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Figure 1. Monthly seasonal variations of number of HRSV activity, NPI indicators, and meteorological conditions during 2014-2020.

Table 1. Generalized linear Poisson regression model for the monthly number of human respiratory syncytial virus cases among prefectures in Japan.

| Indicator | Coef. | Std. Err. | z | P-value |
|-----------|-------|-----------|---|---------|
| Relative humidity | -0.0001 | 0.00009 | -1.08 | 0.28 |
| Average temperature | 0.0000 | 0.00001 | 9.4 | 0.0000 |

Conclusion. This study suggests that there is an association between the decrease in the monthly number of HRSV cases and improved hygiene and sanitary measures and travel restrictions for COVID-19 in Japan, indicating that these public health interventions can contribute to the suppression of HRSV activity. These findings may help in public health policy and decision making.

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1200. Healthcare Claims-Based Lyme Disease Case-Finding Algorithms in the United States: A Systematic Literature Review
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Session: P-71. Public Health

Background. Lyme disease (LD) is the fifth most common notifiable disease in the US with 30,000-40,000 LD cases reported annually via public health surveillance. Recent healthcare claims-based studies utilizing case-finding algorithms estimate national LD cases are >10-fold higher than reported by surveillance. The reliability of claims-based data depends on the accuracy of the case-finding algorithms using the information available in the claims primarily generated for the administrative purposes. To assess the true burden of LD, it is imperative to use validated well-performing LD case-finding algorithms (“LD algorithms”). We conducted a systematic literature review to identify LD algorithms based upon healthcare claims data in the US and their respective performance.

Methods. We searched PubMed and Embase for articles published in English from January 1, 2000 through the most recent date as of February 20, 2021. We selected articles including all of the following search terms: (1) “Lyme disease”; (2) “claim*” or “administrative* data”; and (3) “United States” or “the US*”. We then reviewed the titles, abstracts, and full texts to identify articles describing LD algorithms developed for claims data. Figure 1 shows the flow diagram following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement.

Figure 1. Flow diagram of the identification of articles for literature review on the US claims-based Lyme disease case-finding algorithms published in English since 2000.
1201. Diphtheria in Veterans Health Administration (VHA), 2000-2021
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Background. Diphtheria is caused by Corynebacterium diphtheriae and can cause respiratory or skin infections. Transmission occurs primarily person-to-person via respiratory tract and rarely from skin lesions or fomites. In the Veterans Health Administration (VHA), we perform surveillance for nationally notifiable diseases such as diphtheria. In early 2021, there were 4 alerts for C. diphtheriae. Therefore, we investigated diphtheria prevalence in VHA over the last 20 years.

Methods. Isolates of C. diphtheriae were identified from VHA data sources from 1/1/2000-2/28/2021. Patient demographics, co-morbidities, microbiologic data, treatment outcomes, and vaccination status were obtained via electronic medical record (EMR) review.

Results. 33 C. diphtheriae isolates were identified representing 32 unique individuals. Isolates were identified from 2000-2015 and 16 were identified from 2016-2021. Isolates were from cutaneous (16), blood (10), urine (4), pulmonary (2), and otic (2) specimens. In 11 individuals, clinical significance was unclear (no antibiotics given, note mentioned that it was being considered a contaminant - i.e., isolate was identified in addition to C. diphtheriae). Only 3 isolates had toxin testing documented. One C. diphtheriae biovar gravis blood isolate was associated with sepsis without another source identified. The throat isolate was a biovar mitis.

3 isolates had toxin testing documented. One C. diphtheriae biovar gravis blood isolate identified in addition to C. diphtheriae. Table 1 describes demographics, co-morbidities, and vaccination status of cutaneous cases. Only 1 case (in 2021) had EMR documented in addition to C. diphtheriae but were not treated. EMR documentation of toxin production and public health department reporting was lacking.

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1202. Chagas Disease Awareness in a Hispanic Community of the Greater New Orleans Area
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Background. Chagas disease is a neglected tropical disease responsible for severe disease burden in Latin American countries (2-6 million cases). It is increasingly reported in the Southern United States, with an estimated 89,410 human cases (nation-wide estimate: 300,000), many of them acquired in endemic zones in Latin America.

Methods. Cross-sectional study to assess the change in knowledge about Chagas disease and triatomine vectors among Hispanic immigrants living in the Greater New Orleans area. All consented participants answered the baseline questionnaire, then received a short video presentation, and completed a post-test to evaluate change in knowledge. Consents, online questionnaires and training were administered in Spanish and English, as needed. Frequencies were computed to describe differences in demographic variables and questions in the pre-posttest. Data was analyzed with R software.

Results. A total of 64 adults (66% women, median age 58 years) completed the pre-post tests and attended the educational intervention. Participants have been living in the US for an average of 23 years and represented 11 countries. Majority were born in Honduras (27%) followed by Nicaragua (16%), United States (13%), Colombia (11%), Ecuador (9%), Guatemala (6%), Mexico (6%) and other counties (12%). Most participants recalled exposure to Chagas disease vectors. Although in the pre-test almost half reported ever seeing a Triatomine, less than 2% correctly identified one of three images of a Triatomine provided in the questionnaire. Knowledge about how the disease is transmitted to humans increased from pre to posttest. While higher percentages of men (80%) than women (69%) answered correctly at the pre-test, in the post-test higher percentages of women (98%) than men (95%) responded correctly. In addition, 98% of participants reported that the presentation was clear, 85% would like to learn more about Chagas Disease, and 100% would like to be screened.

Conclusion. Results indicate the positive impact that an educational intervention may have in the knowledge about the disease. Considering the high percentage of Hispanic immigrants in US, increasing awareness of Chagas disease may contribute in the prevention and early detection of the disease among this high-risk population.

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1203. A Descriptive Analysis of an Opioid Use Disorder Care Continuum in an Infectious Diseases Clinic
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Session: P-71. Public Health

Background. On December 17, 2020, U.S. CDC released an advisory reporting the highest drug overdose rate on record. Kentucky ranks in the top 5 states for opioid overdose deaths. Retention in opioid use disorder (OUD) treatment is associated with decreased overdose deaths. University of Kentucky HealthCare’s infectious disease division (UKID) implemented a multi-disciplinary approach to expand access to medication for opioid use disorder (MOUD) for patients with injection drug use-associated infections (IDU-AI). This program is modelled after the Ryan White Cares Act to engage and retain patients.

Methods. This ongoing project began enrollment in June 2019. Any patient ≥18 years old with IDU-AI and OUD is eligible for enrollment unless pregnant or incarcerated. Patients are eligible for transportation assistance, mental health services, and medical case management. They may start MOUD with UKID or be referred elsewhere. In this analysis, we describe our opioid use disorder care continuum and identify reasons for patient attrition and areas to improve.

Results. Our continuum components are referral, eligible, enrolled, start MOUD, and retention at month 1, 3, and 6. To date, 533 patients have been referred. Of these, 383 (71.9%) were eligible and 350 (39%) enrolled. Reasons patients did not enroll: discharged stable (41.5%), left AMA (16.9%), declined (10.8%), deceased (6.7%), discharged to other hospital (3.6%), missed clinic visit (9.7%), hospice (1%), other (10.8%). Reasons patients declined: no reason (28.6%), refused to discuss (19.1%), no interest (10.0%), travel (4.8%), declined ID follow-up (4.8%), time limits (9.5%). Ninety-three patients have been enrolled ≥6 months; 83 are on MOUD. Sixty-seven, 29, and 20 patients were retained at month 1, 3, and 6, respectively.

Conclusion. UKID engages patients in OUD treatment, but retention rates are comparable to those described in medical settings. Most attrition occurs between eligibility and month 3, suggesting patients are most vulnerable when they consider change and start MOUD. These time points should be priority for patient engagement by clinic staff. Also our staff size struggles to meet the demand. The number of referrals is prohibitive for our small team to approach everyone in a timely manner. More programs like this one are needed.

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