Table 1. Descriptive Analysis of COVID-19 Patients at a Large Rural Community Hospital System, Southern California, March 1, 2020 to July 31, 2020.

	All COVID-19 Diagnoses n (%)	COVID-19 Hospitalizations n (%)	COVID-19 Deaths n (%)
Total	2,132 (100)	1,044 (100)	112 (100)
Demographics			
Gender			
Female	1107 (51.9)	484 (46.3)	43 (38.4)
Male	1025 (48.1)	560 (53.6)	69 (61.6)
Average Age (Median)	50.6 (51.0)	50.6 (51.0)	75.1 (74.0)
Age groups			
0-4	5 (0.2)	--	--
5-17	39 (1.8)	<5	--
18-29	360 (16.9)	46 (4.4)	--
30-39	308 (14.4)	69 (6.6)	<5
40-49	306 (14.4)	102 (9.8)	<5
50-64	534 (25.0)	283 (27.1)	18 (16.1)
65-74	284 (13.3)	218 (20.9)	35 (31.3)
75-84	203 (9.5)	211 (20.2)	22 (19.6)
85+	93 (4.4)	114 (10.9)	34 (30.4)
Race			
American Indian/Alaska Native	8 (0.4)	<5	<5
Asian/Native Hawaiian or Other Pacific Islander	34 (1.6)	12 (1.1)	<5
Black or African American	33 (1.5)	30 (2.9)	<5
White	1,311 (61.5)	660 (63.2)	72 (64.3)
Other Race	717 (33.6)	332 (32.0)	31 (27.7)
Missing/Unknown	29 (1.4)	6 (0.6)	<5
Ethnicity			
Hispanic or Latino	1,167 (54.7)	494 (47.3)	48 (42.9)
Non-Hispanic or Latino	918 (43.1)	540 (51.7)	62 (55.4)
Missing/Unknown	47 (2.2)	10 (1.0)	2 (1.8)

Table 2. Length of Stay and Risk Factors Associated with COVID-19 among Patients at a Large Rural Community Hospital System, Southern California, March 1, 2020 to July 31, 2020.

	All COVID-19 Diagnoses n (%)	COVID-19 Hospitalizations n (%)	COVID-19 Deaths n (%)
Total	2,132 (100)	1,044 (100)	112 (100)
Length of Stay			
Average LOS (Standard Deviation (SD))	--	6.46 (6.59)	--
Average LOS among Females (SD)	--	6.10 (6.82)	--
Average LOS among Males (SD)	--	6.76 (6.38)	--
Alcohol Use			
No/Never/Not currently	746 (35.0)	629 (60.2)	64 (57.1)
Yes	614 (28.8)	337 (32.3)	30 (26.8)
Blank/Not Asked/Defer	772 (36.2)	78 (7.5)	18 (16.1)
Smoking Status			
Current smoker	54 (2.5)	25 (2.4)	<5
Former smoker	364 (17.1)	221 (21.2)	43 (38.4)
Never smoker	824 (38.6)	444 (42.5)	61 (54.5)
Unknown/Blank	344 (16.1)	28 (2.7)	13 (11.6)
Passive smoke exposure – Never smoker	6 (0.3)	<5	--
BMI			
Underweight (<18.5)	35 (1.6)	37 (3.5)	<5
Normal/Healthy Weight (18.5-24.9)	407 (19.1)	249 (23.9)	35 (31.3)
Overweight (25.0-29.9)	582 (27.3)	294 (28.2)	25 (22.3)
Obese (>30.0)	739 (34.7)	463 (44.3)	47 (42.0)
Blank/Missing	369 (17.3)	3 (0.3)	1 (0.9)

Table 3. Occupational Analysis of COVID-19 Patients at a Large Rural Community Hospital, Southern California, March 1, 2020 to July 31, 2020.

Occupation Group	Overall n (%)	Hospitalizations n (%)	Deaths n (%)
Total	682 (100)	292 (100)	54 (100)
Occupation (n=682)[1]			
Management	95 (13.9)	40 (13.7)	<5
Business and financial operations	21 (3.1)	10 (3.4)	<5
Computer and mathematical science	6 (0.9)	<5	<5
Architecture and Engineering	9 (1.3)	7 (2.4)	--
Life, physical, and social science	<5	2 (0.7)	<5
Community and social service	9 (1.3)	5 (1.7)	<5
Legal	5 (0.7)	<5	--
Education, training and library	25 (3.7)	14 (4.8)	5 (9.3)
Arts, design, entertainment, sports, and media	18 (2.6)	9 (3.1)	<5
Healthcare practitioner and technical	83 (12.2)	25 (8.6)	<5
Healthcare support	35 (5.1)	10 (3.4)	<5
Protective service	17 (2.5)	9 (3.1)	<5
Food preparation and serving related	36 (5.3)	12 (4.1)	<5
Building and grounds cleaning and maintenance	54 (7.9)	24 (8.2)	7 (13.0)
Personal care and service	28 (4.1)	8 (2.7)	--
Sales and related	72 (10.6)	29 (9.9)	6 (11.0)
Office and administrative support	69 (10.1)	26 (8.9)	<5
Farming, fishing, and forestry	12 (1.8)	10 (3.4)	<5
Construction and extraction	23 (3.4)	11 (3.8)	<5
Installation, maintenance and repair	16 (2.3)	12 (4.1)	<5
Production	8 (1.2)	<5	<5
Transportation and material moving	34 (5.0)	20 (6.8)	<5
Armed Forces	<5	<5	<5

[1] A total of n=105 were excluded from the occupational analysis: 40=homemaker; 10=unemployed/retired; 6=student/minor; 9=declined; 5=unknown/blank; <5=disabled; 27=insufficient information.

potential health disparities among severe cases and deaths in different occupational groups.

1. Baker MG, Peckham TK, Seixas NS. Estimating the burden of United States workers exposed to infection or disease: a key factor in containing risk of COVID-19 infection. *PLoS One* 2020;15:e0232452.

Presentation Type:
Poster Presentation - Poster Presentation
Subject Category: COVID-19
COVID-19 among healthcare workers of a tertiary-care hospital in Singapore

Aung Myat Oo; Indumathi Venkatachalam; Xiang Ying Jean Sim; May Kyawt Aung; Conceicao Edwin Philip; Yang Yong; Shalvi Arora; Shawn See Wee Jin; Wai Leong Lester Lee; Fong Yuke Tien; Lai Chee Lee and Moi Lin Ling

Background: Singapore General Hospital (SGH) is the largest acute tertiary-care hospital in Singapore. Healthcare workers (HCWs) are at risk of acquiring COVID-19 in both the community and workplaces. SGH has a robust exposure management process including prompt contact tracing, immediate ring fencing, lock down of affected cubicles or single room isolation for patient contacts, and home isolation orders for staff contacts of COVID-19 cases during the containment phase of the pandemic. Contacts were also placed on enhanced surveillance with PCR testing on days 1 and 4 as well as daily antigen rapid tests (ARTs) for 10 days after exposure. Here, we describe the characteristic of HCWs with COVID-19 during the third wave of the COVID-19 pandemic. **Methods:** This retrospective observational study included all SGH HCWs who acquired COVID-19 during the third wave (ie, the 18-week period from September 1 to December 31, 2021) of the COVID-19 pandemic. Univariate analysis was used to compare characteristics of work-associated infection (WAI) and community-acquired infection (CAI) among HCWs. **Results:** Among a workforce of >10,000 at SGH, 335 HCWs acquired COVID-19 during study period. CAI (exposure to known clusters or household contact) accounted for

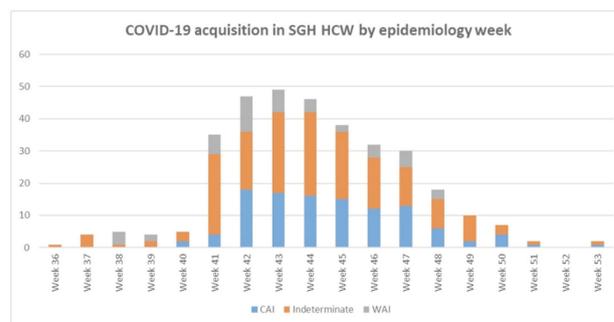Figure 1: Epidemiology curve of SGH HCW COVID-19 acquisition

COVID-19 acquisition in SGH HCW by epidemiology week

Figure 2: Epidemiology curve of weekly new COVID-19 cases in Singapore

New COVID-19 cases in Singapore by epidemiology week
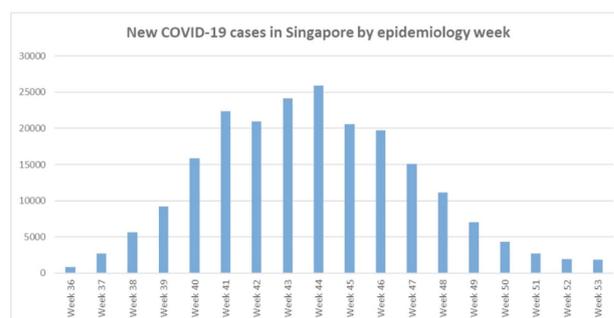
Table 1: Characteristics of HCWs who tested positive for COVID-19

	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 thrid 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.

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

Mayyadah Alabdely; Sonya Kothadia; Taissa Bej; Brigid Wilson; Sunah Song; Ukwen Akpoji; Federico Perez and Robin Jump

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.
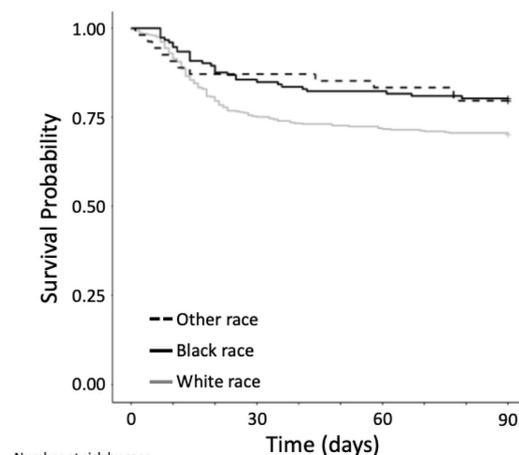
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Disclosures: None

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				
Other	54	47	45	43
Black	152	130	125	122
White	445	335	320	314