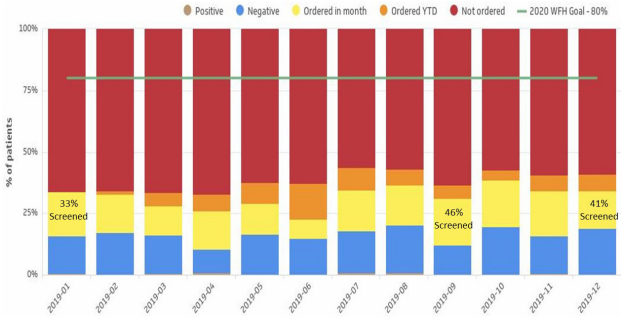

Conclusion. The early adoption of universal HCV screening in adults (prior to 2020 USPSTF update) at an urban FQHC, together with an initiative to provide multidisciplinary HCV care at this FQHC (Figure 1), led to increasing rates of ordered screening. The presented 6-month data does not fully account for lag times between test ordering and fulfillment, resulting in under-reporting of universal HCV screening rates. Multidisciplinary care models to address HCV in patients' medical homes are vital to HCV eradication with the robust implementation of universal HCV screening a vital first step in this continuum.

Disclosures. **Deborah A. Kahal, MD,MPH, FACP**, **Gilead** (Speaker's Bureau)**Viiv** (Speaker's Bureau)

919. Rates of False-Positive Hepatitis B Surface Antigen Is Low in Cancer Patients

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Session: P-52. Hepatitis

Background. Accurate interpretation of hepatitis B virus (HBV) laboratory testing is paramount in avoiding inaccurate diagnosis and incorrect management that could lead to unnecessary and overtreatment. This is particularly relevant in patients with cancer where universal testing is recommended in order to avoid HBV reactivation. Hepatitis B surface antigen testing (HBsAg) positivity indicates chronic or acute HBV infection. The rates and outcomes of a false-positive HBsAg have not been established for patients with cancer.

Methods. Three hundred and ninety-seven patients with any type of cancer and positive HBsAg seen at MD Anderson Cancer Center from January 2016 – January 2021 were retrospectively reviewed in this study approved by the institutional review board. Cases of false-positive HBsAg were defined as those patients with a positive HBsAg but negative HBsAg quantitative, negative HBV core antibody (total Ig), and undetectable HBV DNA within 30 days of positive HBsAg testing. Serum samples from patients were tested for HBsAg using Vitros Enhanced Chemiluminescent Immunoassay (Ortho-Clinical Diagnostics, Raritan, NJ, USA). Data collection includes demographics, past medical history, underlying cancer and its stage, prior cancer treatment, risk factors for HBV, co-infections (hepatitis C, HIV), symptoms, liver function tests, anti-HBV treatment, and interruptions on cancer treatment.

Results. Out of 397 patients with a positive HBsAg, 33 were excluded as they did not meet the diagnostic criteria or have insufficient HBV data. Of them, 3 cases (0.8%) were identified as false positive HBsAg. All 3 patients were female, white, and had progressive malignancy (Table 1). No prior history of liver disease or liver function abnormalities were noted with these 3 patients. Initially, antiviral treatment was started on 1 patient which was discontinued shortly after confirmation of false-positive HBsAg. All 3 patients had additional workup and evaluation by an HBV specialist. In 2 patients, cancer treatment was canceled or delayed.

Table 1. General characteristics of patients with false-positive HBsAg

Characteristics	Patient 1	Patient 2	Patient 3
Age	76	66	45
Sex	Female	Female	Female
Race	White	White	White
Cancer type	MDS	Gastric adenocarcinoma	DLBCL
Cancer stage	N/A	Metastatic	N/A
Progressive cancer	Yes	Yes	Yes
HBsAg	Reactive	Reactive	Reactive
HBsAg quant (IU/mL)	Negative	Negative	Negative
HBV DNA quant (IU/mL)	Undetected	Undetected	Undetected
HBcAb total	Negative	Negative	Negative
HBsAb	Negative	Negative	Negative
HBe Ab	Negative	Negative	Negative
HBe Ag	Negative	Negative	Negative
HCV Ab	Negative	Negative	Negative
HAV Ab	Positive	Positive	Negative
HIV 4th generation	Negative	Negative	Negative
ALT (I/U)	25	9	17
AST (I/U)	20	19	17
Absolute neutrophil count (K/μL)	3,710	9,730	3,002
Absolute lymphocyte count (K/μL)	710	1,880	1,000
Need for HBV specialist	Yes	Yes	Yes
Unnecessary antiviral treatment	No	Yes (Entecavir)	No
Chemotherapy delay or cancellation	Yes	Yes	No

Abbreviations: MDS, myelodysplastic syndrome; DLBCL, diffuse large B cell lymphoma; HBsAg quant, hepatitis B surface antigen quantitative; HBV DNA quant, hepatitis B virus DNA quantitative; HBcAb total, hepatitis B core antibody total; HBsAb quant, hepatitis B surface antibody quantitative; HBe Ab, hepatitis B e antibody; HBe Ag, hepatitis B e antigen; HCV Ab, hepatitis C antibody; HAV Ab, Hepatitis A antibody; HIV 4th generation, human immunodeficiency virus 4th generation test; ALT, alanine aminotransferase; AST, aspartate aminotransferase; HBV, hepatitis B virus

Conclusion. Although uncommon, cancer patients with false-positive HBsAg need further workup to avoid overtreatment and unnecessary interruptions in cancer care

Disclosures. **Jessica P. Hwang, MD, MPH , Merck** (Grant/Research Support)

920. Automated Hepatitis C Screening and Linkage to Care among Hospitalized Patients Born Between 1945-1965

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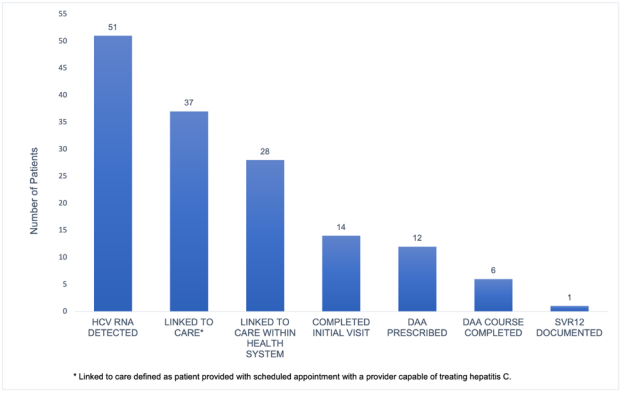
Session: P-52. Hepatitis

Background. Hepatitis C virus (HCV) infects 4.1 million people in the United States, of whom 50% are unaware of their status. In 2016, Pennsylvania introduced a law mandating HCV screening for patients born between 1945-1965 in inpatient settings. However, HCV screening during hospital admissions has remained low in part due to limited knowledge on HCV testing requirements, interpretation of results, and treatment approaches. To overcome these barriers, we implemented a quality improvement initiative to automate HCV screening as part of hospital admission order sets, facilitate linkage to HCV treatment, and sought to evaluate its effectiveness.

Methods. Between September 2020 and May 2021, the automated inpatient HCV screening strategy was implemented at a single 328-bed academic hospital in Philadelphia, PA. Patients born between 1945-1965 without documentation of HCV screening or diagnosis in the electronic medical record had a HCV antibody with reflexive confirmatory RNA assay automatically populated in the admission order set. Admitting providers could opt out of the screening as appropriate. All patients with reactive HCV antibody were approached by the Hepatitis Linkage Team for result disclosure, counseling, and linkage to treatment for those with HCV viremia. Cascade of care was detailed for those linked to providers within the health system.

Results. During the initial 8 months of the program, 2,203 patients were screened for HCV, identifying 156 with reactive HCV antibody (7.1% seroprevalence). Among 147 with completed HCV RNA assay, 51 were viremic (34.7%). Fourteen viremic patients were not linked to care, including six with a terminal illness, two who declined linkage, and six who did not respond to linkage attempts. Nine were linked to care at other health systems. Among the 28 patients linked to providers in the health system, 50% completed initial visits, 42.8% were prescribed direct acting antivirals (DAA), and 21.4% completed therapy by May 2021. One person achieved sustained virologic response 12 weeks after treatment as of May 2021 (**Figure 1**).

Figure 1. Cascade of HCV Care Among Patients Screened During Hospital Admission from September 2020 to May 2021



Conclusion. Automated inpatient HCV screening is a viable strategy to identify people with HCV and facilitate linkage to care. Optimal strategies to ensure patients access and maintain care require further study.

Disclosures. **All Authors**: No reported disclosures

921. Acute HAV Infection in an Inpatient Psychiatry Unit

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Session: P-52. Hepatitis

Background. The incidence of hepatitis A virus (HAV) infection has been rising in the US since 2016, and in New York State since 2019. New York City has also seen an increase of HAV infection among high risk populations. We present a case of acute HAV infection in an inpatient psychiatry unit which has its own unique isolation and management challenges.