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Santana P, (21.2%) three and 5,319 (20.9%) increased by 112.8%: BRL 25,039,624 in 2015 to BRL 53,285,820 in 2019. Most hospitalizations for CRSWNP and mean (SD) cost per hospitalization of BRL 8,961 (870.4). Hospitalizations with at least one surgery procedure previously selected by an otorhinolaryngologist. Results: Overall, 52.7% of patients were male, with mean age at index date was 46.3 (±15.4) years; 68.9% were female. One-year post-index, 35.4% of patients had ≥1 all-cause inpatient admission; 30.0% had ≥1 MS-related admission (n=7,871), of which 15.3% had inpatient care longer than 1 month. About 96.6% of patients had ≥1 all-cause outpatient specialist visits; 90.3% had ≥1 MS-related specialist visits (n=23,677) and 8.4% had ≥5 visits. About 44.5% of patients used DMT, and median initiation time from MS diagnosis to DMT use was 5.8 days (Q1-Q3: 0.95-41.5 days). Frequently used DMTs were interferon beta-1a (26.1%), glatiramer acetate (10.9%) and interferon beta-1b (9.4%). Conclusion: Patients with MS should be encouraged to consider resource use based on following MS diagnosis. About 44.5% patients were treated with an approved DMT. Future studies are warranted to evaluate the impact of different DMTs on outcomes such as health care resource use and associated costs.

WRO105
HEALTHCARE RESOURCE UTILIZATION AND DISEASE MODIFYING TREATMENT USE AMONG PATIENTS WITH MULTIPLE SCLEROSIS IN SWEDEN: A NATIONAL REGISTER-BASED STUDY
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Objective: Study objective was to evaluate health care resource utilization and disease modifying treatment (DMT) use among patients with multiple sclerosis (MS) in Sweden. Methods: Data came from four nationwide population-based registries with National Board of Health and Welfare and Statistics Sweden and linked by unique personal identity number. Patients with ≥1 diagnosis of MS (ICD-10 G35) were selected from 1/1/2001 to 12/30/2017 and date of first MS diagnosis was designated as index date. Individuals were followed from the index date until death or end of study period. One-year post-index, all-cause and MS-related healthcare resource use including hospital admission and outpatient specialist visits were evaluated. Post-index utilization of approved DMTs throughout the study period were also examined. Results: A total of 26,219 patients with MS were identified between 2001 and 2017 with median follow-up of 9.79 (interquartile range= 4.80, 14.7) years. Mean (±SD) age at index date was 46.3 (±15.4) years; 68.9% were female. One-year post-index, 35.4% of patients had ≥1 all-cause inpatient admission; 30.0% had ≥1 MS-related admission (n=7,871), of which 15.3% had inpatient care longer than 1 month. About 96.6% of patients had ≥1 all-cause outpatient specialist visits; 90.3% had ≥1 MS-related specialist visits (n=23,677) and 8.4% had ≥5 visits. About 44.5% of patients used DMT, and median initiation time from MS diagnosis to DMT use was 5.8 days (Q1-Q3: 0.95-41.5 days). Frequently used DMTs were interferon beta-1a (26.1%), glatiramer acetate (10.9%) and interferon beta-1b (9.4%). Conclusion: Patients with MS should be encouraged to consider resource use based on following MS diagnosis. About 44.5% patients were treated with an approved DMT. Future studies are warranted to evaluate the impact of different DMTs on outcomes such as health care resource use and associated costs.

WRO106
CHARACTERIZING TELEHEALTH UTILIZATION FROM ADMINISTRATIVE CLAIMS IN THE US USING A STANDARDIZED DEFINITION
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Objectives: In response to the disruption of in-person healthcare visits during the Covid-19 pandemic in the US, public and private payers expanded their coverage and reimbursement for telehealth (TH) services with HC-820. To account for this new driver of healthcare resource utilization, we created a standardized definition of

TH utilization from administrative claims to improve research quality. We used this definition to investigate trends in TH utilization in a large US commercial insured/ Medicare population. Methods: Administrative claims from 1/1/2006 to 8/31/2021 from the HealthCore Integrated Research Database® were used to identify TH claims. We defined TH based on outpatient claims containing at least one of the following TH designations (not mutually exclusive): place of service codes, CPT modifiers, HC-820. We determined TH use by CPT modifiers and coding patterns. We expected over time to be evaluated. All analyses were descriptive. Results: Over the 15-year period, 57% of TH claims occurred in 2020 and an additional 39% in 2021 (through August). In 2019/2020/2021, the share of commercial claims designated as TH was 0.1%/4.8%/4.4%. Utilization was slightly higher among commercially-insured compared to Medicare Advantage/Supplement patients (5.0%/ vs. 3.9% in 2020). Most TH use was identified via CPT modifier codes (80%), followed by place of service codes (53%). Evaluation & management visits and specialty care needed for approximately 45% of all TH claims. Approximately 8% of TH claims were for audio-only visits based on submitted codes. Conclusions: We created a standardized algorithm to identify TH using claims data. Consistent with prior reports, TH utilization increased substantially following onset of the Covid-19 pandemic in conjunction with increased coverage and reimbursement for the service. Incorporation of TH utilization via this algorithm is an essential tool for all health economic and outcomes research studies evaluating time periods from 2020 and beyond.

WRO107
PREVALENCE OF HEALTHCARE CONDITIONS AND SERVICES USED BY PATIENTS WITH MYOTONIC DYSTROPHY PRE-AND POST-DIAGNOSIS, A REAL-WORLD DATA ANALYSIS
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Objective: Describe the changes in outcomes (healthcare conditions, services, costs, and care days) for patients with myotonic dystrophy compared with matched controls (MCs) two years pre-post diagnosis. Background: Myotonic dystrophy (DM, Types 1 and 2) are dominantly inherited multisystem disorders that cause progressive weakness and myotonia along with variable cardiopulmonary, gastrointestinal, endocrine, and neurological manifestations that adversely affect quality of life. Literature describing the DM patient journey is limited. Design/Methods: We used PharMetrics deidentified-US-claims (Jan–2010–Mar–2021) to retrospectively evaluate outcomes for DM-patients vs non-DM MCs. DM-patients had ≥2 DM claims ≥30 days apart (index date-first diagnosis date). Cohorts were matched (5:MC:1-DM) on index date, age, region, gender, plan, and payer types. Outcomes were compared two-years post-diagnosis minus two-years pre-diagnosis (Post-PreDx) using US Agency for Healthcare Research & Quality (AHQ) categories. Data reported is per-member-per-year. All reported findings significant (p<0.05).
Results: We identified 519 DM-patients and 2595 MCs. Most outcomes demonstrated higher care utilization in DM-patients than MCs. Post-PreDx care days increased at all service settings except lab for both cohorts (19.9 DM; 1.5 MCs). Post-PreDx DM-patients’ AHQ-prevalence changed in 58/157 = 37% categories. “other nervous system disorders” (37.6% DM;3.2% MCs), “cardiac dysrhythmias” (17.3% DM,2.3% MCs) and “other lower respiratory disease” (16.0% DM,2.7% MCs). DM-patients’ mean number of pharmacy claims increased Post-PreDx (9.29 MCs). Post-PreDx DM-patients’ utilization increased in 21 AHQ-service and 7 AHQ-cost categories. Total medical and drug costs increased for DM-patients ($18,705 to $25,594) vs MCs ($5640 to $6884). Conclusions: Health care utilization increased significantly in DM patients following diagnosis and was overall higher and in different categories than MCs. This likely reflects the need to investigate and manage previously unsuspected manifestations of DM following formal diagnosis.

WRO108
COMPARING SELF-REPORTED PRESENTEEISM WITH OBJECTIVELY MEASURED DIRECT AND INDIRECT COSTS, LOST TIME AND COMORBIDITY ASSESSMENTS FOR EMPLOYEES WITH CANCER
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Objectives: Assess whether self-assessed presenteeism (SAP) matches objectively measured costs and absences for employees with cancer and the relationship between medical costs and the Charlson Comorbidity Index (CCI). Methods: Retrospective analysis using Workpartners RRDs (2012–2019). For each employee, years who completed the Health Productivity Questionnaire [HPQ] or WebMDs’ SAP survey were checked for claims with ICD-9s/-10s within the US Agency for Healthcare Research & Quality (AHRQ) categories. We identified each year eligible. Analysis focused on #of employees completing the survey, with the condition, and each cancer-cohorts included each year continuous eligibility for the calendar-year they completed a SAP-survey and were measured costs and absences for employees with cancer and the relationship between medical costs and the Charlson Comorbidity Index (CCI).