

Results. We found 15 articles meeting the inclusion criteria. Of these, 7 study algorithms used only LD diagnosis codes (ICD-9, 088.81; ICD-10, A69.2 or A69.2x), 4 studies additionally used antibiotic dispensing records, and 4 studies additionally used serologic test order codes (CPT 86617, 86618). Three studies used different algorithms for inpatient and outpatient settings. Only one study (in Tennessee, a low-incidence state for LD) provided validation results for their algorithm, which only used a LD diagnosis code (ICD-9, 088.81), with reported sensitivity=50% and positive predictive value=5%.

Conclusion. Validation data on the LD algorithms developed for healthcare claims data are limited, and suggest algorithms using only LD diagnosis codes may not perform well. Further validation of high-performance claims-based LD algorithms is critical to inform the true burden of LD overall and within subgroups.

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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. 17 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 throat (1) specimens. In 11 individuals, clinical significance was unclear (no antibiotics given, note mentioned that it was being considered a contaminant - i.e., isolate may have been incorrectly labeled as "*C. diphtheriae*" instead of "diphtheroid"). 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 nontoxicogenic strain. No cutaneous isolates underwent susceptibility testing, but all 15 individuals received antibiotics (1 patient had 2 isolates). 11 had additional organisms 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 documentation of local public health department reporting.

Table 1. Characteristics of Unique Individuals with Cutaneous Diphtheria Isolates in VHA, 2000-2021

	Unique Individuals with Cutaneous Diphtheria Isolates N=15*
Median Age (Range)	61 (31-86)
Gender	
Male	14
Female	1
US Census Regions:	
Northeast	1
Midwest	4
South	3
West	7
Death^ <12mo after positive culture	2
Number of Cultures with other microbiologic growth	11
Organisms Identified:	
Streptococcus species	5
Other Staphylococcus	7
Staphylococcus aureus	3
Pseudomonas aeruginosa	1
Escherichia coli	1
Proteus vulgaris	1
Stenotrophomonas maltophilia	1
Arcanobacterium haemolyticum	1
Enterococcus faecalis	1
Bacillus	1
Co-morbidities:	
HTN	8
CAD	3
Hyperlipidemia	8
DM2/Glucose intolerance	8
Obesity	6
Peripheral Vascular Disease	5
Homelessness	3
Alcohol Abuse	3
Tobacco Use	4
History of Illicit Drug Use	3
Chronicity of Skin Source:	
Acute (<4 weeks)	8
Chronic (>4 weeks)	7
Vaccination* <10 years before positive culture	13
Vaccination* not up to date	2

#One individual grew *C. diphtheriae* twice >30 days apart from same skin source

^Cause of death not determined

*Tdap or Td

Conclusion. Nearly as many isolates have been identified in the last 5.5 years compared to the previous 15 years which may be related to more robust molecular

identification methods available in VHA. Most *C. diphtheriae* isolated was from cutaneous sources that were acute in onset. About 33% were identified as *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 (≥ 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 about half reported ever seeing a Triatomine, less than 20% 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 (97%) 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 on 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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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 modeled 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 150 (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 (14.3%), 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 non-ID 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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