Background. HCV is highly prevalent in criminal-justice-involved populations (CJIP). Nationally, the operationalization of guideline-driven HCV care (including testing and treatment) for CJIP has been challenging, prompting this study to understand barriers and facilitators.

Methods. We used purposeful sampling strategies to recruit key stakeholders including (1) people who are incarcerated, (2) clinicians providing care in jail, clinics, providing care outside of jail, corrections administrators, and representatives of industry, public health and public policy. Semi-structured interviews were performed in Spanish or English, based on preference of participant. Written notes were used to capture details from interviews in jails and interviews outside of jail were recorded. People interviewed outside of jail were offered a stipend. Interviews were coded and analyzed with a compare and consensus approach.

Results. Of 120 people, 49 (41%) people agreed to be interviewed in each of the stakeholder categories including 21 men who were incarcerated (mean age 32 [IQR 25, 39], 60% non-White). Barriers to HCV care delivery included (1) Fragmented healthcare delivery because of transient nature of CJIP (2) Frustration and disempowerment experienced by people incarcerated in jail and (3) Heterogeneous views on stakeholders responsible for providing HCV financing and care in jail. Facilitators to HCV care delivery included (1) Incarcerated populations interested in HCV care for public and personal health and (2) An existing strong public health infrastructure in place supporting HIV care delivery.

Conclusion. Understanding various stakeholders’ views of barriers to HCV care in jails is a necessary first step to building improved care delivery. This recruitment may help to focus limited administrative and fiscal resources on HCV care for this transient population.

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300. Drug Use Characteristics and Hepatitis C Antibody Prevalence in Southern Illinois
Kali E. Defever, MPH1; Sarah L. Patrick, MPH, PhD2; Jennifer E. Layden, MD, PhD3; Scott Fletcher, MPH4; Brent Van Ham, MS, RN, CRN, CADC5; Wiley D. Jenkins, PhD6 and Ma T. Pho, MD, MPH7; 1University of Chicago, Chicago, Illinois; 2Jackson County Health Department, Murphysboro, Illinois; 3Illinois Department of Public Health, Springfield, Illinois; 4Community Action Place, Murphysboro, Illinois; 5Southern Illinois University School of Medicine, Springfield, Illinois; 6University of Chicago Medicine, Chicago, Illinois

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Background. Hepatitis C virus (HCV) infection rates have increased among younger, rural persons nationally. We report on a preliminary sample of a study examining HCV acquisition risk factors among rural persons who inject drugs (PWID) or persons who use opioids (PWUO) non-medically.

Methods. We used respondent-driven sampling (RDS) to recruit PWID/PWUO in southern, rural Illinois as part of a larger study on infectious disease rates among social networks of PWID and illicit opiate users. Participants were surveyed regarding drug and sexual risk behavior, healthcare access, stigma, and social networks, and underwent rapid screening for HCV (OraQuick) using urine and blood screening for hepatitis A, B, and C. Using R software, we generated descriptive statistics to characterize HCV prevalence. Effective networks of PWID and illicit opioid users. Participants were surveyed regarding drug and sexual risk behavior, healthcare access, stigma, and social networks, and underwent rapid screening for HCV (OraQuick) using urine and blood screening for hepatitis A, B, and C. Using R software, we generated descriptive statistics to characterize HCV prevalence.

Results. Between July 2018 and April 2019, 135 current PWID/PWUO were identified. Of the 256 patients, 63/256 (25%) underwent an ARV switch (Table 1). In the most common regimen in the ARV switch group was protease inhibitor (PI)-based while for the no ARV switch group, it was an integrase strand transfer inhibitor (INSTI)-based regimen. HCV/HIV transmission risk factors, HCV genotype, and AST/ALT were similar among the two groups (Table 1). The proportion of patients free of HCV treatment and virologic failure, and the proportion achieving SVR12/24 were similar among the ARV switch and no ARV switch groups.

Conclusion. HIV treatment and virologic failure, and SVR12/24 were not different among patients who did or did not undergo a switch in their ARV regimen prior to DAA treatment. We compared baseline characteristics, the proportion of patients free of HCV treatment failure, free of HIV virologic failure, and that achieved sustained viral response (SVR) at 12 and 24 weeks after DAA treatment among ARV switch and no ARV switch groups.

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Table 1. Baseline characteristics and outcomes summary among those that did and did not switch ARV medications when initiating DAA-based treatment for HCV

| ARV Switch | No ARV Switch | P Value |
|-----------|---------------|---------|
| N=63      | N=93          |         |
| Female    | 25/63 (40%)   | 33/93 (36%) | 0.59 |
| Transexual | 11/63 (17%)   | 19/93 (21%) | 1.00 |
| Non       | 40/63 (65%)   | 74/93 (80%) | 0.024 |
| Race: White | 36/63 (57%)   | 70/93 (76%) | 0.27 |
| Other     | 27/63 (43%)   | 23/93 (25%) | 0.14 |
| Age       | 53/63 (86%)   | 61/93 (66%) | 0.07 |
| Yes       | 52/63 (82%)   | 69/93 (74%) | 0.21 |
| No        | 11/63 (18%)   | 24/93 (26%) | 0.07 |
| Risk factor: Heterosexual contact | 22/63 (35%) | 50/93 (54%) | 0.21 |
| Injection drug use | 25 (63%) | 35 (94%) | 0.05 |
| Men who have sex with men | 16 (25%) | 57 (53%) | 0.01 |
| Men who have sex with men and injection drug use | 9 (14%) | 32 (35%) | 0.01 |
| Other | 3 (5%) | 6 (6%) | 0.40 |
| Unknown | 1 (2%) | 2 (2%) | 0.40 |
| HIV genotype | 2 (3%) | 5 (5%) | 0.40 |
| ART regimen of start of DAA | INSTI 47 (75%) | 75 (81%) | 0.30 |
| INS + OTHER 2 (3%) | 3 (3%) | 0.40 |
| SRRT 6 (10%) | 15 (16%) | 0.34 |
| ART failure | <0.001 | 0.001 | 0.001 |
| Free of HCV treatment failure | 60 (95%) | 100 (100%) | 0.57 |
| Free of HIV virologic failure | 40 (64%) | 55 (60%) | 0.57 |

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Background. Direct-acting antivirals (DAA) and antiretroviral (ARV) medications pose treatment challenges in HIV/HCV co-infection. Management of contraindicated combinations varies across practices. ARV switches may increase the risk of HCV and cotreatment failure, and has been reported to increase the risk of DAA treatment failure. This analysis assesses how switches in ARV regimen impacts treatment outcomes in HIV/HCV co-infection.

Methods. This retrospective cohort study includes patients 18 years and older with stable HIV/HCV co-infection (HIV RNA <50 for 26 months) who received DAA HCV therapy. Data were obtained using the Centers for AIDS Research Network of Integrated Clinical Systems. The “ARV switch” cohort is defined as patients undergoing a switch in ARV regimen within 6 months prior to DAA treatment. The “no ARV switch” cohort was defined as patients without a change in HIV ARV during the same time period. The primary outcome is HIV treatment failure which is a composite endpoint including HIV virologic failure (defined as confirmed loss of HIV viral suppression), discontinuation/change of ARV regimen, progression to AIDS, or death. We compared baseline characteristics, the proportion of patients free of HCV treatment failure, free of HIV virologic failure, and that achieved sustained viral response (SVR) at 12 and 24 weeks after DAA treatment among ARV switch and no ARV switch groups.

Results. Of the 256 patients, 63/256 (25%) underwent an ARV switch (Table 1). At baseline, the most common regimen in the ARV switch group was protease inhibitor (PI)-based while for the no ARV switch group, it was an integrase strand transfer inhibitor (INSTI)-based regimen. HCV/HIV transmission risk factors, HCV genotype, and AST/ALT were similar among the two groups (Table 1). The proportion of patients free of HCV treatment and virologic failure, and the proportion achieving SVR12/24 were similar among the ARV switch and no ARV switch groups.

Conclusion. HIV treatment and virologic failure, and SVR12/24 were not different among patients who did or did not undergo a switch in their ARV regimen prior to DAA treatment. We compared baseline characteristics, the proportion of patients free of HCV treatment failure, free of HIV virologic failure, and that achieved sustained viral response (SVR) at 12 and 24 weeks after DAA treatment among ARV switch and no ARV switch groups.

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Background. Antiretroviral Switches in HIV/HCV Coinfection.

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