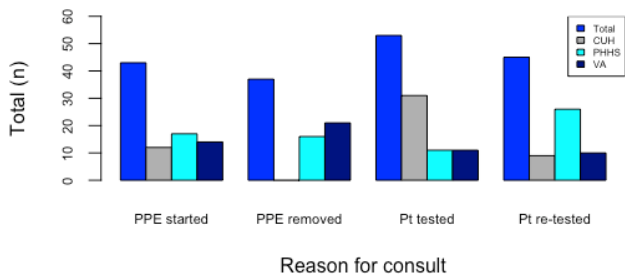


86(43%) Caucasian, 71(36%) Hispanic, 42(21%) African American, 6(3%) Asian and mean(sd) age of 55.1(15.9). Patient comorbidities included: 89(45%) with a heart condition, 77(39%) diabetes, 30(15%) asthma and 14(7%) liver disease.

Median time to completion for all hospitals was 4 hours(h); ((CUH (4h) vs PHHS (2h), $p < 0.05$; VA (5.5h) vs PHHS (2h) $p < 0.05$). Most common reasons for e-consult included: (63)32% regarding re-testing ((CUH 14(21%) vs PHHS 43(50%), $p < 0.05$; CUH vs VA 14(27%), $p < 0.05$; PHHS vs VA, $p < 0.05$), (61)31% testing ((CUH 25(37%) vs PHHS 39(45%), $p < 0.05$; CUH vs VA 7(16%), $p < 0.05$; PHHS vs VA, $p < 0.05$) and 61(31%) infection prevention (IP). Based on the e-consult recommendation, 53(27%) of patients were tested ((CUH 31(45%) vs PHHS 11(13%), $p < 0.05$, CUH vs VA 11(25%), PHHS vs VA, $p < 0.05$), 45(23%) were re-tested, 44(22%) of patients had PPE started on and 19% had PPE removed ((CUH 0(0%) vs PHHS 16(19%), $p < 0.05$; CUH vs VA 21(48%), $p < 0.05$; PHHS vs VA, $p < 0.05$).

Reason for Consult

Outcomes of E-consult



Conclusion: E-consult services can provide prompt ID input during the COVID-19 pandemic, minimizing the risk of infection to the patient and health care workers while preserving PPE and testing supplies.

Disclosures: Roger Bedimo, MD, MS, Gilead Sciences (Consultant)Merck & Co. (Advisor or Review Panel member)ViiV Healthcare (Advisor or Review Panel member, Research Grant or Support)

473. Using Serosurveillance for SARS-CoV-2 to Conserve PCR Tests in a Resource Constrained Combat Environment

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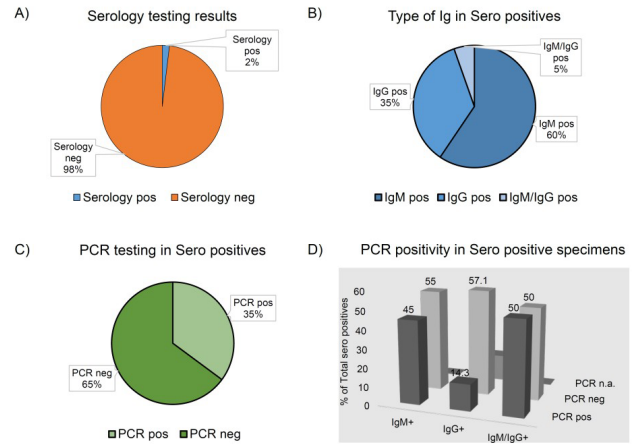
Session: P-14. COVID-19 Epidemiology and Screening

Background: In March 2020, COVID-19 threatened combat operations in Afghanistan. At that time, the NATO Resolute Support mission involved nearly 17,000 troops from 38 partner nations, plus civilians who support the mission, scattered throughout Afghanistan. While Afghanistan did not initially report many confirmed cases, large numbers of cases were reported from neighboring countries with known migration across the borders (sometimes thousands/day). Military medical leaders advised commanders regarding the potential health risks to the force, balancing with risks to the mission. Quarantine and isolation protocols were established. Public health interventions of social distancing, cloth mask wear, enhanced environmental cleaning, active case finding, and emphasis on hand hygiene and cough etiquette were enforced. However, many base locations were unable to alleviate close living quarters. Testing was identified as a means to assess risk to the population. Testing capabilities were limited, particularly PCR. When this testing strategy was established, the utilization and interpretation of antibody tests was quite controversial. With rapid antibody kits, the time to detection of both IgM and IgG are similar; detection of either cannot identify the time since exposure.

Methods: A novel surveillance plan was established whereby subpopulations at highest risk for exposure to the virus were screened with antibody tests from 17 Apr-1 Jun, 2020. High risk populations included: those leaving quarantine, base defense guards, isolation unit guards, medical personnel, dining facility workers, and those who interact with local populations. Individuals with detectable antibody (either IgM or IgG) were further evaluated with PCR tests.

Results: In the first six weeks of this testing strategy, 1957 antibody tests were utilized. A total of 37 specimens were identified antibody positives with seroprevalence of 2% (Figure 1). Thirteen were identified to have positive IgG, 22 with IgM, and 2 with both. PCR was performed on those with detectable antibody, 13 (35%) had positive PCR.

Figure 1: Seroprevalence of SARS-CoV-2 in Asymptomatic Populations at a Deployed Military Base



Conclusion: Serosurveillance of populations at high risk for exposure to the virus is a logical way to conserve testing resources in a constrained combat environment.

Disclosures: Alex M. Case, n/a, United States Air Force (Employee)

474. Using telemedicine to provide virtual care for COVID-19 patients at home

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Session: P-14. COVID-19 Epidemiology and Screening

Background: In response to the COVID-19 pandemic in San Diego, California, the Infectious Disease Division at the University of California San Diego established a COVID-19 Clinic dedicated solely to managing patients safely in their homes. This strategy was developed in response to: i) concerns regarding transmission of infection in the healthcare setting, ii) avoiding overwhelming the healthcare system with COVID-19 patients, iii) providing patients with expedited access to specialists, and iv) reducing the burden on the emergency department and urgent care.

Methods: The COVID-19 clinic staff is comprised of a dedicated nurse, administrative assistant, and four infectious diseases (ID) physicians who aim to see patients within 24 hours of referral via virtual clinics 5 days a week. An ID physician initially assesses each patient in a direct telemedicine visit and answers their questions, assesses disease severity, provides both symptom management and emotional support, and education about self-isolation and transmission-based precautions. The patients are then triaged to daily nursing phone calls and follow up visits as needed.

Results: Over a period of 12 weeks (March 27 to June 16, 2020), the clinic has seen 179 patients. To assess the impact of the clinic, patients are asked to complete a 6-point verbal patients satisfaction survey after their visit. Of the 133 patients who have completed the survey to date, the vast majority reported high satisfaction with their encounters with the COVID-19 physician, with a mean score of 4.8 or higher on all six questions (on a scale of 1 to 5). When asked "Did you feel comfortable talking to your COVID-19 ID physician?" on a scale of 1 to 5, the average score was 4.9. When asked "Did the physician do a good job answering your questions?" the average was 4.9. Patients reported feeling safer after talking with their physician (mean score 4.8), and felt better educated on how to self-quarantine at home (mean score 4.85) and when to seek care from an emergency room, urgent care or hospital (mean score 4.83).

Conclusion: The UCSD COVID-19 Clinic demonstrates how telemedicine can be utilized in response to a public health crisis by creating a virtual clinic to provide ID care for patients in their homes.

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475. Describing the impact of the COVID-19 pandemic on HIV care in Latin America

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Session: P-15. COVID-19 Global Response/Response in Low Resource Settings

Background: The effects of the COVID-19 pandemic on people living with HIV (PWH) are unknown. Beyond SARS-CoV-2 co-infection, the pandemic may have devastating consequences for HIV care delivery. Understanding these is crucial as reduced antiretroviral therapy (ART) availability alone could lead to ≥500,000 AIDS-related deaths in 2020–2021. With Latin America now a focal point in the pandemic, we sought to describe the impact of COVID-19 on HIV care at Latin American clinical sites.

Methods: Caribbean, Central and South America network for HIV epidemiology (CCASAnet) and additional Brazilian HIV care sites in Argentina, Brazil, Chile, Haiti, Honduras, Mexico, and Peru were included. An electronic survey of COVID-19 effects on HIV clinic operations was administered in Spanish or English via phone and email, April 28–June 2, 2020. We also compared national COVID-19 case, mortality, and policy data from public sources.

Results: Brazil's and Mexico's epidemics appear most pronounced, with >10,000 confirmed COVID-19-related deaths (Figure 1); countries implemented "social distancing" policies at different times after initial cases, with Haiti earliest and Mexico latest (Figure 2). Nearly all 13 sites reported decreased hours and providers for HIV care. Twelve of 13 reported increased use of telehealth, suspension/postponements of routine HIV appointments, and/or suspension of HIV research. Eleven of 13 reported initiation of new COVID-19 research but suspension of community HIV testing, and nearly half provided additional ART supplies. Nearly 70% reported impacts on HIV viral load testing and nearly 40% reported personal protective equipment stock-outs (Table). All 13 sites experienced changes in resources/services in tandem with national policies; there was wide variation, however, in the number of economic and health supports implemented thus far (e.g., quarantines, tax deferrals, interest rate reductions, etc.), from 172 COVID-19-related policies in Brazil to only 30 in Mexico.

Table: Site Assessment of Impacts of the COVID-19 Pandemic on HIV services in Latin America at CCASAnet and Coorte Sites, N=13

	Yes	No	N/A
Has the locality of this HIV care and treatment unit been subject to a national, state/province, county, or municipal lockdown, restrictions on travel and/or business operations, or social distancing orders to curb the spread of COVID-19?	13	0	0
Do restrictions remain in place at the time of survey?	13	0	0
Has this HIV care and treatment unit been subject to a national, state/province, county, or municipal order to suspend or reduce non-emergency health services in order to curb the spread of COVID-19?	9	4	0
Do non-emergency services remain suspended at the time of survey?	9	0	0
During the past 3 months has the COVID-19 response resulted in any of the following changes in operations of the HIV care & treatment clinic?			
a. Decreased Hours/Days	11	2	0
b. Decreased # of Providers	11	2	0
c. Re-assignment of HIV Providers	8	5	0
d. Reduced availability of HIV Providers	7	3	0
e. Postponement of appointments/service	12	1	0
f. Reconfiguration of hospital/clinic space	11	2	0
g. Increased use of PPE	13	0	0
h. Increased use of telehealth	12	1	0
i. Interruptions in recording data for care	8	5	0
j. Postponement of ongoing research	12	1	0
k. Interruptions in recording data for research	7	6	0
l. Initiation of new research for COVID-19	11	2	0
m. Withdrawal/suspension of NGOs	6	5	2
During the past 3 months has the COVID-19 response resulted in any of the following changes in community-based HIV services for patients referred to or enrolled in care at this HIV clinic?			
a. Partial or complete suspension of community-based HIV testing	11	1	1
b. Partial or complete suspension of community-based ART refills	1	10	2
c. Partial or complete suspension of community-based support group meetings/activities	12	0	1
d. Partial or complete suspension of community-based defaulter tracing activities	4	3	6
e. Withdrawal/suspension of activities of non-governmental partners that support community-based programs for patients	7	1	5
During the past 3 months, have ART services at your clinic/hospital been impacted by COVID-19?	7	6	0
How have routine ART services at this clinic been affected?			
ART clinics have been suspended or shutdown	1	12	0
ART pick up points have been designated in the community	1	12	0
Patients are being given additional supplies/refills of ART to reduce the frequency of refills	6	7	0
How have ART initiation services for newly enrolling patients been affected by COVID-19?			
ART initiation services have been suspended or shut down	2	11	0
Same-day or rapid ART initiation services have been introduced	2	11	0
Adherence counseling has been modified to avoid delays in ART initiation	3	10	0
Not Applicable (no change)	3	10	0
During the past 3 months, have viral load testing services for patients enrolled in HIV care at your clinic/hospital been impacted by COVID-19?	9	4	0
How have viral load testing services been affected by COVID-19?			
Sample collection for viral load testing have been suspended	4	9	0
Laboratory for viral load testing not accepting samples	3	10	0
Viral load results turnaround time longer	2	11	0
During the past 3 months, has this hospital/clinic experienced stock outs of HIV test kits?	0	11	2
Has this hospital experienced stockouts of antiretroviral drugs during the past 3 months?	0	13	0
During the past 3 months, has this hospital/clinic experienced stock outs of personal protective equipment (PPE)?	5	8	0
Which of the following types of PPE have recorded stock out(s)?			
Masks	5	8	0
Gowns	3	10	0
Gloves	2	11	0
Disinfectants	1	12	0
Other (see below for specific other)	2	11	0
Facial protection	1	0	0
Face shields	1	0	0
During the past 3 months, has this hospital/clinic provided health education/messaging related to COVID-19 for patients enrolled in HIV care?	10	3	0
Does this hospital/clinic have a surveillance system for COVID-19 incidence?	7	6	0
Does this hospital/clinic have the ability to do contact tracing for individuals who have tested positive for COVID-19?	9	4	0

Figure 1. Cumulative mortality due to COVID-19 in countries within which CCASAnet and Coorte sites are located Figure 1 footnote: Source for mortality counts: the WHO COVID-19 Dashboard, available at: <https://covid19.who.int/> All data were up-to-date as of, and were accessed on, June 17th, 2020

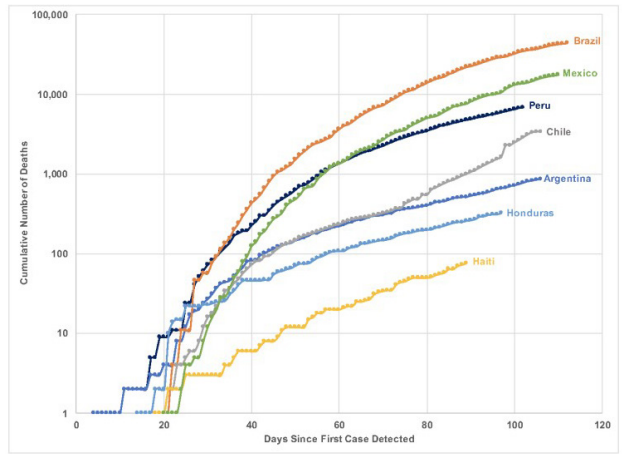
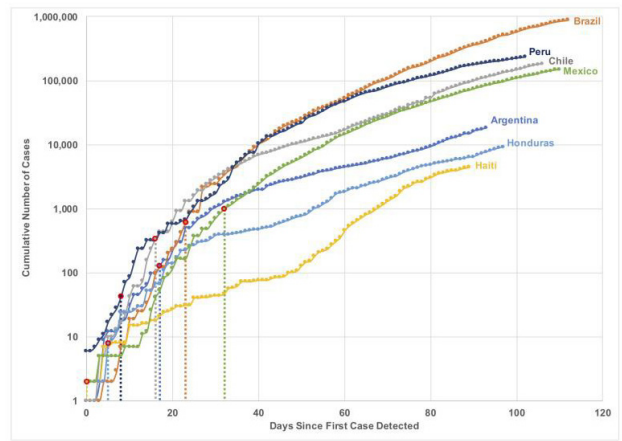


Figure 2. Cumulative cases of COVID-19 in countries within which CCASAnet and Coorte sites are located and dates (relative to the day on which the first positive case of COVID-19 was detected) of general social distancing, public health emergency, or mass quarantine policy introduction (vertical dashed lines), 2020 Figure 2 footnote: Source for case counts: the WHO COVID-19 Dashboard, available at: <https://covid19.who.int/> Source for health policy implementation: the United Nations Economic Commission for Latin America & the Caribbean, available at: <https://cepalstat-prod.cepal.org/forms/covid-countrysheet/index.html> All data were up-to-date as of, and were accessed on, June 17th, 2020



Conclusion: The COVID-19 pandemic has already had a substantial effect on daily operations of HIV clinics in Latin America. The downstream effects of these impacts on HIV outcomes in Latin America will need to be further studied.

Disclosures: All Authors: No reported disclosures

476. Gilead Sciences' Commitment to the COVID-19 Pandemic

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Gilead Sciences

Session: P-15. COVID-19 Global Response/Response in Low Resource Settings

Background: COVID-19 has spread rapidly: from the first case in Dec 2019, the declaration of a global pandemic in Mar 2020, to Jun 18, 2020 with >8 M confirmed cases and >400,000 deaths worldwide. Throughout this rapid spread, Gilead has focused on contributing antiviral expertise and resources to help patients (pts) and communities fighting COVID-19

Methods: Gilead is supporting the efforts of governments, partnering with professionals, and community-based org., and collaborating with healthcare providers to accelerate research and access to remdesivir (RDV), the first medicine with demonstrated efficacy in treatment of COVID-19. This is a review of the programs initiated in RDV research, access, research grants and collaborative education

Results: In Jan 2020 Gilead began working with government and regulatory authorities to make RDV accessible to pts globally through the compassionate use and expanded access programs. These programs has treated >2000 COVID-19 pts. By Feb