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Study Objectives: A non-food-borne hepatitis A outbreak occurred in Michigan between August 2016 and September 2019, resulting in 920 cases, 738 hospitalizations, and 30 deaths. To support the Michigan Department of Health and Human Services’ efforts to increase hepatitis A vaccination rates among high-risk individuals, our multicenter health system implemented an electronic medical record (EMR)-based vaccination intervention across its nine emergency departments (ED). The primary objective of this retrospective cohort and survey analysis was to quantitatively determine whether this intervention was successful in increasing vaccination rates. The secondary objective was to qualitatively assess the attitudes towards, and barriers to use of, the computerized vaccine reminder system.

Methods: All patients 18 years or older who arrived to any of the nine EDs between August 2018 and January 2020 were screened using an electronic nursing questionnaire embedded in the EMR (Epic). If a patient was determined to be high-risk based on the questionnaire (homeless, incarceration history, illicit drug use, liver disease, or a man who has sex with men), an electronic best practice advisory (BPA) would trigger and give the patient’s physician the option to order the hepatitis A vaccine. If consented, patients would receive a one-time dose of the hepatitis A vaccine in the ED. We also administered a survey to physicians and nurses to evaluate perceptions and barriers to use of the EMR intervention.

Results: During the pre-intervention period from August 2016 to July 2018, 885,344 patients visited the EDs. 49 vaccines were ordered (5.5 per 100,000 patients) and 34 were administered (3.8 per 100,000 patients). During the intervention period from August 2018 to January 2020, 774,034 patients visited the EDs and 574,865 (74.3%) were screened. Of those screened, 11,016 patients were found to be high-risk. Between August 2018 and January 2020, 774,034 patients visited the EDs and 574,865 (74.3%) were screened. Of those screened, 11,016 patients were found to be high-risk. Between August 2018 and January 2020, 774,034 patients visited the EDs and 574,865 (74.3%) were screened. Of those screened, 11,016 patients were found to be high-risk.

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Study Objectives: The COVID-19 pandemic has exacerbated longstanding inequities in opioid use disorder (OUD) that reflect multiple facets of structural racism. In Massachusetts, opioid overdose deaths in 2020 rose by nearly 70% in Black men compared to just 5% overall. Emergency department (ED) visits in people with OUD may represent key touchpoints for overdose prevention. Although racial inequities in buprenorphine and methadone maintenance initiation, dosing, and retention have been well documented, less is known about the administration of medications for opioid use disorder (MOUD, buprenorphine and methadone), in the ED. ED leadership initiated an internal review to explore racial equity in multiple clinical quality metrics, including frequency of MOUD administration in patients with OUD.

Methods: Retrospective data were analyzed for quality improvement (QI) purposes. Patients presenting to the ED with OUD July 29, 2020-March 12, 2021 were identified via ICD-10 codes. Patient demographics and MOUD administration were explored using descriptive statistics; χ² tests compared the frequency of MOUD administration by race. An intensive QI intervention to improve MOUD utilization will be delivered to all ED prescribers in June 2021. The intervention includes content on racial inequities in OUD treatment and factors that drive them, including provider bias, reasons for mistrust of the medical system among patients of color, and structural barriers to OUD treatment and retention. Through educational sessions for providers, transparency of data of system among patients of color, and structural barriers to OUD treatment and retention.

Results: A total of 998 unique patients with OUD were seen for 1452 ED visits. Documented race was 56.7% White, 21.5% Black, 13.5% Hispanic, 1.7% Other, and 6.6% unknown. MOUD were administered during 945/1452 visits (65.1%). The likelihood of administration varied significantly by race: 80.3% of White patients received MOUD compared to 35.9% of Black patients, and 59.9% of Hispanic patients (p<0.001, Table 1). Significant differences in treatment were also observed when comparing white and Black patients (p<0.001) and white and Hispanic patients (p<0.001) directly.

Conclusion: Renewed attention to ensuring racial equity in clinical practice prompted an exploration of ED data at our institution, including equitable administration of buprenorphine and methadone in patients with OUD. This QI analysis identified a racial inequity, prompting the development of a QI initiative to improve overall utilization of MOUD, with a specific focus on mitigating observed racial inequities. Data analysis from the post-QI intervention period will be completed prior to presentation at ACEP.

264 Racial Inequities in Emergency Department Administration of Buprenorphine and Methadone Among Patients With Opioid Use Disorder

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Study Objective: To determine if COVID-19 markers of severity, positive test, and hospitalization, differ among racial groups. Additionally, to examine whether these differences are associated with mortality and to identify predictive variables for potential prevention and intervention.

Methods: This is a retrospective cohort design studying those tested for COVID-19. A multistate model was created using Trinity Health electronic health records in the US (January 1 - June 30, 2020). The primary outcome variable was mortality and secondary outcomes were COVID-19 positivity and hospitalization. Predictive variables included age, sex, race, insurance, income status, BMI, zip code population density and measures of comorbidities using the Charlson Comorbidity Index (CCI). Adjusted treatment effects were estimated using logistic regression.

Results: The data included 181,199 patients of which 18,083 patients (9.95%) were COVID-19 positive in 13.7% of African Americans (AA) and 4.97% of Whites. AA patients had higher rates of comorbidities (p < 0.001), lower rates of commercial insurance (p < 0.001) and higher population densities (p < 0.001) as compared to White patients. Unadjusted logistic regression shows that AA patients have higher odds of infection (OR = 3.033, p < 0.001), mortality (1.3% vs 0.8%), OR = 1.656, p < 0.001), and hospitalization (OR = 1.165, p = 0.031) compared to white patients. After adjusting for predictors, the odds of SARS-CoV-2 infection are higher for AA (OR = 1.744, p < 0.001). There is no significant difference in the odds of mortality between AA patients and White patients who were COVID positive (OR = 0.740, p = 0.09), after adjusting for the other predictive variables.

Conclusion: In this large multi-state study of COVID-19 tested patients, African Americans were infected much more often and had greater mortality than Whites before adjusting for covariates. The rate of hospitalization was lower for COVID positive AA than Whites, and mortality was nearly the same as Whites after adjusting for predictors such as comorbidities. Our study identifies variables associated with COVID-19 morbidity and mortality, highlighting the disproportionate impact of COVID-19 on the African American community. This analysis may provide opportunities to employ preventive medicine approaches and mitigate systemic inequities to improve the health of vulnerable populations.

265 A Multi-state Study of Racial Disparities During the United States COVID-19 Pandemic: Opportunities for Prevention and Intervention

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