patients received treatment through prior authorizations and uninsured through pharmaceutical patient assistance programs. We examined demographics, homelessness, insurance, fibrosis score, substance use, and psychiatric illness, as potential predictors to treatment initiation using univariate and multivariate logistic regression analysis.

Results. Among the 16,363 BBs screened from March 1, 2016 to December 31, 2017, 1,445 (8.8%) were HCV Ab+ and 1,038 (7.2%) had HCV RNA completed. Among the 724 (5%) with confirmed HCV infection, 139 (19%) received LTC without notification, 299 (41%) received navigation, and 286 (40%) could not be contacted after three attempts. Among those who received navigation, 225 (75%) completed a follow-up visit of which 81 (36%) did not start treatment, 34 (15%) are awaiting treatment initiation, and 110 (49%) started treatment. Gender, race/ethnicity, psychiatric illness, and homelessness were not predictive of starting HCV treatment. In multivariate analysis, current substance users, none/past use (OR 0.52 (0.29, 0.93)) was associated with a lower likelihood of starting treatment and advanced fibrosis (OR 2.25 (1.20, 4.21)) was associated with higher likelihood of starting treatment. Compared with uninsured patients, Medicaid patients were less likely to start treatment (AOR 0.15 (0.07, 0.34)) in a multivariate analysis.

Conclusion. Insurance status was independent predictor of starting treatment among patients at our safety-net hospital. Medicaid remained a barrier to HCV treatment access in safety-net systems.

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2208. Fibrosis Surveillance by Transient Elastography in Patients with Untreated Hepatitis C Infection

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Background. Despite the widespread availability of curative HCV therapy and recommendations to consider all HCV-infected patients for treatment, many remain untreated. Illinois medicaid continues to restrict HCV therapy to patients with stage F3 or F4 fibrosis. In our Hepatitis Clinic, untreated patients are counseled and scheduled for follow-up scans at 6–12 months. This keeps patients engaged in care and allows us to identify progression of liver disease. Our study aims were to describe fibrosis assessments in HCV patients and identify predictors of fibrosis progression among untreated HCV-infected patients.

Methods. HCV-infected untreated patients with >1 transient elastography by Fibroscan® between April 2014 and March 2018 and with a baseline scan ≤Stage 2 fibrosis were included in the study. All scans were done by certified operators; 793 (63%) done by one operator. Fibroscan criteria; Stages 0–1 fibrosis; ≤7.0 Kpa and Stage 2 fibrosis; ≥7.1 Kpa.

Results. A total of 545 patients had a total of 1,260 scans. Median age of 59 years. 64% male, 70% African American, 23% White and 14% Hispanic. 196 (36%) HCV+; 399 (73%) patients had two scans, 127 (23%) patients had three scans and 14 (4%) patients had 4+ scans. Median time between scans was 12.8 months (range 9.2–17.3 months) with a median duration of 12.8, 24.5 and 40 months between the baseline and second, third or fourth scans respectively. Median baseline score was 6.4 (range 5.3–7.7); 65.3% F0–F1 and 34.7% F2. At last scan, 62% remained at the same stage, 23% had moved 1 stage and 15% regressed from Stage 2 to Stage 1. In the subset who regressed, scores went from 7.6 to 8.1.

Conclusion. For the majority of HCV+ patients with mild liver fibrosis at baseline, fibrosis severity remained essentially flat. Progression to moderate/severe fibrosis occurred more often among patients with Stage 2 fibrosis at baseline. Engagement in care remains important to identify patients with fibrosis progression as advocacy to ensure access to curative treatment for all continues.

Table 1. Proportion of Patients with ≥F3 at Follow-Up Stratified by Baseline Stage

| Baseline Fibrosis | N (%) | F3 at Follow-Up 1 (Median Time to Scan) | N (%) | F3 at Follow-Up 2 (Median Time to Scan) | N (%) | F3 at Follow-Up 3 (Median Time to Scan) |
|-------------------|-------|----------------------------------------|-------|----------------------------------------|-------|----------------------------------------|
| Stages 0–1         | 133 (5.1%) | 170 months | 3 (0.4%) | 19.0 months | 0 (0.0%) | 0.0 months |
| Stage 2           | 41 (0.1%) | 12.7 months | 11 (25.0%) | 20.1 months | 2 (15.2%) | 21.0 months |

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2209. Discordance Between FibroSure and FibroScan Results in Hepatitis C and Human Immunodeficiency Virus Co-infected Patients Prior to Treatment for Hepatitis C Virus Infection

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Background. The accurate diagnosis of hepatitis C virus (HCV)-related fibrosis is crucial for prognosis and treatment decisions. FibroSure and FibroScan are commonly used to approximate METAVIR HCV fibrosis treatment. Both methods have been validated for their correlation to the five-level (F0–F4) METAVIR scoring system. However, the correlation between these two tests in HIFV/HCV co-infected patients has not been well described. Here, we evaluated the concordance between FibroSure and FibroScan-derived METAVIR results in HCV/HIV co-infected patients.

Methods. We performed a retrospective cross-sectional study of HIFV/HCV co-infected patients that were treated between 2014 and 2017 at Drexel University, Philadelphia, PA. We described patient demographics and overall METAVIR scores of treated patients. Further, we compared the concordance between FibroSure and FibroScan results among patients who had both tests before the start of HCV treatment.

Results. One hundred and thirty-eight HIV/HCV co-infected patients were treated. Most of them (N = 134, 97%) achieved sustained virologic response after 12 weeks of treatment. One hundred and thirty-three patients underwent FibroSure testing before starting HCV treatment. Of those, 62 (47%) fell in the F0–F2 range and 71 (53%) in the F3–F4 range. Of those 133 patients, 21 also underwent FibroScan. Fourteen (67%) fell in the F0–F2 range, while seven (33%) fell in the F3–F4 range. Of the 21 patients who both had FibroSure and FibroScan testing, 12 (57%) had concordant and 9 (43%) discordant results. Of the patients with discordant results, eight had higher fibrosis scores (F3–F4) with FibroSure, while only one had a higher fibrosis score (F3–F4) with FibroScan.

Conclusion. In our study, more than half of HIV/HCV co-infected patients had advanced fibrosis score at the time of HCV treatment. When FibroSure and FibroScan scores were compared, close to half of co-infected patients had discordant results; the preponderance of which had higher FibroSure scores. As early initiation of HCV treatment is crucial to co-infected patients, further studies will need to evaluate the clinical significance of the discrepancy between different non-invasive fibrosis testing systems in co-infected patients.

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2210. An Online Survey of Hepatitis C Testing Attitudes and Practice Habits Among Residents at an Urban Medical Center

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Background. The hepatitis C virus (HCV) is the most common blood-borne infection; treatments are well tolerated, highly effective, and improve health outcomes. A recent blinded seroprevalence study of ED patients identified an undiagnosed HCV prevalence of 68%. New York State recently highlighted a strategic plan to reduce the incidence and prevalence of HCV through aggressive testing, linkage, and treatment. To evaluate HCV screening practices, we conducted a survey of resident attitudes and practice habits surrounding HCV screening.

Methods. From August 1, 2017 to April 30, 2018 we conducted an anonymous online survey to examine attitudes about sexual health screening among residents at an upper Manhattan academic medical center. Response rates were 22% (33) for internal medicine (IM), 45% (35) for pediatrics (Peds), and 21% (10) for emergency medicine (EM). Results. A majority of IM residents (61%) agreed that HCV screening was one of their responsibilities as compared with Peds (23%, P = 0.002) and EM residents (20%). This differed from HCV testing where the majority of residents across disciplines (73, 71, 60%) considered HCV screening to be their responsibility. IM residents were more likely to agree that it is important to screen for HCV in all care settings. However, less than half of them considered HCV screening (42%) or successfully screened (45%) the majority of their eligible patients. Barriers to HCV screening were diverse across specialty groups with the majority of EM residents concerned about inadequate resources (90%) and issues surrounding minority (47%) females. When IM residents were concerned about higher priority issues (85%) and time constraints (58%). Peds residents were concerned that HCV testing was outside their scope of practice (69%) and that the prevalence was too low (63%). When informed that one-third of individuals diagnosed with HCV were treated, IM residents were twice as likely to consider screening their patients for HCV.

Conclusion. IM residents acknowledged the importance of HCV screening and felt it was appropriate to screen in all settings but identified challenges to screening.