HIV-positive patients linked to care. HCV testing was then added to HIV screening and expanded to other testing sites.

Results. The first visit with a clinical pharmacist consists of education, reviewing lab tests, cost assistance, and providing treatment options. From 2017 to 2018, 169 of 172 HCV positive individuals (98.2%) achieved SVR by treatment completion. The HCV LTC program demonstrated a 3.8% increase in HCV testing from 2017 to 2018.

Conclusion. Pharmacist-led care for a large volume of HCV patients allows time for specialty physicians to manage more complex cases. The collaboration between the FQHC, MCO, and LTC team showed HCV elimination is possible based on high SVR rates. HCE is projecting successful linkages to care and continuous campaigning for individuals to be treated for HCV in the Coachella Valley.

Disclosures. All authors: No reported disclosures.

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308. Slow Adoption of a Nurse-Driven Protocol for Universal Hepatitis C Virus Screening in a Hospital Emergency Department: Lessons Learned
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Background. In areas with a high prevalence of hepatitis C virus (HCV) infection, emergency department (ED) visits may provide unique opportunities for screening. The catchment area for Hahnemann University Hospital (HUH) has an HCV seroprevalence rate of >20%. However, limited data exist addressing HCV testing strategies in the ED. This study describes the experience of piloting a nurse-driven HCV screening protocol in an urban hospital ED.

Methods. A nurse-driven HCV screening protocol was developed and implemented on August 1, 2018. We performed a retrospective analysis of the protocol's performance from July 1, 2018, through December 31, 2018. Patients who were evaluated in the ED and had blood collected were analyzed. We provided universal HCV screening regardless of age or risk factors. If HCV-positive by antibody screen and viral load confirmation, an attempt was made to link patients to care. Linkage was defined as having received an inpatient evaluation by either infectious diseases or hepatology physician.

Results. Among 20,705 unique patients seen in the ED, 7841 (38%) had blood work collected. 821 (10.5%) patients had HCV antibody testing. After the implementation of the nurse-driven protocol, the testing rate increased from 68/1340 (5.1%) to 753/6501 (11.6%). 260 Baby Boomers (born between 1945–1965) were screened, of which 60 (23.1%) had positive screens. 561 non-Baby Boomers were screened, of which 30 (5.4%) had positive screens. Barriers of implementing nurse-driven protocol were: (1) multiple steps of the ordering process in the electronic medical record (EMR), (2) the complexity of staff schedules, and (3) staff concerns regarding the disclosure of HCV test results. Among the patients who were diagnosed with chronic HCV, 60 % were linked to care for treatment.

Conclusion. We piloted a nurse-driven universal HCV testing protocol in the ED of a hospital with high HCV prevalence. Though the screening rate doubled, it was still low. We identified barriers that may be addressed to improve future screening rates. In areas with a high seroprevalence of HCV, universal screening may be an excellent public health intervention to identify asymptomatic HCV-infected patients.

Disclosures. All authors: No reported disclosures.

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309. Should Primary Care Practitioners Follow Hepatitis C Exposed Infants?
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Background. Hepatits C virus (HCV) infection in pregnancy is estimated between 1–4% and risk of vertical transmission ~5%. While the benefits of HCV testing for perinatally exposed infants under a year is debatable, a strategy for follow-up (F/U) is important. We instituted interventions to improve the F/U rate for HCV exposed infants in December 2012. Pediatric infectious diseases (PID) service was consulted in the newborn period to establish care. Perinatal HCV exposure was added to the infant's electronic record. Educational brochures were given to guardians at discharge. We aimed to assess the efficacy of the interventions in improving the F/U rate.

Methods. A retrospective chart review of 227 HCV exposed infants born between January 2013 and December 2016 was done after obtaining IRB. Infant charts were reviewed for maternal age, race, insurance, HCV risk factors, HIV and Hep B co-infection, third trimester HCV PCR, delivery type, gestational age, birth weight and infant custody. Based on 2002 NIH guidelines: first visit at 6–8 weeks, second at 6–8 months, final visit ≥18 months of age. Maternal HCV infection is positive HCV antibody (Ab) during pregnancy, medical care defined as at least one infant PID clinic visit, and appropriate F/U as an 18-month visit for HCV (Ab) check. Univariate analysis is used for demographics, descriptive summaries were recorded as frequencies and percentages.

Results. 214 infants included in analysis (1 deceased and 12 adopted and left area). Baseline characteristics of those who had medical care vs. not were similar except for infant custody and HIV co-infection 94/214 (44%) had medical care. Of those, 32/94(34%) had appropriate F/U while 62/94(66%) did not 31/214 infants were followed by primary care practitioners (PCPs) at our institution. Of those 24/31(77.5%) were either tested inappropriately or lost to F/U HIV co- infection and custody by a relative (not mom) increase the likelihood of F/U (P 0.003 and 0.002, respectively) 5 infants contracted HCV infection. One infant who lost to F/U was diagnosed incidentally in the ER.

Conclusion. Appropriate F/U for HCV exposed infants poses challenges despite established systems of care. Because current guidelines recommend antibody testing at 18 months, educating PCPs who are more likely to establish regular F/U is important for appropriate testing.

Disclosures. All authors: No reported disclosures.

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310. Disparities in Hepatitis C Linkage to Care in the DAA Era: Findings from a Referral Clinic with an Embedded Nurse Navigator Model
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Background. Direct-acting antivirals (DAAs) have simplified and expanded access to Hepatitis C virus (HCV) treatment. Only 17% of the estimated 2.4 million Americans currently infected with HCV have linked to HCV specialty care. We evaluated linkage to care (LTC) in a non-urban hepatitis C referral clinic with a nurse navigator model of care and identified disparities in LTC during the DAA era.

Methods. A single-center retrospective cohort analysis was performed among all patients referred to an infectious diseases HCV clinic between 2014 and 2018. The primary outcome was LTC, defined as attendance at a clinic appointment. A multivariable Poisson regression model estimated associations of patient characteristics with LTC.

Results. Among 824 referred patients, 624 (76%) successfully linked to care and 369 (45%) achieved sustained virologic response. The mean age was 48.5 years (SD 13.5 years) and 46% (382 of 824) were uninsured. Common reasons for failure of LTC included no-shows (26.5%), could not be contacted (20.5%) and incarceration (10%). On multivariable analysis, LTC rates were higher among women (incidence rate ratio (IRR) 1.11, 95% CI 1.03–1.20, P = 0.01) and those with cirrhosis (IRR 1.20, 95% CI 1.11–1.30, P < 0.001). Lower rates of LTC were seen for young people (< 40 years old) (IRR 0.88, 95% CI 0.79–0.98, P = 0.02) and uninsured people (IRR 0.85, 95% CI 0.77–0.94, P = 0.002). Race, proximity to care, substance use, and HIV status were not associated with differences in LTC rates.

Conclusion. In an embedded nurse navigator model of care, a high rate of LTC was achieved despite the prevalence of barriers, including a high uninsured rate. LTC was the biggest drop-off in the cascade. Disparities in LTC based on age, sex, and insurance status are present. Substance use was not associated with differences in LTC, supporting current recommendations to provide treatment to all patients with HCV. No-shows were common, potentially due to lack of reliable contact information or lack of transportation. Qualitative work exploring patients' experiences leading to failure of LTC would be helpful. Future interventions to improve care could include expanded access to insurance, affordable medical tests, and programs bridging care for incarcerated populations.

Cascade of Care
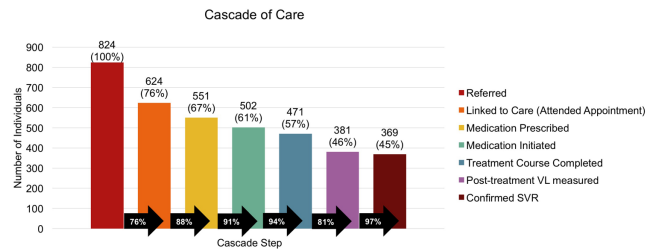
Abbreviations: VL=viral load, SVR=sustained virologic response.

Table: Patient characteristics associated with successful linkage to care in a multivariable Poisson regression model (N=762).

Patient Characteristic	IRR (95% CI)	P
Age		
> 40 years	1 (ref)	na
≤ 40 years	0.88 (0.79-0.98)	**0.02**
Sex		
Men	1 (ref)	na
Women	1.11 (1.03-1.20)	**0.007**
Race		
White	1 (ref)	na
Black	1.07 (0.97-1.18)	0.17
Other	1.06 (0.93-1.21)	0.41
Insurance Coverage		
Private	1 (ref)	na
Medicaid/Medicare	0.91 (0.83-1.01)	0.07
Uninsured	0.85 (0.77-0.94)	**0.002**
Close Proximity to medical center	0.93 (0.85-1.02)	0.13
Cirrhosis	1.19 (1.10-1.30)	**<0.001**
Hepatitis B	1.18 (1.06-1.32)	**0.002**
HIV	1.02 (0.90-1.15)	0.78
Substance Use	0.99 (0.90-1.10)	0.90

Incidence rate ratios are adjusted for the variables included in the table.
Abbreviations: IRR=Incidence Rate Ratio; CI=Confidence Interval.