Table 2. Description of 3,140 COVID-19 Infections in Employees from 3/2020 to 4/2021

| Variable                          | N   | (%) |
|-----------------------------------|-----|-----|
| Age                               |     |     |
| 18-25                             | 405 | 13.0|
| 26-35                             | 1054| 33.8|
| 36-45                             | 625 | 20.0|
| 46-55                             | 579 | 18.6|
| 56-65                             | 187 | 12.7|
| 65+                               | 91  | 2.9 |
| Initial Symptoms*                 |     |     |
| Congestion or Runny Nose          | 810 | 25.8|
| Headache                          | 709 | 22.6|
| Cough                             | 654 | 20.8|
| Muscle or Body Aches              | 533 | 17.0|
| Sore Throat                       | 441 | 14.0|
| Fatigue                           | 378 | 12.0|
| Fever or Chills                   | 288 | 9.2 |
| Other*                            | 149 | 4.7 |
| New Loss of Taste or Smell        | 139 | 4.6 |
| Nausea or Vomiting                | 97  | 3.1 |
| Shortness of Breath or Difficulty Breathing | 74  | 2.4 |
| Diarrhea                          | 57  | 1.8 |
| Asymptomatic                      | 269 | 8.6 |
| Worked during infectious window    | 2518| 80.8|
| Worked during pre-symptomatic window*** | 1337| 44.5|
| Worked with symptoms              | 1341| 43.6|
| Quarantined prior to symptom onset | 219 | 7.2 |
| Tested negative followed by a positive test | 63 | 2.0 |
| Severe disease                    | 70  | 2.3 |
| Reinfection                       | 21  | 0.7 |
| Attribution                       |     |     |
| Community                         | 1146| 52.4|
| Unknown, likely community          | 129 | 12.0|
| Unknown                            | 1057| 31.7|
| Workplace                         | 308 | 0.8 |
| Workplace-patient                 | 81  | 2.4 |
| Workplace-employee                | 223 | 7.2 |
| Workplace-visitor                 | 5   | 0.2 |

*Initial symptoms included all symptoms that the employee reported on the first day of symptom onset, therefore making the denominator greater than 3,140 symptoms.
**Examples of “Other” symptoms include loss of appetite, night sweats, abdominal pain, diziness
***Defined as 2 calendar days prior to the onset of symptoms.

Methods. We prospectively tracked and traced COVID-19 infections among employees across our health system and university. Each employee with a confirmed positive test and 3 presumed positive cases were interviewed with a standard contact tracing template that included descriptive variables such as high-risk behaviors and contacts, dates worked while infectious, and initial symptoms. Using this information, the most likely location of infection acquisition was adjudicated (Table 1). We compared behavior frequency between community and unknown, likely community and community and unknown cases using descriptive statistics.

Table 3. Risk Factors for Community, Likely Community, and Unknown Cases

| Risk Factor                      | Community N=1669 | Unknown, Likely Community N=129 | Unknown N=5057 |
|---------------------------------|------------------|---------------------------------|---------------|
| Travel within 24 days           | 385 (23.4)       | 36 (27.9)                       | 213 (42.0)    |
| Masked gatherings (e.g., church) | 937 (56.9)       | 73 (56.6)                       | 543 (51.4)    |
| Unmasked gatherings/activities   | 745 (46.3)       | 61 (37.4)                       | 395 (37.4)    |

Figure 1. Percent of students from each campus and sports team screened per week offered.

Number of SARS-CoV-2 cases among employees between 3/2020 and 4/2021 by month and stratified according to clinical employee working in the healthcare system, non-clinical employee employed by the healthcare system, and university employee.

Results. From 3/2020 to 4/2021 we identified 3,140 COVID-19 infections in 3,119 employees out of a total of 34,562 employees (9.0%) (Figure 1). Of those 3,119 employees, 1,685 (54.0%) were clinical employees working in the health system, 916 (29.4%) were non-clinical employees working in the health system, and 518 (16.6%) were university employees. Descriptive characteristics for the COVID-19 infections and adjudications are outlined in Table 2. Severe disease among employees was significantly less frequent compared to patients in the health system (15.3% vs 22.2%, p< 0.01). The frequency of travel within 14 days, masked gatherings and unmasked gatherings/activities was not significantly different between the community and unknown, likely community groups or the community and unknown groups (Table 3).

Conclusion. The majority of COVID-19 infections were linked to acquisition in the community, and few were attributed to workplace exposures. Employees with unknown sources of COVID-19 participated in higher-risk activities at approximately the same frequency as employees with community sources of COVID-19. The most frequently reported initial symptoms were mild and non-specific and rarely included fever. Despite a comprehensive testing and benefit program, a large proportion of COVID-positive employees worked with symptoms, highlighting ongoing challenges with presenceism in healthcare.

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379. Abstract For Comparison of Mandatory vs Non-Mandatory Compliance Rates For SARS-CoV-2 Testing in Grades K-12

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Background. Rapid testing to identify asymptomatically infected students with SARS-CoV-2 in elementary schools has been suggested as a possible method to reduce risk for in person instruction. As of August 3, 2020 (updated on January 25, 2021), California schools who obtained a waiver to conduct in-person instruction are not required to have mandatory testing for asymptomatic students, except for high contact sports which are required to undergo weekly testing. We explored the uptake of voluntary vs mandatory testing in a private waivered school.

Methods. Between the dates January 25, 2021 to April 16, 2021, the K-12 school superintendent sent an email to all parents outlining the voluntary testing program with a link to the on-line sign up and consent form. All students were offered weekly self-collected anterior nares BinaxNOW Rapid Antigen Test. Signed parental consent was required and tests were performed at the school. Students participating in contact sports were required to undergo testing the week a varsity game was played as a condition of participation. Data was gathered from the school administration and de-identified.

Results. K-5 Lower school had a school population of 448 students. Testing was offered on 8 weeks during the period of 2/15-2/19 to 4/5-4/9. 2 students (0.45%) receive screening on the week of 3/22-3/26. The other seven weeks when screening was offered on 8 weeks during the period of 2/15-2/19 to 4/5-4/9. 2 students (0.45%) receive screening on the week of 3/22-3/26. The other seven weeks when screening was offered 0 students received screening, 6-12 Upper school had a school population of 360 enrolled students. Testing was offered 3/8-3/12 and 3/15-3/19. The upper school had 22 students (6.11%) receive testing on the week of 3/8-3/12 and 21 students (5.83%) on the week of 3/15-3/19. Contact sports teams had 67 students on their roster. Weekly testing was offered from 3/22-3/26 to 4/12-4/16. Contact sports teams had 10 students (14.93%) receive testing on the week of 3/22-3/26, 33 students (52.24%) on the week of 4/5-4/9, and 32 students (49.25%) on the week of 4/12-4/16.

Conclusion. Voluntary SARS-CoV-2 screening was not a feasible approach for detection of asymptomatically infected individuals due to low uptake, however in the same school, mandatory testing had high uptake and would be a feasible strategy.

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380. Environmental Contamination with SARS-CoV-2 in Nursing Homes

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