Methods: In addition to the usual demographics, comorbidities, and categories of outpatient prescriptions, the registry has 75 laboratory, 2 imaging, 19 therapeutic, and 4 outcome-related parameters. Mann-Whitney U Test for continuous variables and Chi-squared and Fisher Exact Test for categorical variables were performed in R and Minitab.

Results: The registry currently includes data from 399 patients: 236 ambulatory and 163 inpatient. Several comorbidities were associated with requirement for admission compared to ambulatory status, including obesity and kidney, liver, and cardiovascular disease (all p < /= 0.01) (Table 1). Use of angiotensin inhibitors and receptor blockers, statins, and acid suppressants was higher in admitted vs. ambulatory patients (all p < /=0.001) (Table 1 and Figure). Diabetes mellitus and statin use were more common in patients who required intensive care, p=0.04 and 0.01 respectively (Table 2).

Table 1

Table 1: Inpatient vs. Outpatient

	Total (n=399)	Outpt (n=236)	Inpt (n=163)	p-value
Demographics				
Age	55.0 (38.0, 68.0)	48.0 (33.0,61.0))	62.0 (52.0, 73.0)	<0.0001 **
Male Gender	188 (47%)	95 (40%)	93 (57%)	0.002 **
Race	Black 88/345 (26%) White 203/345 (59%) Hispanic 30/345 (9%) Asian 5/345 (1%) Other 19 /345 (6%)	52/185 (28%) 110/185 (59%) 11/185 (6%) 3 /185 (2%) 9 /185 (5%)	36/160 (23%) 93/160 (58%) 19/160 (12%) 2/160 (1%) 10/160 (6%)	0.10
BMI	30.9 (26.5,36.8)	31.2 (26.1,35.5)	30.5 (27.2,37.8)	0.89
Current Smoker	27/336 (8%)	17/178 (10%)	10/158 (6%)	0.28
Current or Former Smoker	148/336 (44%)	71/178 (40%)	77/158 (49%)	0.10
Health Care Worker	107/342 (31%)	82/188 (44%)	25/154 (16%)	< 0.0001 **
Comorbidities				
Morbid Obesity	38/397 (10%)	14/234 (6%)	24/163 (15%)	0.006 **
Chronic Resp Dz	79/397 (20%)	38/234 (16%)	41/163 (25%)	0.04 *
CKD/ESRD	33/397 (8%)	12/234 (5%)	20/163 (12%)	0.01 *
HTN	177/397 (45%)	72/234 (31%)	105/163 (64%)	<0.0001 **
DM	108/397 (27%)	41/234 (18%)	67/163 (41%)	<0.0001 **
Cardiovascular Dx	91/397 (25%)	35/234 (15%)	56/163 (34%)	<0.0001 **
Cancer Dx	17/397 (4%)	7/234 (3%)	10/163 (6%)	0.14
Autoimmune Dx	12/397 (3%)	5/234 (2%)	7/163 (4%))	0.24
Liver disease Dx	5/397 (1%)	0/234 (0%)	5/163 (3%)	0.01 *
Medications				
ACE/ARB use	83/353 (24%)	33/196(17%)	50/157 (32%)	0.001 **
Acid suppression med use	115/354 (32%)	48/197 (24%)	67/157 (43%)	0.0003 **
Statin use	105/356 (31%)	40/197 (18%)	65/159 (45%)	<0.0001 **
Sick Contact				
COVID Contact	125/298 (42%)	76/157 (48%)	49/141 (35%)	0.02 *
Sick Contact	172/304 (57%)	98/159 (62%)	74/145 (51%)	0.06
Time from Symptoms to first ED visit (days)	5.0 (2.5, 8.0)	5.0 (2.0, 8.0)	5.0 (3.0, 8.0)	0.96
Labs				
WBC1	5.9 (4.5, 8.1)	5.4 (4.2, 7.4)	5.9 (4.6,8.9)	0.08
Lymph1	1.0 (0.7, 1.4)	1.1 (0.9, 1.6)	1.0 (0.6, 1.4)	0.04 *
ANC1	4.3 (3.1, 7.2)	3.8 (2.7, 5.9)	4.5 (3.4, 8.3)	0.03 *
D-Dimer	701 (526, 1315)	380 (325,472)	754 (594, 1393)	0.01 *
LDH1	315 (236, 399)	Only 1 value	317 (244, 400)	XXXXX
Procalcitonin1	0.13 (0.08, 0.30)	Only 1 value	0.14 (0.08, 0.30)	XXXXX
CRP1	64.0 (30.0, 121.3)	Only 1 value	66.0 (30.1, 121.7)	XXXXX
CK1	95 (71,201)	No values	95 (71, 201)	XXXXX
Imaging				
Presentation CXR positive	101/180 (56%)	10/36 (28%)	91/144 (63%)	0.0003 **
Presentation CT positive	29/37 (78%)	2/5 (40%)	27/32 (84%)	0.06

Figure

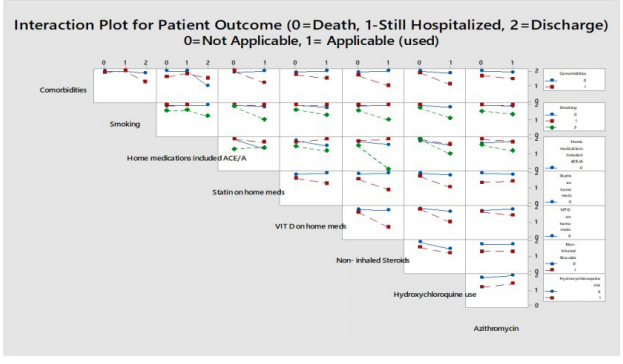

Table 2

Table 2: ICU vs. non-ICU admitted patients

	Total (n=163)	ICU (n=63)	Non-ICU (n=100)	p-value
Demographics				
Age	62.0 (52.0, 73.0)	64.0 (54.5, 71.5)	61.0 (50.0, 73.3)	0.47
Male Gender	93 (57%)	40 (63%)	53 (53%)	0.25
Race	Black 36 (22%) White 93 (57%) Hispanic 19 (12%) Asian 2 (1%) Other/Unknown 13 (8%)	14(22%) 40 (63%) 4 (6%) 1 (2%) 4 (6%)	22(22%) 53 (53%) 15 (15%) 1 (1%) 9 (9%)	0.20
BMI	30.5 (27.2, 37.8)	31.5 (27.3, 38.6)	29.9 (27.2, 36.8)	0.44
Current Smoker	10/158 (6%)	5/62 (8%)	5/96 (6%)	0.52
Current or Former Smoker	77/158 (49%)	34/62 (55%)	43/96 (45%)	0.28
Health Care Worker	25/154 (16%)	8/59(14%)	17/95 (18%)	0.51
Comorbidities				
Morbid Obesity	24 (15%)	11 (17%)	13 (13%)	0.58
Chronic Resp Dz	41 (25%)	15 (24%)	26 (26%)	0.90
CKD/ESRD	20 (12%)	11(17%)	9 (9%)	0.14
HTN	105 (64%)	40 (63%)	65 (65%)	0.98
DM	67 (41%)	32 (51%)	35 (35%)	0.04 *
Cardiovascular Dx	56 (34%)	21 (33%)	35 (35%)	0.31
Cancer Dx	10 (6%)	5 (8%)	5 (5%)	0.51
Autoimmune Dx	7 (4%)	5 (8%)	2 (2%)	0.11
Liver disease Dx	5 (3%)	3 (5%)	2 (2%)	0.38
Medications				
ACE/ARB use	50/157 (32%)	22/60 (37%)	28/97 (29%)	0.35
Acid suppression med use	67/157 (44%)	28/60 (53%)	39/97 (38%)	0.43
Statin use	65/159 (41%)	33/61 (54%)	32/98 (33%)	0.01 *
Sick Contact				
COVID Contact	49/141 (35%)	10/57 (18%)	39/84 (46%)	0.001 **
Sick Contact	74/145 (51%)	22/59 (37%)	52/86 (60%)	0.01 *
Time from Symptoms to first ED visit (days)	5.0 (3.0, 8.0)	5.0 (2.0, 7.0)	6.0 (3.0, 8.5)	0.08
Labs				
WBC1	5.9 (4.6, 8.9)	5.6 (4.4, 7.7)	6.2 (4.7, 9.0)	0.22
Lymph1	1.0 (0.6, 1.4)	0.9 (0.6, 1.4)	1.0 (0.7, 1.4)	0.43
ANC1	4.5 (3.4, 8.3)	5.0 (3.5, 8.7)	4.3 (3.3, 7.8)	0.71
D-Dimer	754 (594,1393)	664 (561,1516)	799 (597, 1310)	0.89
LDH1	317 (244,400)	362 (259,406)	309 (242, 393)	0.27
Procalcitonin1	0.14 (0.08, 0.30)	0.14 (0.08, 0.27)	0.14 (0.08, 0.31)	0.72
CRP1	66 (30,122)	74 (47,122)	61 (22,122)	0.23
CK1	95 (71,201)	97 (71, 171)	95 (71, 201)	0.87
Imaging				
Presentation CXR positive	91/144 (63%)	43/61 (70%)	48/83 (58%)	0.17
Presentation CT positive	27/32 (84%)	12/14 (86%)	15/18 (83%)	1.00

Conclusion: The registry captures detailed clinical information from SARS-COV-2 infections, providing a valuable resource for researchers, planners, and policy makers. It also provides a framework for surge planning, predictive modeling, and linking CE data to whole genome sequencing data for precision epidemiology. As SARS-COV-2 reports from China, Italy, and New York City may not be fully generalizable to other regions, especially those not as severely affected or those in suburban and rural settings, reports from other areas are needed. To our knowledge, this is one of the largest U.S. case series outside of New York City.

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

472. The Utility of Infectious Diseases E-consults in the Era of COVID-19

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

Background: During the COVID-19 pandemic, rapid Infectious Diseases (ID) consultation has been required to answer novel questions regarding SARS-CoV-2 testing and infection prevention. We sought to evaluate the utility of e-consults to triage and provide rapid ID recommendations to providers.

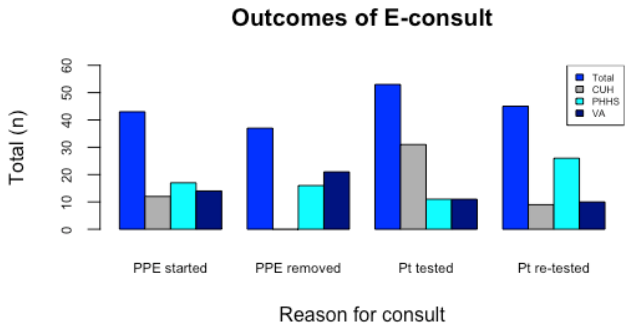
Methods: We performed a retrospective study reviewing ID e-consults in three institutions in the North Texas region: Clements University Hospital (CUH), Parkland Hospital and Health System (PHHS), and the VA North Texas Health Care System (VA) from March 1, 2020 to May 15, 2020. Variables collected include age, sex, ethnicity, comorbidities, time to completion, reason for consult and outcome of consult (initiation or removal of personal protective equipment (PPE) and recommendation to test or retest for COVID-19).

Results: We performed all analysis using R studio (Version 1.3.959). Characteristics of 198 patients included: 112(57%) male, 86(43%) female,

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



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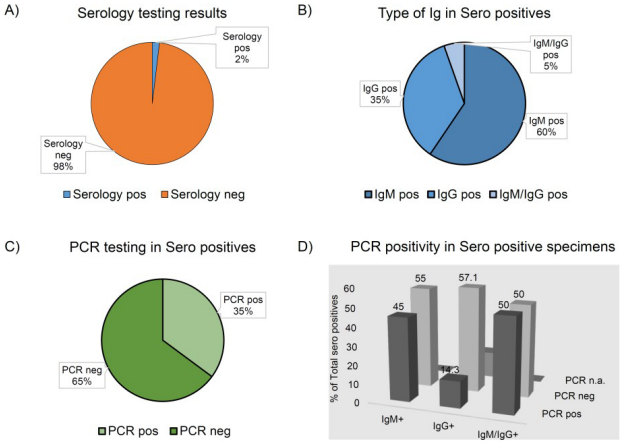
Session: P-14. COVID-19 Epidemiology and Screening

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.

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

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

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