308. Slow Adoption of a Nurse-Driven Protocol for Universal Hepatitis C Virus Screening in a Hospital Emergency Department: Lessons Learned
Zainab Wasti, MD; Dagan Coppock, MD; Zoila Ssep, MD; Tiffany Scott; Tanessa Franks; Anna Keseris; Edgar Chou, MD and Dong Heun Lee, MD; Drexel University College of Medicine, Philadelphia, Pennsylvania
Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM
Background. In areas with a high prevalence of hepatitis C virus (HCV) infection, emergency department (ED) visits may provide unique opportunities for screening. The catchment area for Hahnemann University Hospital (HUH) has an HCV seroprevalence rate of ≥20%. However, limited data exist addressing HCV testing strategies in the ED. This study describes the experience of piloting a nurse-driven HCV screening protocol in an urban hospital ED.
Methods. A nurse-driven HCV screening protocol was developed and implemented on August 1, 2018. We performed a retrospective analysis of the protocol’s performance from July 1, 2018, through December 31, 2018. Patients who were evaluated in the ED and had blood collected were analyzed. We provided universal HCV screening regardless of risk factors, if HCV positive by antibody screen and viral load confirmation, an attempt was made to link patients to care. Linkage was defined as having received an inpatient evaluation by either infectious diseases or hepatology physician.
Results. Among 20,705 unique patients seen in the ED, 7841 (38%) had blood work collected. 821 (10.5%) patients had HCV antibody testing. After the implementation of the nurse-driven protocol, the testing rate increased from 68/1340 (5.1%), to 753/6501 (11.6%). 260 Baby Boomers (born between 1945–1965) were screened, of which 60 (23.1%) had positive screens. 561 non-Baby Boomers were screened, of which 30 (5.4%) had positive screens. Barriers of implementing nurse-driven protocol were: (1) multiple steps of the ordering process in the electronic medical record (EMR), (2) the complexity of staff schedules, and (3) staff concerns regarding the disclosure of HCV test results. Among the patients who were diagnosed with chronic HCV, 60 % were linked to care for treatment.
Conclusion. We piloted a nurse-driven universal HCV testing protocol in the ED of a hospital with high HCV prevalence. Though the screening rate doubled, it was still low. We identified barriers that may be addressed to improve future screening rates. In areas with a high seroprevalence of HCV, universal screening may provide an excellent public health intervention to identify asymptomatic HCV-infected patients.
Disclosures. All authors: No reported disclosures.

309. Should Primary Care Practitioners Follow Hepatitis C Exposed Infants?
Naval Mervaneh, MD; Carmen Smotherman, MS; Nizar Maraga, MD and Ayesha Mirza, MD; University of Florida, Jacksonville, Florida
Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM
Background. Hepatitis C virus (HCV) infection in pregnancy is estimated between 1–4% and risk of vertical transmission ~5%. While the benefits of HCV testing during pregnancy, medical care defined as at least one infant PID clinic visit, and appropriate F/U (as an 18-month visit for HCV (Ab) check. Univariate analysis is used for demographic, descriptive summaries were recorded, frequencies and percentages.
Results. 214 infants included in analysis (1 deceased and 12 adopted and left area). Baseline characteristics of those who had medical care vs. not were similar except for infant custody and HIV co-infection 94/214 (44%) had medical care. Of those, 32/94 (34%) had appropriate F/U while 62/94 (67%) did not 31/214 of infants were followed by primary care practitioners (PCPs) at our institution. Of those 24/31 (77.5%) were either tested inappropriately or lost to F/U HCV co-infection and custody by a relative (not mom) increase the likelihood of F/U (P = 0.003 and 0.002, respectively) 5 infants contracted HCV infection. One infant who lost to F/U was diagnosed incidentally in the ER.
Conclusion. Appropriate F/U for HCV exposed infants poses challenges despite established systems of care. Because current guidelines recommend antibody testing at 18 months, educating PCPs who are more likely to establish regular F/U is important for appropriate testing.
Disclosures. All authors: No reported disclosures.

310. Disparities in Hepatitis C Linkage to Care in the DAA Era: Findings from a Referral Clinic with an Embedded Nurse Navigation Model
Jacqueline Sherbuk, MD; Kathleen McManus, MD, MSc; Terry Knick, MPH and Rebecca Dillingham, MD, MPH; University of Virginia, Charlottesville, Virginia
Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM
Background. Direct-acting antivirals (DAAs) have simplified and expanded access to hepatitis C virus (HCV) treatment. Only 17% of the estimated 2.4 million Americans currently infected with HCV have linked to HCV specialty care. We evaluated linkage to care (LTC) in a non-urban hepatitis C referral clinic with a nurse navigator model of care and identified disparities in LTC during the DAA era.
Methods. A single-center retrospective cohort analysis was performed among all patients referred to an infectious diseases HCV clinic between 2014 and 2018. The primary outcome was LTC, defined as attendance at a clinic appointment. A multivariable Poisson regression model estimated associations of patient characteristics with LTC.
Results. Among 824 referred patients, 624 (76%) successfully linked to care and 369 (45%) achieved sustained vireologic response. The mean age was 48.5 years (SD 13.5 years) and 46% (382 of 824) were uninsured. Common reasons for failure of LTC included no-shows (26.5%), could not be contacted (20.5%) and incarceration (10%). On multivariable analysis, LTC rates were higher among women (incidence rate ratio (IRR) 1.11, 95% CI 1.03–1.20, P = 0.01) and those with cirrhosis (IRR 1.20, 95% CI 1.11–1.30, P < 0.001). Lower rates of LTC were seen for young people (< 40 years old) (IRR 0.88, 95% CI 0.79–0.98, P = 0.02) and uninsured people (IRR 0.85, 95% CI 0.77–0.94, P = 0.002). Race, proximity to care, substance use, and HIV status were not associated with differentiated LTC rates.
Conclusion. In an embedded nurse navigator model of care, a high rate of LTC was achieved despite the prevalence of barriers, including a high uninsured rate. LTC was the biggest drop-off in the cascade. Disparities in LTC based on age, sex, and insurance status are present. Substance use was not associated with differences in LTC, supporting current recommendations to provide treatment to all patients with HCV. No-shows were common, potentially due to lack of reliable contact information or lack of transportation. Qualitative work exploring patients’ experiences leading to failure of LTC would be helpful. Future interventions to improve care could include expanded access to insurance, affordable medical tests, and programs bridging care for incarcerated populations.

Table: Patient characteristics associated with successful linkage to care in a multivariable Poisson regression model (N=762).

| Patient Characteristic | IRR (95% CI) | P |
|------------------------|--------------|---|
| Age                     |              |   |
| > 40 years              | 1 (ref)      | na |
| ≤ 40 years              | 0.88 (0.79–0.98) | 0.02 |
| Sex                     |              |   |
| Male                   | 1 (ref)      | na |
| Female                 | 1.11 (1.03–1.20) | 0.007 |
| Race                    |              |   |
| White                  | 1 (ref)      | na |
| Black                  | 1.07 (0.97–1.18) | 0.17 |
| Other                  | 1.08 (0.90–1.21) | 0.41 |
| Insurance Coverage     |              |   |
| Private                | 1 (ref)      | na |
| Medicaid/Medicare      | 0.91 (0.83–1.01) | 0.07 |
| Uninsured              | 0.85 (0.77–0.94) | 0.002 |
| Close Proximity to medical center | 0.93 (0.85–1.02) | 0.13 |
| Cirrhosis              | 1.19 (1.10–1.30) | <0.001 |
| Hepatitis B            | 1.18 (1.06–1.32) | 0.07 |
| Hepatitis C            | 1.02 (0.91–1.15) | 0.76 |

Incidence rate ratios are adjusted for the variables included in the table. Abbreviations: IRR=Incidence Rate Ratio; CI=Confidence Interval.