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 decreased monthly HIV tests from October 2020 through March 2021 was pronounced (all p < 0.05) and returned to pre-pandemic levels.

| Table 1:Interrupted time series regression parameters based on HIV testing results by month from January 2018 to March 2021. |
|---------------------------------------------------------------|
| Parameters | Estimate | Standard error | t | Sig |
| $b_0$ | 173.11 | 204.24 | 0.83 | <0.001 |
| $b_1$ | -10.29 | 16.62 | -0.60 | 0.541 |
| $b_2$ | -678.48 | 234.07 | -2.89 | 0.008 |
| $b_3$ | 4.84 | 34.98 | 0.14 | 0.891 |

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.

Disclosures. All Authors: No reported disclosures

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

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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 17-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=0.94, CI:0.93, 0.97), 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=0.89, CI:0.82,0.96), and 2.1 (HR=0.92, CI:0.87,1.00) 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 with a Subsequent Viral Load, Comparing Pandemic Periods to Pre-pandemic

| Hazard Ratio | Pre-Pandemic | Pandemic, Lab Closed | Interaction p-value | Pandemic, Lab Open | Interaction p-value |
|--------------|--------------|----------------------|---------------------|--------------------|---------------------|
| All Suppressed Viral Loads | 1.0 | 0.84 (0.63, 1.17) | 0.25 | 0.73 (0.58, 0.90) | 0.01 |
| Age | | | | | |
| Age 20-49 | 1.0 | 1.07 (0.98, 1.16) | 0.23 | 0.82 (0.70, 0.95) | 0.11 |
| Age 50-69 | 1.0 | 1.09 (0.98, 1.21) | 0.16 | 0.83 (0.68, 0.99) | 0.05 |
| Race | | | | | |
| Black | 1.0 | 0.91 (0.73, 1.13) | 0.42 | 0.75 (0.61, 0.92) | 0.03 |
| White | 1.0 | 1.04 (0.85, 1.26) | 0.00 | 0.85 (0.74, 0.98) | 0.02 |
| Other | 1.0 | 0.92 (1.05, 0.79) | 0.53 | 0.85 (0.74, 0.97) | 0.50 |
| Ethnicity | | | | | |
| Non-Hispanic | 1.0 | 0.94 (0.73, 1.21) | 0.64 | 0.72 (0.56, 0.92) | 0.05 |
| Hispanic | 1.0 | 1.10 (0.85, 1.43) | 0.68 | 0.74 (0.52, 1.09) | 0.16 |
| Substance Use | | | | | |
| No Recent Alcohol Use | 1.0 | 0.95 (0.89, 1.02) | 0.35 | 0.75 (0.65, 0.90) | 0.00 |
| Recent Alcohol Use | 1.0 | 0.97 (0.89, 1.05) | 0.54 | 0.75 (0.63, 0.88) | 0.02 |
| No Recent Cocaine/Opiate Use | 1.0 | 0.95 (0.89, 1.02) | 0.35 | 0.75 (0.65, 0.90) | 0.00 |
| Recent Cocaine or Opiate Use | 1.0 | 0.96 (0.89, 1.02) | 0.45 | 0.80 (0.68, 0.95) | 0.05 |
| Insurance | | | | | |
| Non-Paid | 1.0 | 0.94 (0.73, 1.21) | 0.64 | 0.72 (0.56, 0.92) | 0.05 |
| Paid | 1.0 | 1.10 (0.85, 1.43) | 0.68 | 0.74 (0.52, 1.09) | 0.16 |
PWID, possibly due to low access to care. Inpatient admissions may represent missed
treatment for approximately 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.

**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 suppression groups, but not non-suppressed patients. Further studies are needed to investi-gate 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; Amanda Goddard, MD; Sarah Libragda, MD; Carol A. McCarthy, MD,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 regarding demographic and clinical characteristics, comparing SARS-CoV-2 exposed and unexposed infants. The subset of SARS-CoV-2 exposed infants was further analyzed comparing SARS-CoV-2 exposed and unexposed infants. The subset of SARS-CoV-2 exposed infants was further analyzed comparing SARS-CoV-2 exposed and unexposed infants.

**Results.** Twenty four women and their infants were identified with maternal positive SARS-CoV-2 PCR test 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 moth-ers (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 2-33 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 readmission 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. Marrashow, MD, MAHIVS; Jose Caro, MD; Tufts Medical Center**

**Session: O-11. Disparities in HIV PreP and Continuum of HIV Care**

**Background.** Due to the ongoing opioid epidemic, PrEP widely represented 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 disoproxyl 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 que-ried 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 coun-seling on PrEP and offered initiation prior to discharge. We analyzed patient percep-tions 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 esti-mated nearly 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 accept-ing of PrEP, with 2 provided prescriptions. Of those declining, 13 denied active drug use, 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.

**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

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**Session: O-11. Disparities in HIV PreP and Continuum 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 PRO collection at a Historically Black Medical College in the Southern United States

**Paul Parasur, III, MD; Facerlyn Wheeler, MA; Kemokie Bonnet, MA; Peter F. Rebeiro, PhD, MHS; Paul Parisot, III, MD; Facerlyn Wheeler, MA; Kemokie Bonnet, MA; Peter F. Rebeiro, PhD, MHS; Paul Parisot, III, MD; Facerlyn Wheeler, MA; Kemokie Bonnet, MA; Peter F. Rebeiro, PhD, MHS.**

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**Methods.** We enrolled 100 PWH in care at the MCWC consecutively to complete validated PRO tools (Table 1) using the Research Electronic Data Capture (RED-Cap) Abstracts • OFID 2021:8 (Suppl 1) • S35