

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%, $P = 0.04$).

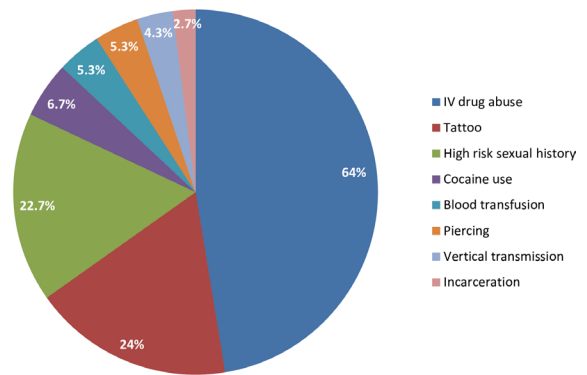
Conclusion. Our study showed only one-third of pregnant women are currently HCV screened in our health system. Universal screening would likely increase the number of HCV-infected women identified. Early HCV detection, repeated testing, and behavioral health intervention of those at high-risk may decrease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

Table 1: Baseline Demographics and Comorbidities:

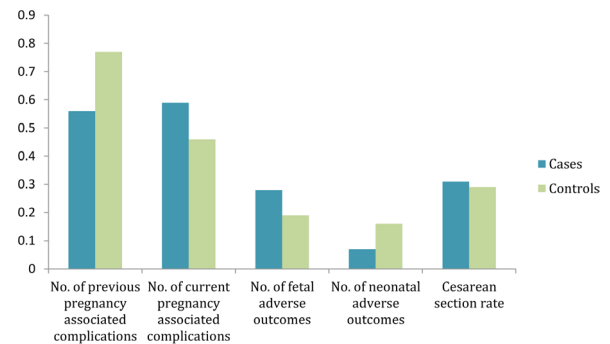
	Cases N (%)	Controls N (%)*	p-value
Age	31.2 ± 5.5	31.6 ± 5.1	0.60
Ethnicity			0.46
Hispanic	2 (2.7)	8 (5.3)	
Non-Hispanic	71 (94.7)	139 (92.1)	
Race			0.84
White	48 (64)	96 (63.6)	
African-American	20 (26.7)	41 (27.2)	
Other	7 (9.3)	14 (9.3)	
State of residence			0.04
District of Columbia	10 (13.3)	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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