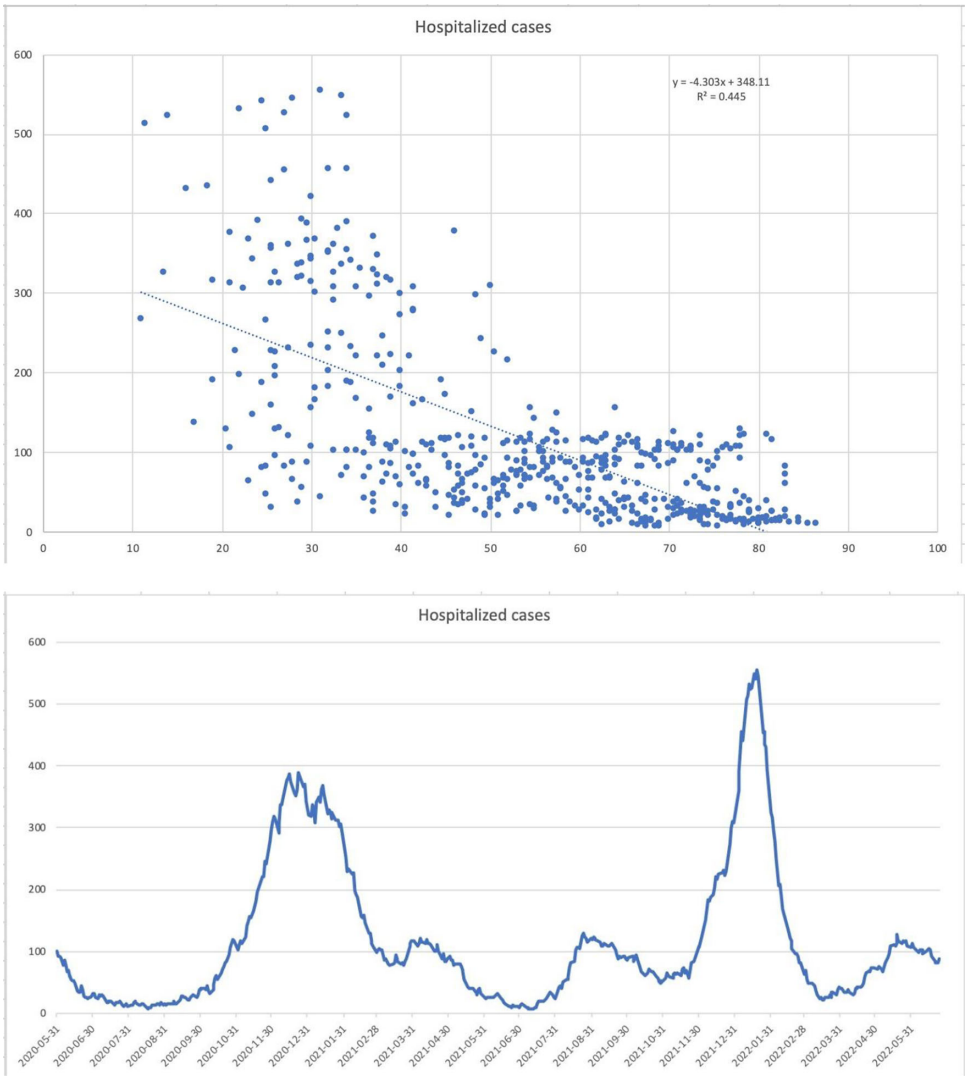

with likely contaminants excluded. Mann-Whitney *U* tests were used to evaluate continuous variables, and *t* tests were used to analyze categorical variables. $P \leq .05$ was considered statistically significant. **Results:** In total, 1,297 patients were included: 787 (60.7%) in SARS-CoV-2 delta-variant–predominant phase and 510 (39.3%) in SARS-CoV-2 omicron-variant–predominant phase. Patients in SARS-CoV-2 omicron-variant–predominant phase were more often vaccinated (37.7% vs 55%; $P < .001$), required lower rates of ICU care (16.0% vs 11.6%; $P = .025$), and required less intubation (13% vs 6.3%; $P < .001$). Utilization of remdesivir (51.0% vs 32.2%; $P < .001$), dexamethasone (70.8% vs 43.3%; $P < .001$), and tocilizumab or baricitinib (14.5% vs 5.3%; $P < .001$) decreased during the SARS-CoV-2 omicron-variant–predominant phase. Length of stay (5 days vs 4 days; $P < .001$) and 30-day mortality also decreased during this period (16.40% vs 9.8%; $P = .001$). Infectious diseases consultation increased during the SARS-CoV-2 omicron-variant–predominant phase (39.8% vs 45.5%; $P = .042$). There was no significant difference in patients with positive blood cultures (3.4% vs 1.8%; $P = .074$), but there was a significant decrease in positive respiratory cultures (5.8% vs 2.7%; $P = .009$), combining for an overall reduction (8.4% vs 4.1%; $P = .003$). The incidence of overall antimicrobial use increased during the omicron-predominant phase (36.1% vs 41.8%; $P = .04$), and duration was lower (5 days vs 4 days; $P < .001$). Antimicrobial class-specific duration was unchanged, with the exception of decreased gram-positive agents (3 days vs 2 days; $P = .012$). **Conclusions:** Our results confirm previous reports of reduced disease severity during the SARS-CoV-2 omicron-variant–predominant period. The incidence of secondary infections decreased, driven by a reduction in respiratory infections. Antimicrobials were used at increased rates and for shorter durations during the SARS-CoV-2 omicron-variant–predominant period.

Disclosures: None

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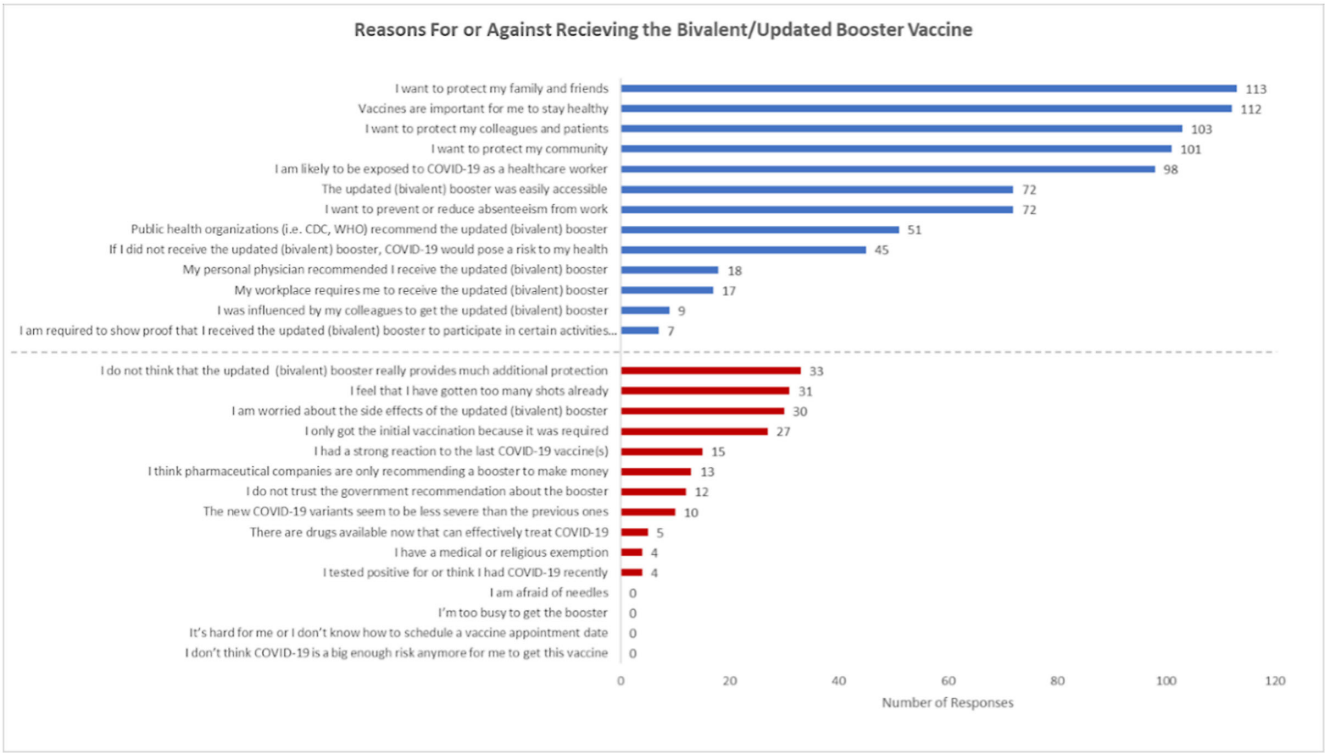
Presentation Type:
Poster Presentation - Poster Presentation
Subject Category: COVID-19

Characterizing healthcare worker attitudes toward the bivalent COVID-19 booster

Kathryn Willebrand; Jacqueline Fredrick; Lauren Pischel; Kavin Patel; Scott Roberts; Thomas Murray and Richard Martinello

Background: Recent evidence has shown that the updated COVID-19 bivalent booster is effective in preventing COVID-19 compared with no previous vaccination and prior monovalent vaccination. Despite its effectiveness, uptake has been poor, and a minority of eligible recipients have received the booster. Understanding healthcare worker (HCW) attitudes for and against voluntary uptake of the bivalent booster dose against COVID-19 can help guide communication strategy to maximize uptake. In this survey study, we investigated attitudes toward updated and/or



bivalent booster uptake in a behavioral health hospital shortly after a COVID-19 outbreak. **Methods:** A survey tool was developed and sent to all HCWs at the Yale New Haven Psychiatric Hospital in December 2022. The survey queried demographic data, job category, history of COVID-19, prior COVID-19 vaccinations, perception of COVID-19 exposure, and updated and/or bivalent booster doses. The survey was administered several weeks after a COVID-19 outbreak on multiple inpatient behavioral health units. Receipt of the COVID-19 primary vaccination series and the first booster dose were mandated for HCWs; however, receipt of the bivalent booster was voluntary. **Results:** The survey was sent to 664 HCWs with primary assignments in behavioral health settings. In total, 182 (27.4%) provided complete responses to the survey and are included in these data. Moreover, 91 HCWs (50.0%) reported previously having COVID-19 at least once. Overall, 100 HCWs (55.0%) received the bivalent booster. The most identified reasons for receiving the bivalent booster were wanting to protect family and friends (n = 113), importance of staying healthy (n = 112), and protecting colleagues and patients (n = 103). The most identified reasons for not wanting to receive the bivalent booster dose were not thinking it provides additional protection (n = 33), "too many" shots already received (n = 31), and concern about side effects (n = 30). **Discussion:** Bivalent booster dose uptake in HCWs on behavioral health units shortly after a COVID-19 outbreak was greater than the general population. HCWs reported varying reasons for and against receipt of the bivalent booster dose, with the most common being protection of family and friends and perceptions of no additional protection, respectively. A limitation of this study was voluntary response bias, in which results are biased toward individuals more likely to receive a bivalent booster vaccine. It is unclear whether reasons for declining the vaccine are representative of HCWs who did not complete the survey. Assessing attitudes for the bivalent booster dose can assist in guiding communication and outreach strategies to increase vaccine uptake by HCWs.

Disclosures: None

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Factors influencing healthcare personnel decision making to work with respiratory symptoms during the COVID-19 pandemic

Rachel Meyer; Michael Kessler; Daniel Shirley; Linda Stevens; Fauzia Osman and Nasia Safdar

Background: Amid the COVID-19 pandemic, healthcare systems were stretched thin, with staffing shortages posing substantial challenges. Limiting spread of COVID-19 among healthcare professionals (HCP) is paramount to preventing exacerbation of such shortages, but strategies are highly dependent on HCP self-screening for symptoms and isolating when present. We examined HCP perceptions of barriers and factors that facilitate staying home when experiencing respiratory symptoms. **Methods:** At an academic tertiary-care referral center, in inpatient and ambulatory settings, we conducted an anonymous electronic survey between March 11, 2022, and April 12, 2022. Using logistic regression analysis, we analyzed predictors of employees reporting to work with respiratory symptoms using STATA and SAS software. **Results:** In total, 1,185 individuals including 829 clinical staff and 356 nonclinical staff responded to the survey. When excluding participants who reported working "remotely" (N = 381) and those who reported being unsure of whether they had worked with symptoms (N = 14), the prevalence of working with respiratory symptoms was 63%. There was no significant difference between clinical and nonclinical staff (OR, 1.1; 95% CI, 0.8–1.5; $P = .60$). Increasing number of years of service was protective against working with symptoms, achieving statistically significance in multivariable analysis after 16 years. Compared to those having worked <1 year, the odds ratios of working with symptoms were 0.32 (95% CI, 0.16–0.65; $P = .002$), 0.33 (95% CI, 0.15–0.74; $P = .007$), and 0.32 (95% CI, 0.13–0.79; $P = .007$) for those working 16–20 years, 21–25 years, and ≥26 years, respectively. More than half of HCP who worked with symptoms identified being understaffed (56.9%), having mild symptoms