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

311. Hepatitis C Screening Within a Large FQHC Network in Brooklyn, New York: How We Measure Across an Ethnically Diverse Population

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Background. With over 100,000 unique lives and 600,000 visits in 2018, The Family Health Centers at NYU Langone (FHC) is one of the largest Federally Qualified Health Center network based primarily in Southwest Brooklyn New York. Within the catchment area 48% of the population report being born out of the United States, with 30% of the population describing themselves of Asian ethnicity and 42% as Latino [1]. Effective January 1, 2014 New York State law mandated hepatitis C screening to be offered to every individual born between 1945 and 1965 receiving health services. Now five years later, with the advancements in treatment options and increased access for patients where cost has become prohibitive we retrospectively reviewed how our performance has been prior to embarking on a goal of 60% screening compliance.

Methods. We performed a retrospective chart review looking at a denominator of patients born between 1945 and 1965 who were seen in the FHC for a visit in 2018. Patients who were previously screened since 2016, have a diagnosis of hepatitis C, history of hepatitis C documented in either past medical history, problem list or ICD code were excluded. Data abstraction for compliance in the numerator included patients who have a resulted hepatitis C antibody or have indicated current treatment (with a hepatitis C viral load).

Results. 51% of patients based on the aforementioned methodology have been screened in 2018. 11,577 patients were eligible with 650 patients having a documented refusal. 261 new diagnosis were made in 2018 and compliance for non-screened patients without any prior screening was 35%. Regarding racial/ethnic composition of the practice sites compared with patients screened, one practice site with an 87% Asian non-Hispanic population had a 35% compliance rate with screening where as the most predominate Hispanic population site (81% of total patients seen) had a 54% compliance rate.

Conclusion. Overall screening rates within the network are commendable, yet more work is being done to drive provider awareness on the need for compliance. Differences in racial/ethnic backgrounds and compliance of screening completion can be seen within the FHC network. Current efforts are focused on increasing culturally appropriate awareness amongst the patient population as well as the providers.

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312. Treatment of Hepatitis C After Identification of Infection During Universal Screening Approach in Pregnant Women

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Background. Identifying asymptomatic individuals with hepatitis C virus (HCV) infection is challenging. Pregnancy presents a unique opportunity to screen women for HCV and then link those positive to care. Universal screening in pregnant women, however, is not recommended by CDC or ACOG. Further, treatment with direct antiviral agents (DAAs) are not currently approved for pregnant women but are warranted following delivery and breastfeeding. We sought to compare treatment uptake before and after universal screening in pregnant women was implemented as the standard of care in our institution and then determine if universal screening leads to increased treatment after pregnancy.

Methods. A retrospective analysis of risk-based HCV screening in pregnant women was used for the first period (2014–2015) and a prospective design was used following 18 months of universal screening (2016–2017). Prenatal data were collected from all pregnant women that sought care at our institution in the prospective part of the study. We tested for differences in relevant outcomes (e.g., screening rates, rate of those eligible for treatment, and those who actually received treatment) between the two periods. Finally, we performed a cost-effective analysis of universal screening considering treatment rates.

Results. During the universal screening period, more women were screened for HCV and diagnosed with chronic infection. Universal screening was not associated with a significant increase in the odds of women receiving treatment after pregnancy. The increased cost for universal screening was $1060 per patient, resulting in an ICER of $219,391 per additional treatment received or $57,734 per quality-adjusted life-year (QALY) gained, which is below the willingness-to-pay threshold to be cost-effective. Universal screening, however, is cost-effective with an ICER well below the established willingness-to-pay threshold of $100,000 per QALY gained, if all women eligible for treatment receive therapy.

Conclusion. Universal screening may not lead to a significant increase in the odds that pregnant women receive DAAs therapy after pregnancy. Barriers to linkage to care should be addressed in an effort to increase antiviral therapy for these women and universal screening should be implemented within this patient population.

Testing Practice	Risk-based screening N=10420 (%)	Universal screening N=9033 (%)	OR [95% CI]
Pregnant women screened	1867 (17.9)	9033 (100)	
HCV antibody AB+	81 (4.3)	483 (4.9)	1.1 [0.9-1.4]
HCV RNA performed	44 (54.3)	483 (100)	1.8 [1.5-2.3]
HCV RNA AB+ (active infection)	31 (1.7)	306 (3.4)	2.1 (1.4-3.0]
DAAs Uptake	n=16, 0.8%	n=92, 1.0%	1.180.69-2.01, p=0.548

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313. Bringing Hepatitis C into FOCUS: Evaluating the Efficiency of a Linkage to Care Program in Improving the Hepatitis C Care Cascade

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Background. In 2016, The MetroHealth System began enhanced hepatitis C (HCV) screening through decision support, coupled with linkage of newly diagnosed patients to specialty care by a Linkage to Care coordinator (LTCC). Prior to this, patients were notified of their HCV diagnosis by a provider and given a referral to a specialist. We hypothesized that an LTCC would shorten time from HCV diagnosis to HCV treatment.

Methods. Patients newly diagnosed with HCV between June 1, 2015 and December 31, 2015 (Pre-LTCC), were compared with patients newly diagnosed between January 1, 2016 and March 31, 2017 (Post-LTCC). Patients who were HCV RNA negative were excluded. The time between diagnosis and linkage, linkage and treatment start date, and diagnosis and treatment start date for each population were compared using unpaired *t*-tests.

Results. 125 newly diagnosed patients were identified in the Pre-LTCC population. 83 (66%) were linked to specialty care and 27 (22%) received HCV treatment. 446 newly diagnosed patients were identified in the Post-LTCC population. 211 (47%) were linked to specialty care and 70 (16%) HCV positive persons were treated. No significant difference was noted between the groups in days between diagnosis and specialty care linkage (Pre-LTCC mean = 120 days; Post-LTCC mean = 102 days). The time from linkage to treatment was significantly longer in Pre-LTCC (260 days) than Post-LTCC persons (152 days), $P < 0.05$. The average time from diagnosis to treatment in pre-LTCC persons was also significantly longer than in Post-LTCC (332 days vs. 237 days, $P < 0.05$) (See Table).

Conclusion. We demonstrate that post-implementation of an LTCC program for HCV, the time between diagnosis and treatment of HCV was significantly reduced. This reduction, however, did not seem to be due to faster linkage to specialty care. A limitation of the study is that differences in HCV care (insurance restrictions, availability of new regimens) between the pre-LTCC and post-LTCC period were not considered. Although the linkage rate in the post-LTCC period was lower, some patients in post-LTCC may still be awaiting linkage. While there was an observed reduction in time between linkage and treatment, further research is needed to determine the causes of this reduction.

Time Period	Pre-LTCC		Post-LTCC		T-Test
	Mean	Standard Deviation	Mean	Standard Deviation	P value
Diagnosis to Linkage	120	237	102	102	0.36
Linkage to Treatment	260	310	152	147	0.02
Diagnosis to Treatmemt	332	303	237	155	0.04

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314. Healthcare Providers' Views on HCV Testing and Counseling Among Sexual Partners of Hepatitis C-Infected Persons

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Background. Current hepatitis C virus (HCV) counseling guidelines from the Centers for Disease Control and Prevention (CDC) do not recommend that HCV-infected-patients notify their partners or encourage them to get tested. Because there is a small but present risk of HCV acquisition through sex, sexual partners should be encouraged to receive HCV counseling and testing. We aimed to assess healthcare professionals' knowledge of and attitudes toward current counseling and testing recommendations for HCV-infected patients.

Methods. A 15-question, anonymous survey was designed and distributed to a convenience sample of healthcare providers (MDs, NPs, PAs) who work with Brown University or Boston University-affiliated hospitals. Questionnaires included demographic information as well as questions regarding providers' current counseling practices and knowledge of current recommendations for HCV counseling. Descriptive statistics were used to analyze the survey data.

Results. Of the 55 respondents (a 20% response rate), 73% believed that current CDC HCV testing guidelines already recommend partners of HCV-infected patients be tested for HCV infection. Furthermore, 80% of respondents believed recommendations should be revisited to explicitly include that HCV-infected patients encourage their partners to get tested. When counseling patients with HCV, 44% of respondents reported they always ask whether the patient's partners have been tested for HCV and 42% reported they sometimes do. Similarly, 42% reported they always suggest that the HCV-infected patient's partners be tested for HCV. If sufficient resources were available, 75% of respondents reported that they would support active partner notification for HCV during an HCV outbreak situation and 72% said they would support active partner notification in a non-outbreak situation where there is still high HCV incidence.

Conclusion. Our survey shows that healthcare providers believe that current HCV-counseling and testing recommendations could be revisited, with specific attention given to the promotion of HCV testing for partners of HCV-infected patients.

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315. Prenatal Hepatitis C Viral (HCV) Screening Practices and HCV-Associated Fetal, Neonatal and Pregnancy Outcomes in a Large Regional Healthcare System

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Background. Prevalence of HCV in pregnancy is 0.1–3.6%. AASLD and IDSA now recommend HCV screening in pregnancy although CDC, USPSTF, or ACOG still do not—though HCV can be perinatally transmitted and carries associated complications for the mother and fetus. Our study objectives were to analyze prenatal HCV screening practices at a large regional healthcare system and the prevalence of HCV-associated maternal and fetal/neonatal outcomes.

Methods. We performed a nested propensity score (PS) case–control study of pregnant women who tested HCV Ab+ in a cross-sectional study of women presenting for prenatal care at a large regional healthcare system from January 17 to December 18. We collected retrospective EHR data, including state of residency, HCV Ab, RNA, care engagement, HCV risk factors, comorbidities, maternal and fetal/neonatal morbidity, and neonatal HCV testing (when available). Mixed and generalized linear models were used to examine differences in continuous and categorical variables, respectively, between cases and controls

Results. 14,363 women were seen for prenatal care; 4,891 (34%) were HCV tested, 75 (1.5%) tested HCV Ab+. Demographic and comorbidity data are shown in Table 1. HCV Ab+ cases had more co-morbidities, including obesity, heart disease, opioid use, and behavioral health issues compared with the controls. HCV risk factors included IVDU (64%) and tattoos (24%) (Figure 1). Neither past/current pregnancy-related complications nor fetal or neonatal adverse events (Figure 2) were statistically significantly different except for cholestasis in HCV Ab+ cases (5.3 vs. 0%, $P = 0.04$).

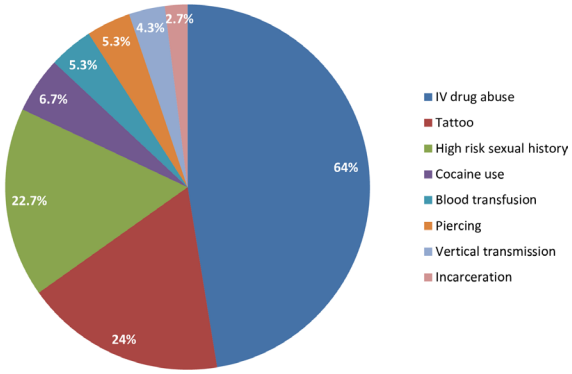
Conclusion. Our study showed only one-third of pregnant women are currently HCV screened in our health system. Universal screening would likely increase the number of HCV-infected women identified. Early HCV detection, repeated testing, and behavioral health intervention of those at high-risk may decrease further horizontal and vertical transmission of HCV in pregnancy.

Table 1: Baseline Demographics and Comorbidities:

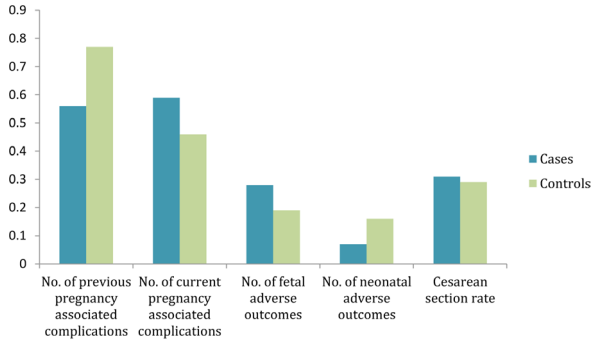
	Cases N (%)	Controls N (%)*	p-value
Age	31.2 ± 5.5	31.6 ± 5.1	0.60
Ethnicity			0.46
Hispanic	2 (2.7)	8 (5.3)	
Non-Hispanic	71 (94.7)	139 (92.1)	
Race			0.84
White	48 (64)	96 (63.6)	
African-American	20 (26.7)	41 (27.2)	
Other	7 (9.3)	14 (9.3)	
State of residence			***0.04***
District of Columbia	10 (13.3)	33 (21.9)	
Maryland	62 (82.7)	115 (76.2)	
Virginia	3 (4.0)	3 (2.0)	
Obstetric facility location			***0.02***
District of Columbia	17 (22.7)	51 (33.8)	
Maryland	58 (77.3)	99 (65.6)	
Virginia	0	1 (0.7)	
Comorbidities			
Mental health disease	36 (48.0)	45 (29.8)	***0.002***
Opioid use	36 (48.0)	23 (15.2)	***<0.001***
Obesity	35 (46.7)	36 (23.8)	***<0.001***
Tobacco use	28 (37.3)	44 (29.1)	0.22
Anemia	15 (20.0)	17 (11.3)	0.12
Asthma	14 (18.7)	17 (11.3)	0.27
Hypertension	10 (13.3)	16 (10.6)	0.52
Heart disease	8 (10.7)	1 (0.7)	***0.01***
Cancer/Pre-cancer	4 (5.3)	18 (11.9)	0.16
Seizure disorder	4 (5.3)	1 (0.7)	0.08
Hypothyroidism	3 (4.0)	10 (6.6)	0.39
Diabetes mellitus	3 (4.0)	6 (4.0)	0.95
Hyperthyroidism	3 (4.0)	3 (2.0)	0.41
Kidney disease	0 (0.0)	2 (1.3)	N/A

* Propensity Score matched on age, race, ethnicity, insurance and county

Maternal HCV Risk Factors:



Effect of HCV in Pregnancy, Fetal and Neonatal Outcomes:



* None of these variables were statistically significantly different between cases and controls

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316. Hepatitis C and Engagement in Health Care Among Persons Who Inject Drugs and Persons Who Use Non-Injection Drugs, Philadelphia

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Background. The growing opioid epidemic is driving increasing rates of hepatitis C virus (HCV) infections in the United States. HCV transmission is most frequently attributed to unsafe injection behaviors, but can occur via other unsafe drug use and sexual behaviors. Differences in demographics, HCV rates and associated risk factors in non-injecting PWUD (NIPWUD), compared with people who inject drugs (PWID) must be understood in order to target elimination strategies.

Methods. Change is Philadelphia's program to eliminate HCV among PWUD and enrollment includes HCV testing, linkage services, and an interviewer-administered survey including risk behaviors and healthcare engagement. This interim analysis includes the first 835 enrollees that identified as PWUD. For this analysis, PWID are enrollees who indicated ever injecting drugs and those who had not are NIPWUD.

Results. Among enrollees, 76% ($N = 637$) reported ever injecting drugs. PWIDs were younger and non-Hispanic (NH) white while NIPWUD were older and NH Black (age: $P = 0.003$; race/ethnicity: $P < 0.0001$). NIPWUDs had a high seropositivity rate though significantly lower than PWIDs (24% vs. 85%, respectively; $P < 0.0001$). Among PWID enrollees, 94% ($N = 596$) ever snorted. Of enrollees, 63% ($N = 124$) of NIPWUD and 56% ($N = 356$) of PWID identified having a PCP ($P = 0.07$). PWIDs are more likely than NIPWUD to have overdosed (OD) (40% vs. 9%; $P < 0.0001$) though high rates of both groups ever witnessed an OD (84% vs. 67%, respectively). While 80% ($N = 105$) of NIPWUDs know how to use Narcan, 60% ($N = 79$) carry it, {94% ($N = 503$) and 71%($N = 381$) in PWID, respectively}. NIPWUDs are more likely to be interested in drug treatment ($P < 0.0001$) and to have received it in the last 12 months ($P = 0.0008$).

Conclusion. Notable HCV infection exists among non-injecting PWUD reinforcing the need for harm reduction counseling and access to drug use equipment used for smoking and snorting. NIPWUD may be able to access drug and HCV treatment through PCPs and fatal ODs may be prevented by ensuring NIPWUDs have access to Narcan. In addition, PWID are likely to snort as well and should be counseled on non-injecting harm reduction methods. To succeed in micro elimination among PWUD, a focus on NIPWUDs as well as PWIDs is necessary to mitigate transmission of HCV.

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