tests (estimate -678.48, p = 0.008), whereas the slope change after the pandemic was non-significant (estimate 4.84, p = 0.891). The number of monthly HIV tests declined significantly during the early phase of the pandemic, particularly between March 2020 and September 2020 (all p< 0.05), with an estimated 48.0% decrease in the March 2020 (estimate -678.48, p = 0.007), 43% in the April 2020 (estimate -673.65, p=0.007), and 50.7% in the May 2020 (estimate -668.83, p=0.009), compared with the same month of the pre-pandemic period (Figure 1). This decline in number of monthly HIV tests is consistent with the first wave of the COVID-19 pandemic in South Florida. Number of decreased monthly HIV tests from October 2020 through March 2021 was less pronounced (all p >0.05) and returned to pre-pandemic levels.

Table 1. Interrupted time series model regression parameters based on HIV testing results from July 2018 to March 2021.

Parameters	Estimate	Standard error	t	Sig.
β_0	1783.11	204.24	8.73	<0.001
β_1	-10.29	16.62	-0.98	0.541
β_2	-678.48	234.07	-2.89	0.008
β_3	4.83	34.98	0.14	0.891

β_0 = Intercept (estimated tests in July 2018).

β_1 = Average monthly change in test (slope) from July 2018 to Feb 2020.

β_2 = Immediate level change observed in March 2020.

β_3 = Change in slope after March 2020 compared with the pre-pandemic slope.

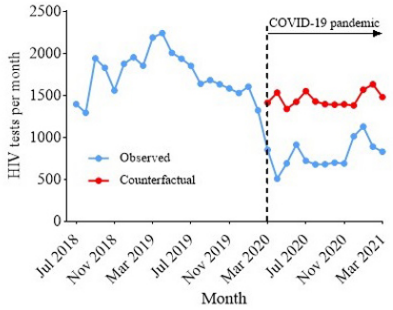

Figure 1. Observed HIV tests (*blue color*) and counterfactual HIV tests (*red color*) in absence of COVID-19 pandemic based on the interrupted time series analysis.

Conclusion. The COVID-19 pandemic led to a significant and immediate decline in monthly number of ED-based HIV tests. Disruption of basic health services by the COVID-19 pandemic is a public health concern. Strategies to develop an infrastructure to meet the demands of HIV testing should be implemented to ensure the current HIV prevention during the COVID-19 period.

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48. Time Between Viral Loads for Suppressed and Non-Suppressed People with HIV During the COVID-19 Pandemic Compared to Pre-Pandemic

Walid El-Nahal, MD[1]; Nicola Shen, MHS[2]; Catherine Lesko, PhD[2]; Anthony Fojo, MD MHS[1]; Bryan Lau, PhD[2]; Jeanne Keruly, NP[3]; Yukari C. Manabe, MD[4]; Joyce Jones, MD MS[1]; Richard Moore, MD[5]; Kelly Gebo, MD, MPH[4]; Geetanjali Chander, MD MPH[1]; [1]Johns Hopkins University School of Medicine, Baltimore, Maryland; [2]Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; [3]The Johns Hopkins University School of Medicine, Baltimore, MD; [4]Johns Hopkins, Baltimore, MD; [5]Johns Hopkins University, Baltimore, MD

Session: O-10. Disparities in COVID Access to Care and Diagnostic Testing

Background. During the COVID-19 pandemic, patients at the John G. Bartlett Specialty practice experienced disruptions in viral load (VL) monitoring due to 1) conversion to telemedicine visits and 2) closure of the onsite lab from March 16-July 13, 2021. We described the impact of the pandemic on VL monitoring.

Methods. We measured time from all index VLs collected during 3 periods: January 1, 2019 to March 15, 2020 (pre-pandemic); March 16 to July 12, 2020 (pandemic, closed onsite lab); and July 13 to December 31, 2020 (pandemic, open onsite lab) until a subsequent VL, 1 year after the index VL, or administrative censoring on December 31, 2020, whichever came first. We classified follow-up time according to these periods (treating period as a time-varying variable). We report hazard ratios (HRs) and 95% Confidence Intervals (CI) from a Cox proportional hazards model comparing the hazard of a VL during the pandemic periods to the pre-pandemic period, stratified by whether the index VL was suppressed (≤200 copies/mL). We tested for interactions between patient characteristics (age, sex at birth, race, ethnicity, and recent substance use) and period, to investigate differential effects of the pandemic on delayed VL.

Results. After 7,760 suppressed VL measurements, median times to subsequent VL during the pre-pandemic, pandemic (closed lab) and pandemic (open lab) periods, were 4.6 (HR=1.0), 8.9 (HR=0.34, CI:0.30, 0.37), and 5.8 (HR=0.73, CI:0.68,0.78) months respectively. After 1,025 non-suppressed VL measurements, median times to subsequent VL were 2.0 (HR=1.0), 3.9 (HR=0.57, CI:0.42,0.79), and 2.1 (HR=0.92, CI:0.76,1.10) months respectively. Time to subsequent VL after an index suppressed VL was less affected by the pandemic for patients who are white; had private insurance; or had no recent cocaine or heroin use. The effect of the pandemic on time to subsequent VL after a non-suppressed index VL did not significantly differ across patient characteristics.

Figure 1: Kaplan-Meier Curve of Time Between Viral Loads for Viral Loads Collected Pre-Pandemic, During the Pandemic (onsite lab closed) and During the Pandemic (onsite lab open) for (A) Suppressed and (B) Non-Suppressed Patients.

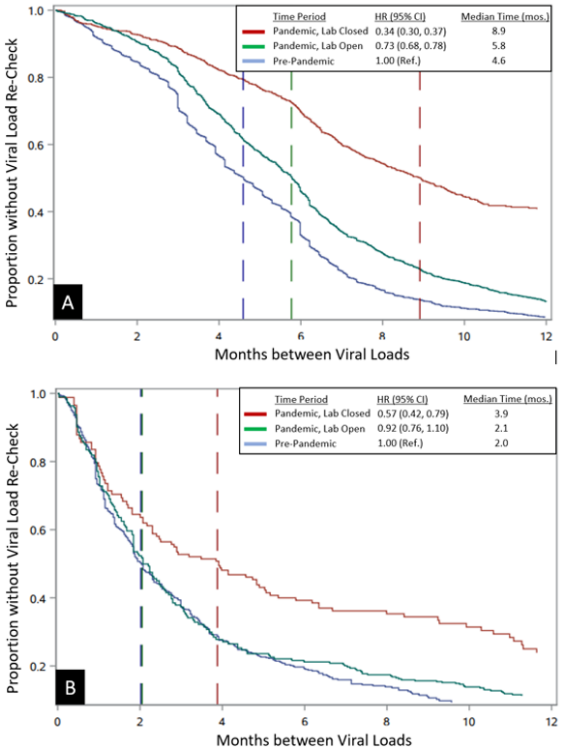

Table 1: Hazard Ratios for Time from a Suppressed Viral Load to a Subsequent Viral Load, Comparing Pandemic Periods to Pre-pandemic

	Pre-Pandemic	Pandemic, Lab Closed	Interaction p-value[d]	Pandemic, Lab Open	Interaction p-value[d]
All Suppressed Viral Loads[a]	1.0	0.34 (0.30, 0.37)	n/a	0.73 (0.68, 0.78)	n/a
Age					
Age 20-39	1.0	0.24 (0.18, 0.34)	REF	0.62 (0.50, 0.76)	REF
Age 40-59	1.0	0.37 (0.32, 0.42)	0.02	0.73 (0.66, 0.80)	0.16
Age 60+	1.0	0.33 (0.29, 0.39)	0.09	0.78 (0.70, 0.87)	0.05
Gender					
Female	1.0	0.34 (0.28, 0.41)	REF	0.79 (0.71, 0.88)	REF
Male	1.0	0.34 (0.30, 0.38)	0.99	0.70 (0.64, 0.76)	0.06
Race					
Black	1.0	0.31 (0.27, 0.35)	REF	0.71 (0.66, 0.76)	REF
White	1.0	0.48 (0.40, 0.58)	<0.01	0.85 (0.74, 0.98)	0.02
Other	1.0	0.32 (0.19, 0.51)	0.92	0.65 (0.48, 0.87)	0.58
Ethnicity					
Non-Hispanic	1.0	0.34 (0.31, 0.37)	REF	0.73 (0.68, 0.78)	REF
Hispanic	1.0	0.30 (0.16, 0.56)	0.69	0.74 (0.52, 1.05)	0.93
Substance Use[b]					
No Recent Alcohol Use	1.0	0.32 (0.29, 0.36)	REF	0.75 (0.69, 0.81)	REF
Recent Alcohol Use	1.0	0.35 (0.26, 0.47)	0.64	0.66 (0.52, 0.84)	0.32
No Recent Cocaine/Heroin	1.0	0.34 (0.30, 0.38)	REF	0.76 (0.71, 0.82)	REF
Recent Cocaine or Heroin	1.0	0.23 (0.16, 0.33)	0.04	0.56 (0.43, 0.73)	0.03
Insurance[c]					
Non-Private	1.0	0.26 (0.22, 0.32)	REF	0.65 (0.58, 0.74)	REF
Private	1.0	0.37 (0.33, 0.42)	<0.01	0.77 (0.71, 0.83)	0.03

[a] Among Suppressed patients: Viral Load < 200 copies/mL on most recent check.
[b] Alcohol, Cocaine and Heroin use were obtained from medical record review of provider notes, toxicology screens and treatment referrals, conducted every 6 months by trained abstractors. Data were restricted to abstractions in the year prior to the viral load.
[c] Non-Private Insurance defined as covered by Medicaid, Ryan White, or Uninsured.
[d] P-value for the interaction between patient characteristic and the time period, to determine if there were statistically significant differences in the effect of time period on the hazard across subgroups.

Table 2: Hazard Ratios for Time from a Non-suppressed Viral Load to a Subsequent Viral Load, Comparing Pandemic Periods to Pre-pandemic

	Pre-Pandemic	Pandemic, Lab Closed	Interaction p-value[d]	Pandemic, Lab Open	Interaction p-value[d]
All Non-Suppressed Viral Loads[a]	1.0	0.57 (0.42, 0.79)	n/a	0.92 (0.76, 1.10)	n/a
Age					
Age 20-39	1.0	0.47 (0.24, 0.95)	REF	0.83 (0.57, 1.19)	REF
Age 40-59	1.0	0.63 (0.43, 0.93)	0.47	0.92 (0.74, 1.16)	0.55
Age 60+	1.0	0.61 (0.36, 1.05)	0.59	1.04 (0.72, 1.50)	0.38
Gender					
Female	1.0	0.59 (0.42, 0.84)	REF	1.01 (0.78, 1.32)	REF
Male	1.0	0.56 (0.41, 0.75)	0.79	0.86 (0.68, 1.08)	0.34
Race					
Black	1.0	0.52 (0.36, 0.75)	REF	0.91 (0.74, 1.11)	REF
White	1.0	0.85 (0.44, 1.65)	0.19	0.87 (0.57, 1.33)	0.84
Other	1.0	0.80 (0.24, 2.68)	0.51	1.23 (0.42, 3.57)	0.59
Ethnicity					
Non-Hispanic	1.0	0.56 (0.44, 0.71)	REF	0.90 (0.75, 1.08)	REF
Hispanic	1.0	1.59 (0.40, 6.36)	0.15	2.37 (0.67, 8.40)	0.14
Substance Use[b]					
No Recent Alcohol Use	1.0	0.51 (0.32, 0.83)	REF	0.96 (0.73, 1.25)	REF
Recent Alcohol Use	1.0	0.52 (0.26, 1.02)	0.83	0.89 (0.64, 1.23)	0.98
No Recent Cocaine/Heroin	1.0	0.51 (0.32, 0.83)	REF	0.91 (0.70, 1.17)	REF
Recent Cocaine or Heroin	1.0	0.50 (0.21, 1.21)	0.95	0.98 (0.62, 1.53)	0.78
Insurance[c]					
Non-Private	1.0	0.58 (0.35, 0.97)	REF	0.90 (0.67, 1.21)	REF
Private	1.0	0.56 (0.38, 0.80)	0.89	0.92 (0.74, 1.15)	0.91

[a] Among Non-Suppressed patients: Viral Load > 200 copies/mL on most recent check
[b] Alcohol, Cocaine and Heroin use were obtained from medical record review of provider notes, toxicology screens and treatment referrals, conducted every 6 months by trained abstractors. Data were restricted to abstractions in the year prior to the viral load.
[c] Non-Private Insurance defined as covered by Medicaid, Ryan White, or Uninsured.
[d] P-value for the interaction between patient characteristic and the time period, to determine if there were statistically significant differences in the effect of the time period on the hazard across subgroups.

Conclusion. Onsite lab closure disrupted VL collection for all groups. Once the onsite lab opened, the pandemic period was still associated with a delay among suppressed patients, but not non-suppressed patients. Further studies are needed to investigate if these delays are associated with lapses in viral suppression.

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

49. Effects of Maternal SARS-CoV-2 Infection on Neonatal Discharge Planning and Care: Exacerbation of Racial and Ethnic Healthcare Disparities

Jennifer Jubulis, MD[1]; Amanda Goddard, MD[1]; Sarah Dibrigida, MD[1]; Carol A. McCarthy, MD[1]; [1]Maine Medical Center, Portland, Maine

Session: O-10. Disparities in COVID Access to Care and Diagnostic Testing

Background. SARS-CoV-2 has exacerbated healthcare disparities. Maine's population of 1.3 million is comprised of only 6% Black, Indigenous, People of Color (BIPOC); however, statewide 18% of SARS-CoV-2 infections have occurred in this group. This study examines newborn care inequities for infants born to mothers with SARS-CoV-2.

Methods. This study was conducted at Maine Medical Center in Portland, the largest hospital in Maine. Maternal SARS-CoV-2 infections from March 15, 2020 through April 1, 2021 were identified by PCR near time of delivery. Cases were matched to uninfected women by date of delivery. Chart review was conducted assessing demographic and clinical characteristics, comparing SARS-CoV-2 exposed and unexposed infants. The subset of SARS-CoV-2 exposed infants was further analyzed for trends in care by race. Protocol was exempt by MaineHealth IRB.

Results. Twenty four women and their infants were identified with maternal positive SARS-CoV-2 PCR just prior to delivery. An additional 24 unexposed infants were enrolled. When compared to unexposed infants, SARS-CoV-2 exposed were more likely to be racial minorities (63% vs 21%, p = 0.003), to have foreign-born mothers (58% vs 0.4%, p< 0.05) or to receive health care in a language other than English (29% vs 0.4%, p =0.02). For infants born to SARS-CoV-2 infected mothers, only 29% had initial follow up visit in person with their primary care provider (13% of BIPOC infants vs 56% of non-BIPOC infants, p = 0.03). Time to in-person follow up for exposed infants varied by race, with median time of 21 days (range 2-53 days) for racial minorities and 7.5 days (range 2-30 days) for non minorities. All families were discharged with a thermometer and scale for home management. No infants required re-admission during the month after discharge. One exposed infant tested positive for SARS-CoV-2.

Conclusion. The American Academy of Pediatrics recommends evaluation of newborns 3-5 days after discharge to identify maternal and child health factors affecting newborn well-being. The SARS-CoV-2 pandemic has made this challenging for patients, particularly for racial minorities. BIPOC pediatric patients were disproportionately affected by the pandemic in Maine, and were disproportionately affected by care discrepancies even when the infant was uninfected.

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50. Pilot Study on Offering HIV Pre-Exposure Prophylaxis (PrEP) to People Who Inject Drugs (PWID) in the Inpatient Setting

Terry A. Marryshow, MD, AAHIVS[1]; Jose Caro, MD[1]; [1]Tufts Medical Center

Session: O-11. Disparities in HIV PrEP and Continum of HIV Care

Background. Due to the ongoing opioid epidemic, PWID represent an increasingly high-risk population for HIV infections in the United States, accounting for 10% of all new HIV diagnoses in 2018 and 12.5% of all deaths among people living with HIV. PrEP is an effective means of preventing HIV, though uptake has been low among PWID, possibly due to low access to care. Inpatient admissions may represent missed opportunities for provision of PrEP to PWID.

Methods. Inpatient prescriptions for tenofovir disoproxil fumarate-emtricitabine (TDF-FTC) from 10/2019 to 8/2020 were analyzed to assess baseline provision of PrEP to PWID. Physicians on the Infectious Diseases ward service were anonymously queried on perceived barriers and their practices regarding provision of PrEP to PWID. PWID admitted from 9/2020 to 5/2021 were approached at bedside, provided counseling on PrEP and offered initiation prior to discharge. We analyzed patient perceptions and acceptance of PrEP.

Results. 16 total prescriptions for TDF-FTC were provided at discharge from 10/2019 to 8/2020, with 0 being for PrEP in PWID. The 8 physicians surveyed estimated caring for an average 4 PWID per week of service. 5/8 physicians reported that at least one PWID was offered PrEP during their most recent week of service. The most commonly reported physician barrier to prescribing PrEP was uncertainty regarding adherence and follow up (5/8). 30 patients were approached, with 14 reporting prior knowledge of PrEP. 18 were willing to engage in further education. Only 4 were accepting of PrEP, with 2 provided prescriptions. Of those declining, 13 denied equipment sharing, 4 denied active drug use, 7 stated a commitment to future abstinence, 3 were unwilling to adhere to a daily medication, 2 declined due to concerns of adverse effects and 1 due to concerns regarding stigma.

Table 1. Physician Reported Barriers to Prescribing PrEP (n = 8)

Uncertain Follow up	5
Uncertain Access to Care	2
Short Length of Stay	2
Patients Declined HIV Testing	1
Short Time Since Last High-Risk Exposure	1

Table 2. Patient Knowledge and Acceptance of PrEP (n = 30)

Knowledge of PrEP Prior to Counseling	14 (46.67%)
Interested in Further Education/Counseling	18 (60%)
Wishes to be Initiated on PrEP	4 (13.33%)
PrEP Prescribed Prior to Discharge	2 (6.67%)

Table 3. Patient Reasons for Declining PrEP (n = 30)

Denied Sharing of Injection Drug Equipment	13 (43.33%)
Stated Commitment to Future Abstinence	7 (23.33%)
Denied Active Drug Use	4 (13.33%)
Felt Contacts were Low Risk for HIV	2 (6.67%)
Finds Daily Dosing Undesirable	3 (10%)
Concerned Regarding Possible Side Effects	2 (6.67%)
Concerned Regarding Stigma	1 (3.33%)

Conclusion. In this pilot study, few admitted PWID were accepting of PrEP. Attempts to initiate PrEP in PWID in the inpatient setting may not be effective at our institution. The most common reason for declining was low self-perceived risk of HIV acquisition; however, a significant proportion of patients showed interest in further education. Therefore, the inpatient setting may be a valuable site of initial counseling and referral for future potential provision of PrEP in the outpatient setting.

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

51. Patient Reported Outcomes Collection: A Mixed Methods Study at an urban HIV Clinic associated with a Historically Black Medical College in the Southern United States

Paul Parisot, III, MD[1]; Facerlyn Wheeler, MA[2]; Kemberlee Bonnet, MA[3]; Peter F. Rebeiro, PhD, MHS[1]; Korlu McCainster, LCSW, LAPSW[2]; Robert Cooper, PhD[2]; Vladimir Berthaud, MD MPH[4]; David Schlundt, Ph.D.[3]; April Pettit, MD, MPH[1]; [1]Vanderbilt University Medical Center, Nashville, Tennessee; [2]Meharry Medical College, Nashville, Tennessee; [3]Vanderbilt University, Nashville, TN; [4]MEHARRY MEDICAL COLLEGE, NASHVILLE, Tennessee

Session: O-11. Disparities in HIV PrEP and Continum of HIV Care

Background. Black Americans, particularly in the South, are disproportionately affected by the US HIV epidemic. We piloted the use of an electronic tablet to collect patient reported outcomes (PRO) data on social and behavioral determinants of health among people with HIV (PWH) at the Meharry Community Wellness Center (MCWC), an HIV clinic affiliated with a Historically Black Medical College in Nashville, Tennessee. Studies have shown PRO collection can improve patient outcomes and provide oft-overlooked data on mental health, substance use, and patient adherence to ART.

Methods. We enrolled 100 PWH in care at the MCWC consecutively to complete validated PRO tools (Table 1) using the Research Electronic Data Capture (REDCap)