295. South Carolina Hepatitis C Telehealth Initiative (SCHTI): Increasing Access to HCV Care
Caroline Derrick, PharmD1; Cody A. Chastain, MD2; Eric G. Meisner, MD, PhD2; Bryan Love, PharmD, MPH2; Tyler Wagner, PharmD Candidate1; Adriena Harrison, MSN, RN, ACRN2; Kimberly Crawford, NA3 and Divya Ahuja, MD4; University of South Carolina Department of Infectious Disease, Columbia, South Carolina; 1Vanderbilt University Medical Center, Nashville, Tennessee; 2Medical University of South Carolina, Charleston, South Carolina; 3South Carolina College of Pharmacy, Columbia, South Carolina; 4University of South Carolina, Columbia, South Carolina; 5University of South Carolina School of Medicine, Columbia, South Carolina
Session: 41. Hepatitis Thursday, October 3, 2019: 12:15 PM

Background. Lack of access to specialists is often a deterrent to comprehensive health care, especially in rural areas. Chronic Hepatitis C (CHC) affects 1% of the US population, and with the availability of highly efficacious treatment, it is imperative innovative steps are taken to screen and treat these patients. The South Carolina Hepatitis C Telehealth Initiative (SCHTI) is designed to provide Infectious Diseases (ID) consultation to rural providers caring for HCV-infected individuals across the Southeast. SCHTI is an interdisciplinary collaboration incorporating physicians, pharmacists, nurses and case managers from USC, MUSC, and Vanderbilt University.

Methods. SCHTI tele-consultation sessions were initiated in 2016, are held weekly, and provide a short didactic followed by discussion of patient cases with real-time feedback to the presenting providers. In addition, the program provides 1-hour continuing education certification for physicians, pharmacists and nurses. The South Carolina Department of Health and Human Services has approved SCHTI as an alternative to in-office expert consultation.

Results. From July 2016 through December 2018, 63 sessions were conducted, with 43 unique providers presenting cases and over 160 clinical attendees. Participating providers include Infectious Diseases, Family Medicine and Internal Medicine, amongst others. 259 cases have been reviewed, with a mean of 4.11 cases/session. Genotype 1a predominated and 44% of cases had advanced liver fibrosis. An increasing number of cases are young patients outside the high-prevalence birth cohort, and these individuals have a history of intravenous drug use. Overall, 13% of HCV cases were co-infected with HIV.

Conclusion. SCHTI provides multidisciplinary HCV teleconsultation to providers across the Southeast and is improving access to specialists and high-quality health care for patients across rural areas within the Southeast. Future outcomes to be assessed include sustained virologic response rates, relapse rates and impact on hepatic and extra hepatic morbidity and mortality from CHC.

Demographics

| DEMOGRAPHICS | (Overall → July 2016 → Dec. 2018) | Patient Cases (N = 259) |
|--------------|---------------------------------|------------------------|
| AGE (mean)   | 55.3 years                      | 55.3 years             |
| RACE         | African American | White | Other & Unknown |
|              | 41.7%                    | 33.6%  | 24.7%          |
| GENDER       | Male | Female | Unknown |
|              | 53.3%                    | 37.8%  | 8.9%           |
| HEP C GENOTYPE | 1a | 1b | 2 | 3 | 4 | Unknow wn |
|              | 69% | 14% | 7% | 6% | 1% | 3%          |
| CIRRHOSIS    | No | Yes | Unknown |
|              | 48% | 47%  | 4%             |
| HIV CO-INFECTION | No | Yes | Unknown |
|              | 85% | 13%  | 2%             |

Average # of Patients Discussed per Session

| Average # of Patients Discussed per Session | 2016 | 2017 | 2018 |
|--------------------------------------------|-----|-----|-----|
|                                            | 6.00| 4.15| 4.89|

Disclosures. All authors: No reported disclosures.

296. The Hepatitis C Cascade of Care across Four Safety Net Settings in the Southeast
Asher J. Schranz, MD1; Michael Kivasala2; Candice Givens, MSW, LCSW-A, LCAS-A3; Alison Hilton, MPH4; Courtney Maihofer1 and Arlene Sena, MD, MPH5; 1University of North Carolina, Chapel Hill, North Carolina; 2University of North Carolina, Chapel Hill, North Carolina; 3Durham County Department of Public Health, Durham, North Carolina; 4University of North Carolina, Durham County Health Department, Durham, North Carolina
Session: 41. Hepatitis Thursday, October 3, 2019: 12:15 PM

Background. Despite advances in antivirals, disparities in hepatitis C (HCV) treatment remain. We evaluated persons diagnosed with HCV in 4 safety net sites in a large Southeastern county, using care cascades to conceptualize milestones in treatment.

Methods. Persons diagnosed with HCV in 4 screening sites across Durham County, North Carolina, from December 2015 to May 2018 were included, allowing for 9 months of follow-up. Sites included the county health department (CHD), a federally qualified health center (FQHC) where providers trained in HCV care, jail and community outreach. Persons with HCV were eligible for a bridge counselor intervention to enhance linkage to care with an HCV-treating provider (either primary care or specialist). Outcomes were monitored by chart review. Persons linked to care in the prison (n = 36) were censored from subsequent cascade steps due to inability to obtain records. Cascades were compared by the site of diagnosis. Multivariable logistic regression was used to evaluate predictors of being prescribed antivirals.

Results. 505 persons were diagnosed with HCV; 216 in the FQHC, 158 in the jail, 72 in the CHD, and 59 in community outreach. Overall, 89% were counseled on their diagnosis, 65% were linked to care, 41% prescribed antivirals, 38% started medications, 34% completed medications and 24% achieved sustained viral response at 12 weeks (SVR-12). Progression through the cascade was highest for those diagnosed at the FQHC (figure). In analyses adjusted for demographics and risk factors, diagnosis in a community outreach setting had lower odds of antiviral prescription, compared with diagnosis in the FQHC (OR 0.33, 95% CI 0.12–0.89). Linkage to care at a specialist
Clinic (vs. primary care) was associated with antiviral prescription (OR 3.82, CI 1.95–7.46). Sex, race/ethnicity, insurance status and HCV risk factors were not associated with antiviral prescription.

**Conclusion.** Among persons diagnosed with HCV across four safety net sites, a quarter achieved SVR-12. Those diagnosed in community outreach had lower odds of antiviral prescription, and those who were linked to a specialist were more likely to receive antiviral prescription. Improving progression through cascade milestones across safety-net settings is integral to improving population-based HCV outcomes.

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

297. Accessible Care Intervention for Engaging People Who Inject Illicit Drugs in Hepatitis C Virus Care: Preliminary Results from a Randomized Clinical Trial

Benjamin Eckhardt, MD, MS1; Yesenia Aponte-Meledez, MS1; Chunki Fung, MS2; Shashi Kapadia, MD3; La Davis3; Melinda Smith, MA1; Matthew Mateu-Gelabert, PhD1; and Kristen Marks, MD3.1NYU School of Medicine/ Bellevue Hospital, New York, New York; National Development and Research Institutes, New York, New York; 2Weill Cornell Medicine, New York, New York

**Session:** 41. Hepatitis

**Background.** To achieve hepatitis C elimination, treatment programs need to be developed to engage, treat, and cure people who are actively injecting drugs.

**Methods.** We present preliminary data from the first 65 participants in the Accessible Care intervention for engaging people who inject illicit drugs (PWID) in hepatitis C (HCV) care. The randomized clinical trial compares the effectiveness of Accessible Care (low-threshold care in a syringe service program located in New York City) with Usual Care (referral to existing services) in facilitating linkage, engagement, and retention in HCV care. Eligible participants were HCV RNA positive and had injected drugs in the past 90 days. We compared the percentage of participants in each arm linked to HCV care (defined as one visit with HCV treatment provider), and initiated direct-acting antiviral (DAI) treatment within 6 months of enrollment.

**Results.** Among the 65 participants, the mean age is 41.2 years; 28% are female; 73% homeless; 6% black, 51% Latina/o and 39% white. 82% of participants had injected drugs in the last 30 days, with an average of 13.2 injections/month (median 10). Nearly all participants had health insurance, 88% public insurance, 6% uninsured. Thirty-two percent of participants were randomized to the Accessible Care arm. Within 6 months of enrollment 79% of the Accessible Care arm and 25% of the Usual Care arm had linked to HCV care, and 69% and 13% had been started on DAA therapy, respectively. Of the 26 participants in the Accessible Care arm who started DAA therapy, the median time from enrollment to treatment initiation was 87.5 days (range 22–180).

**Conclusion.** Among HCV-infected PWID enrolled at a syringe service program, 79% of the Accessible Care arm and 25% of the Usual Care arm had linked to care with an experienced HCV provider or referred to hepatologists (decompensated cirrhosis).

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

298. Collocation of Hepatitis C Care Continuum with MAT for High-Prevalence, High-Risk Population

Shivakumar Narayanan, MD1; Ameer Abutaleb, MD2; Jennifer Hoffmann, MPH, CRNP3; Aaron Greenblatt, MD2; Shyam Kotttil, MD PhD3; Aaron D’Amore, BS3; Christopher Brokus, BS3; and Sarah Kattakuzhy, MD3.1University of Maryland Medical Center, Midtown Campus, Ellicott City, Maryland; 2University of Maryland School of Medicine, Baltimore, Maryland; 3University of Maryland School of Medicine, DC Partnership for HIV/AIDS Progress, Bethesda, Maryland; NIMH, Bethesda, Maryland; University of Maryland School of Medicine; DC Partnership for HIV/AIDS Progress, Washington, DC

**Session:** 41. Hepatitis

**Background.** The hepatitis C virus (HCV) epidemic in the United States disproportionately impacts people who inject drugs (PWID) who account for 80% of new infections and have a high prevalence of chronic infection. Baltimore City has the highest case rate of HCV in the state of Maryland with over 25% of new cases statewide occurring in the city. Only 10% of PWID have access to directly acting antiviral (DAA) therapy and are cured of HCV. Medication-assisted treatment (MAT) is currently offered in isolated facilities with limited access to other specialty care. In this study, we collocated HCV care continuum in a MAT facility offering opioid agonist therapy and psychosocial interventions.

**Methods.** Collocation of HCV care was initiated in an MAT (methadone and buprenorphine) clinic, the University of Maryland Drug Treatment Center (UMDTC) serving over 700 patients, for Opioid Use Disorder (OUD) in Baltimore City (Figure 1). Screening for HCV was expanded through health education of patients and staff and expanded testing. HCV antibody-positive patients were linked to care with an experienced HCV provider or referred to hepatologists (decompensated cirrhosis).

**Results.** Most of the attendees were African-American with an average age of 52 years. 354 out of 701 clients attending clinic for methadone/suboxone (50.5%) were screened for HCV. Of the 251 patients who were hepatitis C antibody positive (70% of tested), 54 had undetectable HCV RNA. 46 had no HCV RNA labs available. 151 of the remaining HCV Ab positive patients who had a detectable HCV RNA result were evaluated for treatment (Figure 2). At initial assessment, 45 (48%) with liver fibrosis staged greater than F3, including 25 (27%) with cirrhosis. Sixty-four patients initiated DAA therapy. Fifty-four patients completed treatment (84%). Forty patients achieved sustained virologic response (100%) and 14 patients who completed treatment await SVR labs.

**Conclusion.** Collocation of HCV care continuum in MAT setting is an effective way to achieve micro elimination of HCV. The follow-up of this marginalized population still remains challenging given the high rates of homelessness and incarceration. In this regard, coordinated care between MAT settings and prisons are likely to demonstate successful elimination of hepatitis C.

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

299. “Where the Rubber Meets the Road”: Stakeholders’ Perspectives about the Current State of HCV Care Delivery in Massachusetts Jails

Alyse G. Wurzel, MD MS1; Jessica Reyes, MPH1; Julia Zubiaga, MPH1; Deirdre Burke, MPH1; Tom Concannon, PhD2; Karen Freund, MD MPH3; John Wong, MD2; Curt Beckwith, MD2; and Amy LeClair, PhD1.1Tufts Medical Center, Boston, Massachusetts; 2RAND, Boston, Massachusetts; 3Brown University School of Medicine, Providence, Rhode Island

**Session:** 41. Hepatitis

**Background.** In this study, we collocated HCV care continuum in a MAT facility offering opioid agonist therapy and psychosocial interventions.

**Methods.** Collocation of HCV care was initiated in an MAT (methadone and buprenorphine) clinic, the University of Maryland Drug Treatment Center (UMDTC) serving over 700 patients, for Opioid Use Disorder (OUD) in Baltimore City (Figure 1). Screening for HCV was expanded through health education of patients and staff and expanded testing. HCV antibody-positive patients were linked to care with an experienced HCV provider or referred to hepatologists (decompensated cirrhosis).

**Results.** Most of the attendees were African-American with an average age of 52 years. 354 out of 701 clients attending clinic for methadone/suboxone (50.5%) were screened for HCV. Of the 251 patients who were hepatitis C antibody positive (70% of tested), 54 had undetectable HCV RNA. 46 had no HCV RNA labs available. 151 of the remaining HCV Ab positive patients who had a detectable HCV RNA result were evaluated for treatment (Figure 2). At initial assessment, 45 (48%) with liver fibrosis staged greater than F3, including 25 (27%) with cirrhosis. Sixty-four patients initiated DAA therapy. Fifty-four patients completed treatment (84%). Forty patients achieved sustained virologic response (100%) and 14 patients who completed treatment await SVR labs.

**Conclusion.** Collocation of HCV care continuum in MAT setting is an effective way to achieve micro elimination of HCV. The follow-up of this marginalized population still remains challenging given the high rates of homelessness and incarceration. In this regard, coordinated care between MAT settings and prisons are likely to demonstrate successful elimination of hepatitis C.

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