or HBsAg seronegative to seropositive), or flare of hepatitis (HBV viral reactivation plus ALT increase ≥10 times baseline value) at any time after initiating DAA treatment. We also determined factors associated with HBV use among the Cox regression analysis.

**Results.** We identified 45,137 persons on DAA therapy. Among those with available follow-up data, overall HBV reactivation was observed in 795 persons. HBV reactivation was observed in 4.8% (17/352) of persons on sofosbuvir/daclatasvir and elbasvir/grazoprevir with detectable HBV DNA at baseline (Table). Treatment with any regimen was associated with a significantly lower risk (number of persons on sofosbuvir/daclatasvir and elbasvir/grazoprevir were small to make meaningful inferences) of HBV reactivation.

**Conclusion.** Among HCV infected persons treated with a DAA regimen, HBV viral reactivation and HBV reactivation are common, but clinical hepatitis or ALT flares are rare. DAA regimens are not associated with HBV reactivation.

Table 1: Logistic regression results predicting HCV TX in Safety Net Hospitals in Texas and California

| Characteristic | Total (n = 14,776) HCV TX (n = 648) |
|---------------|---------------------------------|
| Age, per 1 year increase | 1.01 (0.99, 1.03) |
| Black | 1.01 (0.99, 1.03) |
| Other | 1.01 (1.00, 1.02) |
| Hispanic | 1.01 (0.99, 1.03) |
| Other race/NAFLD | 1.01 (0.99, 1.03) |
| Male | 1.01 (0.99, 1.03) |
| Body mass index, per unit increase | 1.01 (0.99, 1.03) |
| Child B | 1.01 (0.99, 1.03) |
| Child A | 1.01 (0.99, 1.03) |
| HIV | 1.01 (0.99, 1.03) |
| Mental Health | 1.01 (0.99, 1.03) |
| N (%) | 95% Confidence Interval |
| HBV RNA, per 1 log10 IU/mL increase | 1.01 (0.99, 1.03) |
| HBsAg+, % (at baseline) | 1.01 (0.99, 1.03) |
| HBsAb+, % (at baseline) | 1.01 (0.99, 1.03) |
| HBV DNA, (Vs. undetectable) | 1.01 (0.99, 1.03) |
| ALT, per 10 IU/mL increase | 1.01 (0.99, 1.03) |

**Disclosures.** A. Butt, Merck: Investigator, Grant recipient

527. Mental Health, Heart Disease, and Lack of Insurance Associated with Not Receiving Hepatitis C Treatment in Safety-Net Hospitals

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**Session:** 59. Hepatitis B and C in Varied Settings

**Thursday, October 5, 2017: 12:30 PM**

**Background.** Those in safety-net hospitals are especially vulnerable to lack of access to specialty care and curative treatment (Tx) for hepatitis C (HCV). We examined predictors of receiving HCV Tx in safety-net hospitals.

**Methods.** We retrospectively examined all adults who received care 1/1/11–2/28/17 in our two safety-net hospitals in California and Texas and had a diagnosis of HCV. We examined age, race/ethnicity, gender, insurance status, body mass index, liver-related complications (hepato-cellular cancer (HCC), cirrhosis, ascites, non-alcoholic fatty liver disease, NAFLD) hepatic encephalopathy, variceal bleeding) non-liver related co-morbidities [HIV, non-HCC cancers, mental health, cardiovascular disease (CVD), hypertension (HTN), diabetes (DM)] alcohol use, and drug use. We evaluated the predictors of receiving HCV Tx using multivariate logistic regression models.

**Results.** Among 14,776 HCV patients in the study, most of the HCV patients (61% male, 43% Black, and 16% Hispanic) had Indigent care (42%), Medicare (14%), and Medicaid (27%). Co-morbidities in this population included mental health (71%), CVD (60%), HTN (51%), DM (21%), and HIV (9%). Indigent care, mental health and CVD co-morbidities were associated with lower rates of HCV Tx but Other race and NAFLD were associated with higher rates of Tx (see Table 1).

**Table 1:** Factors associated with hepatitis B virus reactivation (multivariable Cox model).

| Hazard ratio | 95% confidence interval |
|-------------|------------------------|
| Age, per 1 year increase | 0.96 | 0.91, 1.01 |
| Race | Black | 1.21 (0.87, 1.70) |
| Hispanic | 1.14 (0.78, 1.68) |
| Other | 0.75 (0.52, 1.09) |
| Body mass index, per unit increase | 1.01 | 0.99, 1.03 |
| Child B | 1.01 (0.99, 1.03) |
| Child A | 1.01 (0.99, 1.03) |
| HIV | 1.01 (0.99, 1.03) |
| Mental Health | 1.01 (0.99, 1.03) |
| HBV RNA, per 1 log10 IU/mL increase | 1.01 | 0.99, 1.03 |
| HBsAg+, % (at baseline) | 0.30 | 0.21, 0.45 |
| HBsAb+, % (at baseline) | 0.64 | 0.53, 0.76 |
| HBV DNA, (Vs. undetectable) | 1.01 | 0.99, 1.03 |
| ALT, per 10 IU/mL increase | 1.01 | 0.99, 1.03 |

**Conclusion.** In our safety-net hospitals only 4.4% received HCV Tx. Those with indigent funding, mental illness or cardiac disease were significantly less likely to receive HCV treatment. These data indicate that certain populations are less likely to have access to HCV care. The reasons for this remains unknown. If we are to move towards HCV elimination, we must find strategies to increase access.

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528. HCV Treatment Initiation in Patients with Chronic Kidney Disease: Results from ERCHIVES

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**Session:** 59. Hepatitis B and C in Varied Settings

**Thursday, October 5, 2017: 12:30 PM**

**Background.** Newer directing antiviral agents against HCV (DAAs) are safe and efficacious in persons with chronic kidney disease (CKD). Whether availability of these newer DAAs has resulted in more persons with CKD initiating HCV treatment remains unknown.

**Methods.** We identified HCV+ persons in ERCHIVES. We excluded HIV+ and HBsAg+ and those with missing HCV RNA and eGFR data. We determined the CKD stage according to National Kidney Foundation criteria. We determined the number of persons initiated on any of the approved DAA regimens (defined as >14 days of DAA prescription). Logistic regression analyses were used to determine factors associated with treatment initiation.

**Results.** Among 76,513 evaluable persons, 21.1% initiated DAA treatment. Initiation rates differed significantly by CKD stage: 21.1% (15,136/68,468) for eGFR=90/mL/minute/1.73m2 and CKD stage-2; 14.0% 9683/68,068 for CKD stage-3; and 7.6% (148/1,958) for CKD stage-4. Those with CKD stage-3 were 35% less likely and those with CKD stage-4 were 65% less likely to initiate treatment with a DAA compared with those with baseline eGFR=90/mL/minute/1.73m2. Those with Body Mass Index (BMI)>30 were more likely to initiate treatment (OR 1.24, 95% CI 1.19,1.29). Treatment initiation was less likely in HCV genotype 2 or 3 and those with diabetes (OR 0.82, 95% CI 0.78,0.86), cardiovascular disease (OR 0.73, 95% CI 0.68,0.78), alcohol abuse or dependence (OR 0.75, 95% CI 0.72,0.78) or cirrhosis (OR 0.85, 95% CI 0.80,0.89) at baseline.

**Conclusion.** Persons with more advanced CKD are less likely to receive HCV treatment. Strategies are needed to improve treatment rates in the HCV/CKD population.
529. Evaluation of the Hepatitis C Cascade of Care in a Multidisciplinary Infectious Diseases Clinic
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Session: 59. Hepatitis B and C in Varied Settings
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Background. Despite emerging hepatitis C virus (HCV) treatments, barriers remain within the cascade of care (CoC) that limit impact in real-world practice. Assessing breakdown in the HCV CoC will provide targets for interventions to facilitate improved access and treatment. The objective of this study was to identify factors associated with movement through the HCV CoC after referral to a multidisciplinary infectious diseases (ID) clinic, including both general and historically difficult to treat populations.

Methods. This is a single-center, retrospective, cohort study of patients receiving care at the Vanderbilt University Medical Center (VUMC) ID Clinic between July 2015 and September 2016. Data were collected from the electronic medical record used for patient care. For the purposes of this study, the defined CoC started with referral to the VUMC ID clinic and followed progression through HCV evaluation, prescription, approval, initiation, and completion of treatment, and achievement of sustained virologic response at least 12 weeks after treatment completion (SVR12). The primary endpoint was completion of treatment. Secondary endpoints were achievement of each endpoint and an Internist, within a resident primary care clinic. We describe our experiences from the first year of this program and have developed a cascade of care model to evaluate our progress.

Results. Of the 182 patients referred to the VUMC ID clinic during our study period, 101 (55.5%) achieved the primary endpoint of treatment completion. Having Medicaid insurance was associated with a lower rate of treatment approval compared with those with other forms of insurance or no insurance (76.2% compared with 97.8%, P < 0.001). The largest loss of patients in the CoC occurred from referral to the VUMC ID clinic and followed progression through HCV evaluation, prescription, approval, initiation, and completion of treatment, and achievement of sustained virologic response at least 12 weeks after treatment completion (SVR12). The presence of HIV co-infection, psychiatric disorder, cirrhosis, or ongoing illicit drug use was not found to impact the primary endpoint.

Conclusion. This study shows overall high rates of HCV CoC completion within a multidisciplinary ID Clinic. The primary barrier to treatment completion identified was having Medicaid insurance. Based on our results, emphasis should be placed on improving patient engagement in care from referral to HCV evaluation.

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