

**Table 1: Characteristics of HCWs who tested positive for COVID-19**

	Numbers of HCWs (n=335)	Percentage
Mean age (SD)	39.6 (13.7)	
Gender		
Male	131	39.1%
Female	204	60.9%
Race		
Chinese	154	46.0%
Malay	79	23.6%
Indian	48	14.3%
Others	54	16.1%
Job Categories		
Doctor	10	3.0%
Nurse	105	31.3%
Nursing support	31	9.3%
Administration staffs	59	17.6%
Pharmacist, Therapist, Technologist	44	13.1%
Others*	86	25.7%
Symptomatic at the time of PCR+	223	66.6%
Presence of comorbidities	67	20.0%
Required hospitalization	16	4.8%

\*Others (Environmental service, Facility management, Biomedical Engineering, General services)

**Table 2: Characteristics of community acquired Vs workplace associated COVID-19 infection**

	CAI (n=111)	WAI (n=48)	P value*
Gender (Female)	85 (76.6)	20 (41.7)	<0.001
Age (year)	36.8 (12.3)	40.7 (13.9)	0.077
Race (Chinese)	47 (42.3)	25 (52.1)	0.299
Job category (Nurse)	44 (39.6)	12 (25.0)	0.103
Symptomatic	69 (62.2)	33 (68.8)	0.475
Presence of comorbidities	23 (20.7)	12 (25.0)	0.540
Require hospitalization	3 (2.7)	5 (10.4)	0.055

Categorical data are shown in number (%), Continuous data are shown in mean (SD)

\*Fisher's exact test (Categorical data), t test (Continuous data)

111 HCW infections (33.1%). Also, 48 HCWs (14.3%) had a WAI (ie, acquired at their work places where there was no patient contact). Among WAsI, only 5 HCWs had hospital-acquired infection (confirmed by phylogenetic analysis). The sources of exposure for the remaining 176 HCWs were unknown. Weekly incidence of COVID-19 among HCWs was comparable to the epidemiology curve of all cases in Singapore (Fig. 1 and 2). The mean age of HCWs with COVID-19 was 39.6 years, and most were women. At the time of positive SARS-CoV-2 PCR test, 223 HCWs were symptomatic, and 67 (20.0%) of them had comorbidities. Only 16 HCWs (4.8%) required hospitalization, and all recovered fully with no mortality (Table 1). Being female was associated with community COVID-19 acquisition (OR, 4.6, P **Conclusions:** During the third wave of the COVID-19 pandemic, a higher percentage of HCWs at SGH acquired the infection from the community than from the workplace. Safe management measures, such as universal masking, social distancing, and robust exposure management processes including prompt contact tracing and environmental disinfection, can reduce the risk of COVID-19 in the hospital work environment.

**Funding:** None

**Disclosures:** None

*Antimicrobial Stewardship & Healthcare Epidemiology* 2022;2(Suppl. S1):s34–s35

doi:10.1017/ash.2022.120

**Presentation Type:**

Poster Presentation - Poster Presentation

**Subject Category:** COVID-19

**Absence of racial and ethnic disparities in COVID-19 survival among residents of US Veterans' Affairs community living centers**

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**Background:** COVID-19 has had a disproportionate effect on nursing homes residents as well as people from racial and ethnic minorities.

Whether differences in mortality due to COVID-19 exists for nursing-home residents from racial and ethnic minorities is less clear, with some previous studies reporting systems-level disparities. The Department of Veterans' Affairs (VA) has nursing homes, termed community living centers (CLCs), across the United States. We hypothesized that differences in COVID-19-related mortality among racial and ethnic minorities would be less pronounced among residents of CLCs. **Methods:** Using data from the VA Corporate Data Warehouse, we conducted a retrospective cohort study from April 14, 2020 (implementation of population-based testing) to December 10, 2020 (availability of a COVID-19 vaccine). Inclusion criteria were residents with a positive SARS-CoV-2 test while residing in or <48 hours before admission to a CLC. Positive tests <180 days after a prior positive test were excluded. We assessed the cohort for demographics, including self-reported race or ethnicity, clinical characteristics, and survival probability including all-cause 30-day mortality. A multivariable logistic regression model was used to estimate odds ratios (ORs) and 95% confidence intervals (CIs) for all-cause 30-day mortality that included race, ethnicity, age, and Charlson comorbidity index (CCI). **Results:** Among 14,759 CLC residents, 651 (4.4%) had a positive SARS-CoV-2 test. Their mean age was 75.7 ± 11.3 years, and self-reported race or ethnicity was 68% White (445 of 651), 23% Black (152 of 651), and 4% Hispanic/Latinx (27 of 651). The mean CCI was lower among White residents than Black residents (4.15 ± 2.6 vs 4.61 ± 3.1, respectively). All-cause 30-day mortality for CLC residents following positive SARS-CoV-2 test was 25% for White patients, 14% for Black patients, and 15% for Hispanic/Latinx patients (Fig. 1). Age (in years), but neither race or ethnicity nor CCI, was independently associated with all-cause 30-day mortality (OR, 1.07; 95% CI, 1.05–1.09) in CLC residents with COVID-19. **Conclusions:** Among VA CLC residents with a positive COVID-19 test, minority CLC residents did not have worse outcomes than white residents, suggesting that users of the VA healthcare system may enjoy abrogation of some aspects of health disparities.

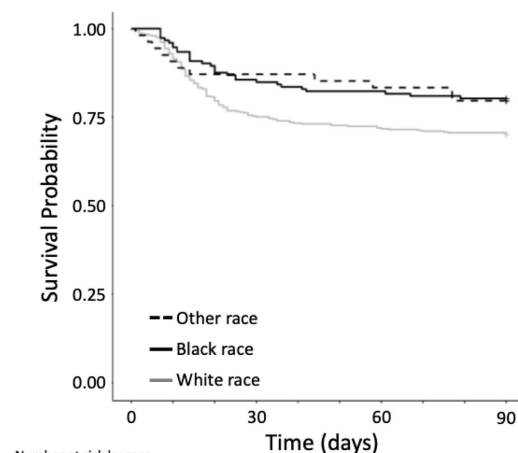
**Funding:** None

**Disclosures:** None

*Antimicrobial Stewardship & Healthcare Epidemiology* 2022;2(Suppl. S1):s35

doi:10.1017/ash.2022.121

**FIGURE:** Kaplan-Meier curves showing survival probability following a positive COVID-19 test among residents of VA Community Living Centers, stratified by race.



Number at risk by race	0	30	60	90
Other	54	47	45	43
Black	152	130	125	122
White	445	335	320	314