

Conclusion: Our study suggests that PLWH do not have a worse prognosis than their matched controls for the most significant comorbid conditions affecting outcome in COVID-19 disease. Further studies with a larger sample size are urgently needed to confirm this finding.

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362. A Modified Early Warning Score Predicts Decompensation in COVID-19 Patients

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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: The novel coronavirus disease (COVID-19) results in severe illness in a significant proportion of patients, necessitating a way to discern which patients will become critically ill and which will not. In one large case series, 5.0% of patients required an intensive care unit (ICU) and 1.4% died. Several models have been developed to assess decompensating patients. However, research examining their applicability to COVID-19 patients is limited. An accurate predictive model for patients at risk of decompensation is critical for health systems to optimally triage emergencies, care for patients, and allocate resources.

Methods: An early warning score (EWS) algorithm created within a large academic medical center, with methodology previously described, was applied to COVID-19 patients admitted to this institution. 122 COVID-19 patients were included. A decompensation event was defined as inpatient mortality or an unanticipated transfer to an ICU from an intermediate medical ward. The EWS was calculated at 12-hour and 24-hour intervals.

Results: Of 122 patients admitted with COVID-19, 28 had a decompensation event, yielding an event rate of 23.0%. 8 patients died, 13 transferred to the ICU, and 6 both transferred to the ICU and died. Decompensation within 12 and 24 hours were predicted with areas under the curve (AUC) of 0.850 and 0.817, respectively. Using a three-tiered risk model, use of the customized EWS score for patients identified as high risk of decompensation had a positive predictive value of 44.4% and 11.1% and specificity of 99.3% and 99.6% and 12- and 24-hour intervals. Amongst medium-risk patients, the score had a specificity of 85.0% and 85.4%, respectively.

Conclusion: This EWS allows for prediction of decompensation, defined as transfer to an ICU or death, in COVID-19 patients with excellent specificity and a high positive predictive value. Clinically, implementation of this score can help to identify patients before they decompensate in order to triage at time of presentation and allocate step-down beds, ICU beds, and treatments such as remdesivir.

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363. Acute Kidney Injury and Renal Replacement Therapy in Hospitalized COVID-19 Patients in the United States and Other Geographic Regions

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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: Acute kidney injury (AKI) is a complication that has been described among severely ill patients with COVID-19 and may be more common in those with underlying chronic kidney disease (CKD). Some patients with AKI require renal replacement therapy (RRT), including continuous RRT (CRRT). During the COVID-19 pandemic, some US areas experienced CRRT supply shortages. We sought to describe the percent of hospitalized COVID-19 patients who developed AKI or needed RRT to inform patient care and resource planning.

Methods: We searched for studies in the literature and public health investigations that described CKD, AKI, and/or RRT in COVID-19 patients from January 2020 onward. Studies were excluded if no CKD, AKI, or RRT information was provided. We abstracted counts of hospitalized COVID-19 patients, including those admitted to intensive care units (ICU) who developed AKI, underwent RRT, and/or had CKD. Data were pooled across cohorts by geographic region with available data (US, China, or United Kingdom [UK]). We compared proportions using Chi-square tests.

Results: A total of 311 studies were identified; 23 studies (US n=11; China n=11; UK n=1) that described kidney disease and/or kidney-related outcomes in hospitalized COVID-19 patients were included. Underlying CKD prevalence was higher in US cohorts (10.3%) compared with China (2.5%) or UK (1.5%) ($p < 0.0001$). AKI was markedly higher among hospitalized (31.3% vs. 6.4%; $p < 0.001$) and ICU patients (55.4% vs. 18.2%; $p < 0.0001$) in the US compared to China. The percent of ICU patients requiring RRT in the US (16.8%) was significantly different from that reported in China (12.5%) and the UK (23.9%) ($p < 0.0001$). Limitations include differences in CKD and RRT definitions across studies.

Table. Kidney-related outcomes and underlying disease among COVID-19 patient cohorts by region, January to May 2020

	U.S. (n=11)	China (n=11)	U.K. (n=1)	P value
Outcomes and Treatments				
AKI in hospitalized patients, n/N (%)	4747/15134 (31.3%)	180/2802 (6.4%)	NR	<0.001
Range across cohorts	18.9%-49.0%	6%-27.3%		
AKI in ICU patients, n/N (%)	2352/4244 (55.4%)	38/79 (18.2%)	NR	<0.0001
Range across cohorts	31.4%-100%	0%-29.0%		
RRT in hospitalized patients, n/N (%)	967/15548 (6.3%)	32/763 (4.1%)	NR	0.05
Range across cohorts	4.8%-15.4%	3.5%-9.1%		
RRT in ICU patients, n/N (%)	188/2304 (8.2%)	11/38 (12.5%)	1442/6027 (23.9%)	<0.0001
Range across cohorts	11.3%-51.4%	5.6%-17.0%	23.9%	
Underlying condition				
CKD in hospitalized patients, n/N (%)	1558/15131 (10.3%)	49/1942 (2.5%)	126/9250 (1.5%)	<0.0001
Range across cohorts	5.0%-38.0%	3.0%-5.5%	1.5%	

U.S. = United States of America; U.K. = United Kingdom
AKI = Acute Kidney Injury; RRT = Renal Replacement Therapy
NR = not reported; ICU = intensive care unit

Conclusion: AKI is a frequent outcome among US COVID-19 patients, affecting almost one third of hospitalized and more than half of ICU patients. AKI was reported more frequently in the US than China. The percent of ICU patients who received RRT was higher in the US and UK than in China. Understanding the occurrence of kidney-related outcomes among patients with COVID-19 including the impact of underlying CKD and regional practice variations is essential for healthcare systems to successfully plan for RRT needs during the pandemic.

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364. Baseline characteristics, comorbidities, and outcomes of COVID-19 patients hospitalized in Southwest Georgia, U.S. – an interim analysis of an early hot spot

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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: Understanding the spectrum of disease severity and death are critical for identifying unrecognized risk factors associated with morbidity and mortality from coronavirus disease 19 (COVID-19). The purpose of this study was to describe the baseline characteristics, clinical presentation, and outcomes among patients hospitalized with COVID-19 in a major hotspot in the U.S. Southeast.

Methods: This multicenter retrospective chart review included adult patients hospitalized with COVID-19, defined by laboratory-detected severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, in Southwest Georgia. The primary outcome was mortality, which was assessed through discharge or June 14, 2020, whichever occurred first. Secondary outcomes included comorbidities, laboratory and radiographic findings, as well as clinical course.

Results: A total of 120 patients were included with a median age of 61 years (IQR 50–72). The majority were African American (73%) and female (56%). Comorbidities on admission were present in 88% of patients; most prevalent were hypertension (76%), diabetes mellitus (55%), and chronic pulmonary disease (27%). Median Charlson comorbidity index was 4 (IQR 2–6) and BMI was 32.8 kg/m² (IQR 26.2–39.5). On presentation, patients most often complained of dyspnea (69%), fever (63%), and cough (53%), with a median SOFA score of 2 (IQR 2–4). Most patients were admitted to the general ward (71%), of which 17% were subsequently transferred to ICU. During hospitalization, 27% were mechanically ventilated for a median 11 days (IQR 5–13.5), 18% developed ARDS, and 43% developed AKI. Median length of stay was 9.5 days (IQR 3.75–14). Overall mortality was 20%, which was significantly higher among patients with comorbidities ($p = 0.047$), as well as those who developed ARDS ($p < 0.001$) or AKI ($p = 0.027$).

Conclusion: Most reports of COVID-19 have focused on large urban settings. However, early during the pandemic, we identified a large cluster of cases with a high-case fatality rate in a semirural setting in Southwest Georgia in the U.S.

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365. Characteristics and outcomes of COVID-19 patients admitted to a regional health system in the southeast

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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: COVID-19, first described in Wuhan, China, is now a global pandemic. We describe a cohort of patients (pts) admitted to our academic health system (HS) in the southeast, where demographics and comorbidities differ significantly from other regions in the U.S.

Methods: This was a retrospective review of 161 consecutive pts admitted with COVID-19 from 3/12/20 to 6/1/20. We assessed demographics, comorbidities, presenting symptoms, treatments and outcomes and compared pts who died during hospitalization to those who survived to discharge (EpiInfo 7.2, Atlanta, GA).

Results: Mean age was 60.5 years, 51.6% were female, 72% African American (AA) and 69.6% admitted from home. 54.5% had a BMI >30, 72% had HTN, 47.2% diabetes, and 33.6% COPD or asthma. The majority (68.8%) presented with fever (>38.0) and required supplemental oxygen within 8 hours of admission (63.4%). Cough (65.6%), dyspnea (57.5%), myalgias (30.6%) and diarrhea (23.8%) were also common. 40.4% received hydroxychloroquine, 23.6% steroids and 19.9% convalescent plasma. 42.9% required ICU care, 27.3% were intubated, and 19.3% died. Characteristics associated with death included older age, male sex, HTN, ESRD on HD, and cancer. Symptoms associated with death included absence of cough, absence of myalgias, previous admission for COVID-19, tachypnea, need for supplemental oxygen, elevated BUN and creatinine, and elevated ferritin. Interventions associated with death included use of steroids, receipt of ICU care, intubation, delay to intubation, and use of vasopressors or inotropes. Complications associated with death included development of a new arrhythmia, bacteremia, pneumonia, ARDS, thrombosis, and new renal failure requiring HD (Table).

Table 1. Patient Characteristics by Death

	Survived (n=130)	Died (n=31)	OR, [95%CI], p-value
Demographics			
Mean age (years)	57.6 (0.02-94.7)	72.5 (0.02-102.9)	1.06 [1.02-1.09], 0.0004
Female	72 (55.4%)	11 (35.5%)	0.44 [0.20-0.99], 0.05
Race AA	90 (69.2%)	26 (83.9%)	NS
Race C	35 (26.9%)	4 (12.9%)	NS
Race H	4 (3.1%)	0	NS
HCW	9 (6.9%)	0	NS
Admit from home	93 (71.5%)	19 (61.3%)	NS
Admit from congregate home	5 (3.8%)	1 (3.2%)	NS
Admit from rehab	3 (2.3%)	3 (9.7%)	NS
Admit from NH/LTCF	13 (10%)	3 (9.7%)	NS
Transfer from OSH	15 (11.5%)	5 (16.1%)	NS
Admit from prison/jail	1 (0.8%)	0	NS
Known travel	6 (4.6%)	0	NS
Known exposure to COVID-19+ case	49 (37.7%)	9 (29%)	NS
Co-morbidities			
Current or former smoker	38 (29.3%)	11 (35.5%)	NS
Obese (BMI>30)	68 (52.3%)	17 (54.8%)	NS
Diabetes	57 (43.8%)	19 (61.3%)	NS
HTN	90 (69.2%)	26 (83.9%)	2.88 [1.04-7.99], 0.03
COPD	26 (20%)	5 (16.1%)	NS
Asthma	19 (14.6%)	4 (12.9%)	NS
ESRD on HD	11 (8.5%)	8 (25.8%)	3.76 [1.36-10.38], 0.007
Liver disease	3 (2.3%)	0	NS
CAD	21 (16.2%)	8 (25.8%)	NS
Heart failure	17 (13.1%)	6 (19.4%)	NS
Neurologic disease	27 (20.8%)	7 (22.6%)	NS
Cancer	11 (8.5%)	7 (22.6%)	3.16 [1.11-8.96], 0.03
Other immunosuppression	16 (12.3%)	4 (12.9%)	NS
Pregnant	1 (0.8%)	0	NS

Table 2. Patient Characteristics by Death

Presenting symptoms			
Fever >38.0	85 (65.4%)	25 (80.6%)	NS
Fever >37.5	103 (79.2%)	27 (87.1%)	NS
Subjective fever	84 (64.6%)	17 (54.8%)	NS
Anosmia/Ageusia	12 (9.2%)	1 (3.2%)	NS
Chills	49 (37.7%)	10 (32.3%)	NS
Cough	91 (70%)	14 (45.2%)	0.35 [0.16-0.79], 0.009
Rhinorrhea	18 (13.8%)	5 (16.1%)	NS
Sore throat	8 (6.2%)	2 (6.5%)	NS
Diarrhea	31 (23.8%)	7 (22.6%)	NS
Nausea or vomiting	19 (14.6%)	7 (22.6%)	NS
Myalgias	45 (34.6%)	4 (12.9%)	0.28 [0.09-0.85], 0.02
Dyspnea	75 (57.7%)	17 (54.8%)	NS
Chest pain	22 (16.9%)	0	NS
Headache	23 (17.7%)	0	NS
Abdominal pain	14 (10.8%)	4 (12.9%)	NS
Mean days from symptoms to admission	7.3 (0-61)	5.6 (0-31)	NS
Previous admission for COVID-19	2 (1.5%)	3 (9.7%)	6.86 [1.09-42.97], 0.02
Mean max temp within 8 hours	37.4°C	37.9 °C	NS
Mean HR	91 (46.2% tachycardic)	90 (48.4% tachycardic)	NS
Mean SBP	132 (none <80)	130 (none <80)	NS
Mean RR	20 (25.4% >20)	22 (48.4% >20)	2.76 [1.23-6.18], 0.01
Need for supplemental O2 within 8 hours	75 (57.7%)	26 (83.9%)	3.81 [1.38-10.56], 0.007
CXR clear	38 (29.2%)	6 (19.4%)	NS
CXR unilateral infiltrate	20 (15.4%)	6 (19.4%)	NS
CXR bilateral infiltrate	57 (43.8%)	19 (61.3%)	NS
CXR pleural effusion	5 (3.8%)	0	NS
CXR not done	10 (7.7%)	0	NS
Mean WBC	7.0	7.6	NS
Mean absolute lymphocyte count	1.29	1.16	NS
Mean Hgb	12.0	11.7	NS
Mean platelet count	240	211	NS
Mean BUN	23.4	35.7	1.03 [1.01-1.04], 0.004
Mean Cr	2.0	3.9	1.12 [1.02-1.24], 0.02
Mean glucose	132	163	NS
Mean albumin	3.2	2.9	NS
Mean ALT	39	40	NS
Mean AST	47	70	NS
Mean total bilirubin	0.79	0.79	NS
Mean troponin	0.12	0.17	NS
Mean ferritin	912	1835	1.0003 [1.0001-1.0006], 0.02
Mean CRP	10.4	15.0	NS

Table 3. Patient Characteristics by Death

Treatment courses			
Hydroxychloroquine	48 (36.9%)	17 (54.8%)	NS
Antibiotics	101 (77.7%)	27 (87.1%)	NS
Remdesivir	12 (9.2%)	3 (9.7%)	NS
Immunomodulator	8 (6.2%)	1 (3.2%)	NS
Convalescent serum/plasma	24 (18.5%)	8 (25.8%)	NS
IVIg	3 (2.3%)	0	NS
Steroids	22 (16.9%)	16 (51.6%)	5.24 [2.26-12.14], <0.0001
Required ICU care	38 (29.2%)	31 (100%)	72.63 [9.56-552.89], <0.0001
Required intubation	18 (13.8%)	26 (83.9%)	32.36 [11.0-95.16], p<0.0001
Mean days to intubation	2 (0-7)	5.7 (0-22)	1.34 [1.02-1.75] p=0.03
Mean days on ventilator	18.5 (3-53)	11.9 (1-36)	NS
Required vasopressors	14 (10.8%)	22 (71%)	20.25 [7.81-52.5], <0.0001
Required inotropic agents	2 (1.5%)	4 (12.9%)	9.48 [1.65-54.42], 0.003
Outcomes			
New MI	8 (6.2%)	4 (12.9%)	NS
New arrhythmia	9 (6.9%)	12 (38.7%)	8.49 [3.15-22.86], 0.0001
New heart failure	3 (2.3%)	3 (9.7%)	NS
Bacteremia	2 (1.5%)	3 (9.7%)	6.86 [1.09-42.98], 0.02
Pneumonia	48 (36.9%)	19 (61.3%)	2.70 [1.21-6.05], 0.01
ARDS	19 (14.6%)	18 (58.1%)	8.09 [3.41-19.18], 0.0001
UTI	8 (6.2%)	3 (9.7%)	NS
Viral co-infection	2 (1.5%)	0	NS
VTE	6 (4.6%)	5 (16.1%)	3.97 [1.13-14.01], 0.02
DIC	2 (1.5%)	1 (3.2%)	NS
Rhabdomyolysis	0	1 (3.2%)	NS
New HD requirement	4 (3.1%)	11 (35.5%)	17.33 [5.03-59.74], 0.0001
Mean LOS (days)	11.1 (1-55)	16.7 (1-34)	1.04 [1.01-1.08], 0.01
Patients who had additional SARS-CoV-2 PCR	74 (56.9%) 59 still positive	20 (64.5%) 19 still positive	NS

Conclusion: COVID-19 pts admitted to our southeast U.S. HS had significant comorbidities, most commonly obesity, HTN, and diabetes. Additionally, AA comprised a disproportionate share (72%) of our cohort compared to the general population of our state (30%), those tested in our region (32.9%), and those found to be positive for COVID-19 (35.8%). In-hospital mortality was 19.3% and intubation, particularly if delayed, was associated with death as were several complications, most notably arrhythmia, ARDS, and renal failure with HD.

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366. Characteristics and Outcomes of COVID-19 Patients with Fungal Infections
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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: There is concern that patients with coronavirus disease 2019 (COVID-19) are at risk of developing secondary bacterial and fungal infections; however, data on the clinical characteristics and outcomes of COVID-19 patients with fungal infections are limited. We evaluated the risk factors and mortality of hospitalized COVID-19 patients with fungal infections.

Methods: This was a retrospective chart review of 51 patients with fungal infections at an 877-bed teaching hospital in Detroit, Michigan from March through May 2020. Demographic data, comorbidities, complications, treatment, and outcomes, including relapse, readmission and mortality were collected. We performed a descriptive analysis.

Results: A total of 51 patients with fungal infections were included, in which 31 (60.8%) had confirmed or suspected COVID-19 infection. Of the COVID-19 patients, the average age was 66 years and the majority (54.9%) were female. The average length of stay (LOS) was 29.3 days. *Aspergillus* sp. (2 *A. fumigatus*, 1 *A. niger*) were isolated in 3 (10%) patients while 23 (74.2%) had candidemia diagnosed via blood culture or T2Candida[®] Panel. One had a positive serum galactomannan. The average time from admission to diagnosis was 13 days. Significant comorbidities included hypertension (74%), diabetes (51.6%), coronary artery disease (25.8%), congestive heart failure (32.2%), chronic kidney disease (22.6%), and malignancy (16.1%). Most patients received steroids (83.9%) and broad-spectrum antibiotics (80.6%), had a central line (80.6%), and required intensive care unit management (90%). Only 71% were treated with antifungals. One

patient with candidemia relapsed due to poor source control; two were readmitted within 30 days. In-hospital mortality rate was 51.6% among COVID-19 patients.

Conclusion: COVID-19 patients with fungal infections had multiple comorbidities, prolonged hospitalization and predisposing risk factors for fungal infections with a high in-hospital mortality rate. Prevention of fungal infections in COVID-19 patients is paramount.

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367. Clinical Characteristics and Outcomes in Patients with Pneumonia secondary to Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: Since discovery in December 2019, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) which causes the disease of COVID-19 has become a global pandemic. Little is known about which risk factors lead to more severe disease or increased mortality in patients diagnosed with SARS-CoV-2. We aimed in this study to compare clinical characteristics associated with disease severity and increased mortality in hospitalized patients with COVID-19.

Methods: This was a single-center, retrospective study at The Ohio State University Wexner Medical Center to compare clinical characteristics associated with increased mortality in hospitalized patients with confirmed SARS-CoV-2. Adults patients positive for SARS-CoV-2 between March 1, 2020 and April 20, 2020 were included in the study. Prisoners and pregnant women were excluded. Baseline demographics, clinical characteristics, and outcomes were collected, and then compared to determine association with mortality. Statistical analysis used univariate and multivariate logistic regression analysis to evaluate the relationship between patient characteristics and mortality.

Results: The cohort included 92 patients. Median age was 58 years (ranging from 25-93) and 47/92 were men (51%). 12 patients were admitted directly to the intensive care unit (ICU), with 22 additional patients transferred to the ICU. 23 patients required mechanical ventilation. Clinical characteristics significantly associated with mortality in univariate analysis included underlying coronary artery disease (CAD) (OR=7.8, p = 0.002), chronic obstructive pulmonary disease (OR=5.21, p=0.02), living in an extended care facility (ECF) (OR=4.2, p=0.025), and immunocompromised status (OR=4.2, p=0.025). Multivariate analysis showed a statistically significant association in patients with underlying CAD (OR=13.1, p=0.001) and those admitted from an ECF (OR=12.1, p=0.005), when adjusted for other variables in the model.

Characteristics Associated with Mortality in Patients with COVID-19 in Univariate Analysis

Characteristics Associated with Mortality in Patients with COVID-19 in Univariate Analysis	Odds Ratio	Confidence Interval	p-value
Clinical Characteristic			
Male Gender	1.40	0.41 – 4.78	0.590
African American	0.61	0.17 – 2.19	0.450
Age Greater Than 60	3.86	0.97 – 15.30	0.055
Coronary Artery Disease	7.88	2.09 – 29.70	0.002
Living in Extended Care Facility	6.17	1.43 – 26.60	0.015
Tobacco Use	0.56	0.11 – 2.77	0.480
Diabetes Mellitus	3.27	0.94 – 11.30	0.060
Obesity (BMI > 30)	2.00	0.50 – 7.95	0.320
Asthma	0.87	0.17 – 4.37	0.860
Chronic Obstructive Pulmonary Disease	5.21	1.24 – 21.77	0.020
Immunocompromised Patient	4.20	1.20 – 14.70	0.025

Conclusion: Our study found that CAD and admission from an ECF were associated with SARS-CoV-2 mortality, when adjusted for age and other comorbidities. Further studies are necessary to identify potential preventative strategies to mitigate mortality in this vulnerable population.

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368. Clinical Characteristics of Hospitalized COVID-19 American Indian Patients in Rural Arizona

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Session: P-12. COVID-19 Complications, Co-infections, and Clinical Outcomes

Background: American Indians have an increased risk of serious complications from COVID-19 due to the high prevalence of comorbidities such as diabetes,