295. South Carolina Hepatitis C Telehealth Initiative (SCHTI): Increasing Access to HCV Care

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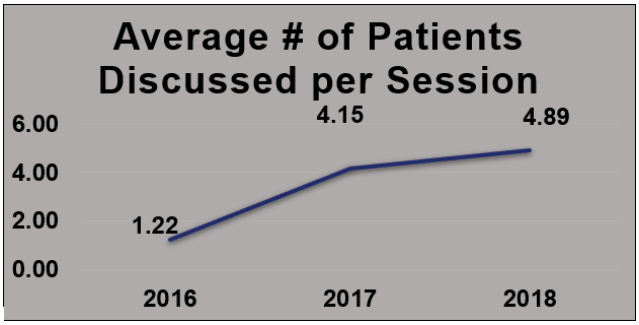
Background. Lack of access to specialists is often a deterrent to comprehensive health care, especially in rural areas. Chronic Hepatitis C (CHC) affects 1% of the US population, and with the availability of highly efficacious treatment, it is imperative innovative steps are taken to screen and treat 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.

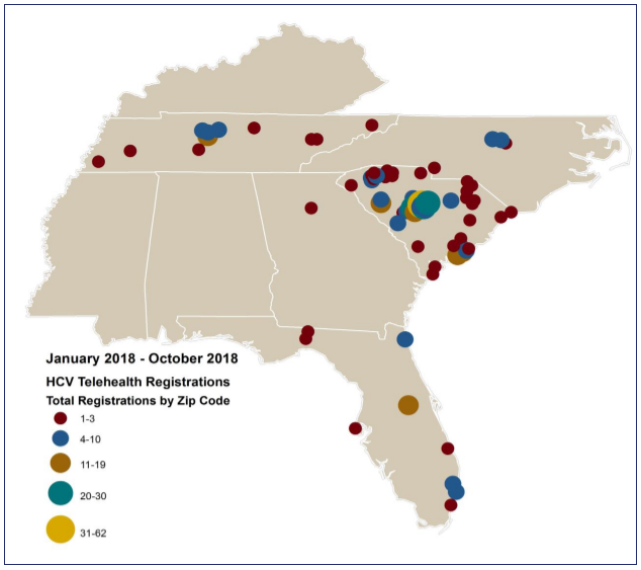
Methods. SCHTI tele-consultation sessions were initiated in 2016, are held weekly, and provide a short didactic followed by discussion of patient cases with real-time feedback to the presenting providers. In addition, the program provides 1-hour continuing education certification for physicians, pharmacists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

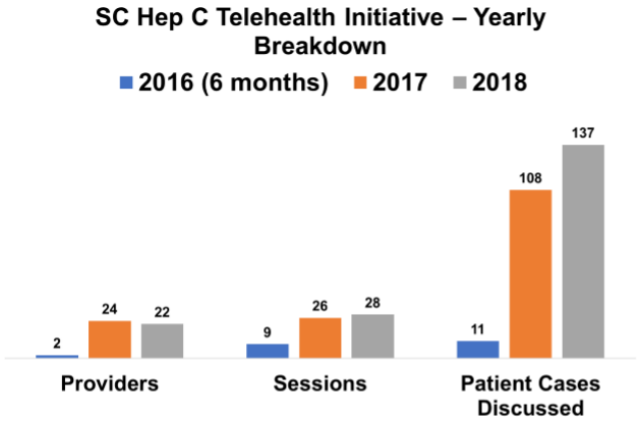
Results. From July 2016 through December 2018, 63 sessions were conducted, with 43 unique providers presenting cases and over 160 clinical attendees. Participating providers include Infectious Diseases, Family Medicine and Internal Medicine, amongst others. 259 cases have been reviewed, with a mean of 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 (Overall → July 2016 – Dec. 2018)	Patient Cases (N = 259)					
AGE (mean)	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	Unknown
	69%	14%	7%	6%	1%	3%
CIRRHOSIS	No		Yes		Unknown	
	49%		47%		4%	
HIV CO-INFECTION	No		Yes		Unknown	
	85%		13%		2%	







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

296. The Hepatitis C Cascade of Care across Four Safety Net Settings in the Southeast

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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