proportionately impacts people who inject drugs (PWID) who account for 80% of

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, MS; Yesenia Aponte-Meledez, MS; Chunki Fung, MS; Shashi Kapadia, MD; La Davis; Melinda Smith, MA; Pedro Mateu-Gelbert, PhD; and Kristen Marks, MD, PhD; NYU School of Medicine/ Bellevue Hospital, New York, New York; National Development and Research Institutes, New York, New York; Weill Cornell Medicine, New York, New York

Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM

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-touch 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.

Results. Among the 65 participants, the mean age is 41.2 years; 28% are females; 73% homeless; 6% black, 51% Latina/o and 39% white. 82% of participants 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.

Conclusion. Among persons randomized to the Accessible Care arm 79% of the Accessible Care arm and 25% of the Usual Care arm had linked to HCV care (defined as one visit with HCV treatment provider), and initiated direct-acting antiviral (DAI) treatment within 6 months of enrollment.

Disclosures. All authors: No reported disclosures.

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

Shivakumar Narayanan, MD; Ameer Abutaleb, MD; Jennifer Hoffmann, MPH, CRNP; Aaron Greenblatt, MD; Shyam Kothil, MD PhD; Aaron D’Amore, BS; Christopher Brokus, BS; and Sarah Kattakuzhy, MD; University of Maryland Medical Center, Midtown Campus, Ellicott City, Maryland; University of Maryland School of Medicine, Baltimore, Maryland; University of Maryland School of Medicine, DC Partnership for HIV/AIDS Progress, Bethesda, Maryland; NIH, Bethesda, Maryland; University of Maryland School of Medicine; DC Partnership for HIV/AIDS Progress, Washington, DC

Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM

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 (DAI) 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 DAI 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.

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

Alyse G. Wurzel, MD MS; Jessica Reyes, MPH; Julia Zuberg, MPH; Deirdre Burke, MPH; Tom Concannon, PhD; Karen Freund, MD MPH; John Wong, MD; Curt Beckwith, MD and Amy LeClair, PhD; Tufts Medical Center, Boston, Massachusetts; RAND, Boston, Massachusetts; Brown University School of Medicine, Providence, Rhode Island

Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM
Background. HCV is highly prevalent in criminal-justice-involved populations (CJIP). Nationally, the operationalization of guided-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 people who use opioids, incarcerated, clinicians 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. Perceived barriers to HCV care delivery included (1) a 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 and financing HCV care in jails. Facilitators to HCV care delivery included (1) incarcerated populations interested in HCV care for personal and public 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 pathways. Additional research may help to focus limited administrative and fiscal resources on HCV care for this transient population.

Disclosures. All authors: No reported disclosures.

300. Drug Use Characteristics and Hepatitis C Antibody Prevalence in Southern Illinois Kali El Deaver, MPH1; Sarah L. Patrick, MPH, PhD2; Jennifer E. Layden, MD, PhD3; Scott Fletcher, MPH4; Brent Van Ham, MS, RN, CRNCAD5; Wendy 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

Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM

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 person who use opioids (PWUO) non-medically.

Methods. We used a semi-structured, purpose-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 opioid users. Participants were screened regarding drug and sexual risk behavior, healthcare access, stigma, and social networks, and underwent rapid testing for hepatitis B (HepB) and HIV. Other infections were not tested. Using R software, we generated descriptive statistics to characterize HCV prevalence.

Results. Between July 2018 and April 2019, 135 current PWID/PWUO were recruited, screened, and surveyed (58.7% male; 82.2% white; mean age 40.1 years). HCV rapid tests detected antibodies (HCV+) among 53 of 112 screened (47.4%). HCV+ participants were more likely to be white (96.2% vs. 83.1%, P = 0.006) than HCV antibody negative (HCV-) participants and showed a bimodal age distribution with peaks in the 25–30 and 45–50 age ranges. Reported injection drug use and heroin use in the past 30 days was significantly more common among HCV+ participants than HCV- participants (11.9 vs. 18.4 days of use in the past 30 days, P = 0.03). HCV+ participants reported fewer social network members than HCV- participants (2.2 vs. 3.0, P = 0.048).

Conclusion. In this analysis of a preliminary sample, HCV exposure was high; with those positive for HCV antibody showing a bimodal age distribution, high frequency of multiple drug use, and smaller social network size compared with HCV negative counterparts. Upon RDS-based enrollment completion and pending analysis we will further examine HIV RNA status as well as the specific associations between network size and other risk factors that may inform drug testing and treatment interventions.

Disclosures. All authors: No reported disclosures.

301. Risk of Virologic Failure with Antitargeting Switches in HIV/HCV Co-infections Diana M. Mosquera, MD1; Julius Wilder, MD, PhD2; Alicia Ellis, PhD3 and Glenda Naggie, MD1; 1Duke University School of Medicine, Durham, North Carolina; 2Duke School of Medicine, Durham, North Carolina; 3Duke Clinical Research Institute, Durham, North Carolina

Session: 41. Hepatitis
Thursday, October 3, 2019: 12:15 PM

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 virologic and treatment 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 ARV regimen 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 HIV 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). In the ARV switch group, 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. HIV/HCV transmission risk factors, HCV genotype, and AST/ALT were similar among the two groups (Table 1). The proportion of patients free of HIV treatment 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. This suggests that switches in the ARV regimen for DAA treatment of HCV do not negatively impact HIV or HCV outcomes among patients with HIV/HCV Coinfection.

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

| ARV Switch | No ARV Switch |
|------------|---------------|
| N=63       | N=193         |
| Baseline Characteristics | P Value |
| --- | --- |
| Average age at start of DAA | 52.7±8.6 (N=63) vs 53.0±8.4 (N=193) | 0.21 |
| Risk factor | P Value |
| HIV strata | 0.97 |
| 0.55±0.67 (N=28) vs 0.57±0.73 (N=173) | |
| Drug of choice | 0.55 |
| Intravenous drug use | 0.97 |
| Injection drug use | 0.97 |
| 25.0±6.0 (N=10) vs 24.9±5.3 (N=157) | |
| Men who have sex with men | 0.97 |
| 16.0±7.8 (N=27) vs 17.9±7.9 (N=151) | |
| Men who have sex with men and injection drug use | 0.97 |
| 9.4±2.1 (N=6) vs 9.2±2.2 (N=187) | |
| Other | 1.00 |
| 3.0±0.8 (N=63) vs 3.0±0.8 (N=193) | |
| Unknown | 1.00 |
| 1.0±0.0 (N=63) vs 1.0±0.0 (N=193) | |
| HCV Genotype | 0.45 |
| 1 | 0.55 |
| 57.1±0.9 (N=10) vs 57.1±0.9 (N=183) | |
| 2 | 0.10 |
| 201±0.0 (N=63) vs 201±0.0 (N=193) | |
| Other | 0.10 |
| 0.1±0.0 (N=63) vs 0.1±0.0 (N=193) | |
| Outcomes | 0.003 |
| Free of HIV Treatment Failure | 0.37 |
| 46.0±10.3% (N=63) vs 48.6±10.2% (N=193) | |
| Free of HIV Virologic Failure | 0.37 |
| 54.0±10.0% (N=63) vs 58.4±10.0% (N=193) | |
| SVR12 | 0.45 |
| 20.3±0.0% (N=63) vs 20.3±0.0% (N=193) | |
| SVR24 | 0.45 |
| 18.1±0.4% (N=63) vs 18.1±0.4% (N=193) | |

Disclosures. All authors: No reported disclosures.