and intervene among populations not consistently screened.

Table 1: Notable Groups Screened for HCV (n = 11,537)

| Demographics                          | Total Screened | HCV Antibody + (% | HCV RNA + (%) |
|---------------------------------------|----------------|-------------------|--------------|
| People Born 1945–1965                  | 3,670          | 346 (11.9%)       | 178 (4.9%)   |
| People Not Born 1945–1965              | 7,967          | 572 (72.7%)       | 310 (3.9%)   |
| Women Age 18–45                        | 2,622          | 156 (5.9%)        | 77 (2.9%)    |

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