Background. At Hahnemann University Hospital, the prevalence of hepatitis C virus (HCV) infection is close to 17%, which is much higher than the estimated 2% prevalence in the United States general population. However, linkage to care from an inpatient setting is historically lower than for those diagnosed with HCV infection in the outpatient setting. In the era of effective HCV treatment, improving linkage to care is an essential step to cure HCV infection. Here we describe the impact of mandatory HCV consults on the success of linkage to care.

Methods. We performed a retrospective observational study of HCV patients who tested positive for HCV from July 2017 to December 2017 and were born between 1945 and 1965 and attended Hahnemann University Hospital, Philadelphia, PA. Once a patient was identified having chronic HCV infection, either the Infectious Disease or Hepatology team evaluated the patient and an HCV navigator facilitated linkage to care. We defined linkage as a patient subsequently being seen at the Outpatient Hepatology Clinic or Infectious Disease Clinic within 3 months of discharge from the hospital.

Results. Among 524 Baby Boomers tested, 106 (20%) had positive HCV antibody tests. Sixty-nine (65%) had chronic HCV infection and 79% were already linked to care. Among 62 patients, 24 (39%) had an infectious disease (ID) or Hepatology consult. Patients who were seen by a consultant were more likely to be linked to care within 3 months (50% vs. Twenty-two%, P = 0.016). One of the main barriers that a consultant did not see a patient was that confirmatory HCV viral load result was not available at the time of discharge. If the viral load was available prior to discharge, a patient was more likely seen by a consultant. (54% vs. 7%, P < 0.0001).

Conclusion. Mandatory HCV consults in the inpatient setting improved linkage to care for HCV-infected patients. One of the main barriers of HCV mandatory consults was HCV viral load result not being available at the time of discharge. In the era of effective treatment, mandatory HCV consults should be implemented to improve the rate of linkage to care. Early routine lab testing for HCV antibody during a hospitalization and timely availability of results will be crucial to the success of such an intervention.

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Background. Hepatitis C virus (HCV) infection is now curable for most individuals and national goals for elimination have been established. Transmission remains ongoing, particularly in non-urban regions affected by the opioid epidemic. To reach elimination goals, barriers to treatment must be identified with a priority placed on those with substance abuse.

Methods. In this retrospective cohort study of all individuals with chronic HCV from 2010 to 2016 at a large medical center serving a predominately non-white population, we identified patient and clinic characteristics associated with our primary outcome, sustained virologic response (SVR) with a subgroup analysis for those with documented substance abuse.

Results. SVR was achieved in 1,544 (41%) of 3,790 people with chronic HCV. In a multivariate Poisson regression model adjusted for patient demographics and year of diagnosis, SVR was less likely in those with substance abuse (IRR 0.8, 95% CI 0.7–0.9). In the subgroup analysis of those with substance abuse (N = 682), SVR rates were higher in those linked to the infectious diseases clinic, which has embedded support services, than in those linked to gastroenterology, which does not (IRR 1.4, 95% CI 1.1–1.9). Higher SVR rates were driven by an increased rate of medication prescribing in those linked to infectious diseases (IRR 1.3, 95% CI 1.1–1.6). (Figure 2).

Conclusion. Those with substance abuse, a high priority population for treatment of HCV, had better outcomes when receiving care in a clinic with embedded support services.

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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 (72%) had HCV RNA completed. Among the 724 (5%) with confirmed HCV infection, 139 (19%) received LTC without navigation, 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 univariate analysis, current substance users, none/past use (OR 0.52 (0.29, 0.93)) was associated with 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 (0.06, 0.34)) in a multivariate analysis.

Conclusion. Insurance status was independent predictor of starting treatment among patients at our safety-net hospital. Medicaid remains 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; 7.1–9.4 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%) HIV+.

Time to Scan

| Stage | Baseline | Fibrin09 | Fibrin15 | Fibrin17 | Fibrin20 |
|-------|----------|---------|---------|---------|---------|
|       | (n=117)  | (n=196) | (n=196) | (n=196) | (n=196) |
| Stages 0-1 | 13 (5.1%) | 170 months | 3 (0.4%) | 19.0 months | 0 (0.0%) |
| Stage 2 | 41 (20.1%) | 12.7 months | 11 (25.0%) | 20.1 months | 2 (15.2%) |

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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 fibrosis stage before HCV 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 HIV/HCV co-infected patients has not been well described. Here, we evaluated the concordance between FibroSure and FibroScan-derived METAVIR results in HIV–HCV co-infected patients.

Methods. We performed a retrospective cross-sectional study of HIV/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 these, 62 (47%) fell in the F0–F2 range and 71 (53%) in the F3–F4 range. Of those 133 patients, 21 also underwent FibroScan. Seventeen (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 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 6.8%. 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 HIV testing where the majority of residents across disciplines (73, 71, 60%) considered HIV 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 minors (85%). IM residents were more 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 not aware of their co-infection with HIV, both Peds and EM residents were more 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.