cooperation between BMT and HCV care may increase HCV treatment among rural PWUD.

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915. Hepatitis A Burden of Disease and Associated Complications in Children and Adults in Mexico: A Retrospective Database Study from 2000-2019
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Session: P-52. Hepatitis

Background. In Mexico, Hepatitis A Virus (HAV) infection is the leading cause of viral hepatitis in children, yet the pediatric HAV vaccine is not included in the national immunization program (NIP). Since 2013, 1-dose HAV vaccine is only given to infants of agricultural workers and in day-care centers. Mexico has intermediate HAV endemicity, yet the real burden of symptomatic HAV is unknown. The objective of this study is to describe the burden of HAV infection and severe complications in children and adults in Mexico.

Methods. A retrospective database study was performed using the national surveillance system from all public health institutions in Mexico. Data on laboratory/clinically confirmed HAV cases, hospitalizations, and deaths, including for severe complications (Fulminant Hepatic Failure, Acute Liver Failure, Liver transplant), from 2000 to 2019 were analyzed (Table 1). Descriptive analyses were performed to estimate the disease burden and direct medical costs due to HAV per year for all ages, sex, and region.

Table 1. Definition of HAV-associated disease based on ICD-10 codes

| Disease Outcome                                      | ICD-10 code |
|------------------------------------------------------|-------------|
| Confirmed cases, hospitalizations, deaths due to HAV infection |             |
| Acute hepatitis A                                    | B15         |
| Hepatitis A with hepatic coma                        | B15.0       |
| Hepatitis A without hepatic coma                     | B15.9       |
| Complications due to HAV infection                  |             |
| Icteric syndrome (IC)                                | R17         |
| Hepatic failure (FHF)                                | K72.1, K72.9|
| Acute liver failure (ALF)                            | K72.0       |
| Liver transplant (LT)                                | T86.4       |

HAV, Hepatitis A Virus; ICD-10, International Classification of Diseases 10 Classification System

Results. During the analysis period, the average annual incidence was 29.4 per 100,000 population (range: 43.0–10.9); the average hospitalization rate/year was 5.8% (range: 2.9%–9.6%); and the average fatality rate/year was 0.44% (range: 0.23%–0.83%) (Figures 1a-b). Overall, there was a decreasing trend in HAV incidence over 2000–2017, with a recent increase in 2017–2019. As the incidence risk of HAV infection decreased, the mean age of infection increased. The biggest burden of HAV continued to be in children (1–9 years-old), yet there was an increase in incidence and hospitalizations (with complications) in older age groups (≥10–64 years-old) (Figures 2–3). The total direct medical costs (2019) due to HAV and related complications was estimated at $3.8 million Mexican pesos, which represented about 0.063% of total 2019 expenditure of the federal public budget for health function.

Conclusion. In addition to Mexico’s intermediate HAV endemicity and improved sanitary conditions, these results describe an increase of HAV infection from children to adolescents/adults, which increases the risk for more severe and complicated disease and greater demand on healthcare resources. Our findings support the evidence for HAV vaccine inclusion in the NIP in Mexico.

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916. Finding the Missing Millions and Addressing Health Disparities: Automated Hepatitis B Screening and Linkage to Care
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Session: P-52. Hepatitis

Background. Globally, HBV is the most common blood-borne infection. An estimated 1.2 million people in the US and 350 million worldwide lived with HBV, a primary driver of liver cancer. It is endemic in many parts of the world and is a major health disparity in immigrant communities, including the US, which has the largest immigrant population in the world. Asian American Pacific Islanders are 3% of the total population in the US, but represent 50% of people living with HBV. In 2016, WHO set a goal of hepatitis elimination by 2030 but with only 10% of those living with HBV diagnosed, screening must be scaled up.

Methods. Modifications were made in the electronic medical record (EMR) to automate screening, with HBV (HBsAg) orders triggered by a patient's country of birth in the chart. The patient's country of birth is then automatically linked to the Centers for Disease Control and Prevention (CDC) database, which determines the likelihood of a hepatitis B infection. The CDC database is then linked to the patient's electronic medical record, and a notification is sent to the provider.

Results. From March 2018 to May 2021, we conducted 23,883 HBV screenings. The patients originated from 173 countries based on registration; top 5 countries of origin were Haiti, Jamaica, Ecuador, Guyana, and Portugal. We found 228 (1.0%) patients with HBV infection, 101 (47%) were newly diagnosed and 182 (85%) were linked to care. We examined race and insurance status for any association with those previously tested versus newly diagnosed. Blacks were more likely to be newly identified HBV versus Asians (61.6% vs. 28.9%, p<.001), as we were self-pay (uninsured) versus insured.
patients (66.7% vs 47.2%, p=0.043). Compared to the approximately 0.4% HBV prevalence in the US, the HBV prevalence in several towns around our hospital in Essex County is two to four times higher.

Table 1. The HBV Prevalence in Towns of Essex County

| Location       | HBV Prevalence |
|----------------|----------------|
| Newark         | 3.9%           |
| East Orange    | 2.1%           |
| Irvington      | 2.3%           |
| West Orange    | 2.2%           |
| Orange         | 2.0%           |
| Livingston     | 2.6%           |

Conclusion. Our community is diverse and social determinants of health, like race and insurance status, may contribute to provider behaviors of HBV screening with blacks receiving less screening than Asians. Automated testing programs can address health disparities and scale up screening. Such micro-elimination approaches are important for achieving global hepatitis elimation by 2030.

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917. Accessible HCV Care for People Who Inject Drugs: Randomized Clinical Trial Comparing Low-Threshold Treatment at a Syringe Service Program Versus Facilitated Referral

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Session: P-52. Hepatitis

Background. To achieve hepatitis C virus (HCV) elimination, treatment programs need to be developed that engage, treat, and cure people who inject drugs (PWID).

Methods. We present final data from the Accessible Care Trial for curing HCV in PWID. The randomized clinical trial compared on-site, low-threshold HCV treatment with care-coordination at a NYC syringe service program (Accessible Care) with facilitated referral to local providers through a patient navigation program (Usual Care). Eligible participants were HCV RNA+ and had injected drugs in the past 90 days. Participants were randomized 1:1 to the Accessible Care or Usual Care arm. The primary endpoint was achievement of sustained virologic response (SVR12) within 12 months of enrollment. Secondary endpoints examined rates HCV care cascade steps from referral to clinician, attending clinical visit, baseline lab testing, treatment initiation, and cure.

Results. Among the 572 participants screened, 167 met eligibility criteria and were enrolled, with two excluded post-randomization (N=165). Demographics were similar with a median age of 41 years; 22% women; 59% Hispanic and 5% non-Hispanic black. At baseline, 84% of participants had injected drugs in the past 30 days with those averaging 22 injections/month, 70% were receiving either methadone or buprenorphine, 57% were recently homeless, 7% were HIV+, and 11% were HCV treatment experienced. In the intention-to-treat analysis, 55/82 (67.1%) of the Usable Care arm and 19/83 (22.9%) of the Usual Care arm achieved SVR12 (p<0.001). The SVR12 rates of those starting therapy were 55/64 (85.9%) and 19/22 (86.3%) in the two arms (p=0.96). Loss to follow-up (12.2% and 16.9%, p=0.51) was similar in the two arms. Significantly more participants in the Accessible Care arm achieved all steps in the care cascade with the greatest attrition in the Usual Care arm seen in referral to clinician and attending clinical visit.

Conclusion. Among HCV RNA+ PWID significantly higher rates of cure were achieved using the Accessible Care model focused on low-threshold, destigmatized, flexible HCV care compared to facilitated referral. To achieve HCV elimination, expansion of treatment programs specifically geared toward engaging PWID is paramount.

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918. 2019 Implementation of Universal Hepatitis C Screening at an Urban Federally Qualified Health Center: A Descriptive Analysis and Lessons Learned

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Session: P-53. Hepatitis

Background. Hepatitis C infection (HCV) is a curable disease that can be effectively managed by non-specialists. Delaware has high HCV rates but limited resources to care for individuals with HCV. Successful HCV micro-elimination starts with universal HCV screening and case identification.

Methods. ChristianaCare (CC) and Westside Family Healthcare (WFH), Delaware’s largest federally qualified health center (FQHC), created a multidisciplinary initiative to support comprehensive HCV care from July 2018-2020 (Figure 1). As part of this partnership, universal opt-out HCV screening in eligible (no prior HCV RNA result) adults ≥ 18 years was implemented at a pilot site in Wilmington in 2019. To characterize screening practices, pre- and post-screening) post-intervention (universal screening) electronic health record data was collected following the first 6 months of the intervention (Jan-June 2019). An HCV dashboard was created and updated monthly to evaluate trends in 2019 screening rates. Collaboration was supported through a 2-year CC Harrington grant.

Figure 1. Components of Federally Qualified Health Center HCV Care Model