Laura Regalini, MD, MD;3 Mariana Schlesinger, PhD, PhD;1 Marta L. Alcaide, MD;3 Gordon M. Dickinson, MD, MD;3 Fighting Infectious Diseases in Emerging Countries, Miami, Florida;1 University of Miami, South Miami, Florida;2 University of Miami Miller School of Medicine, Miami, Florida

Session: 163. Public Health
Friday, October 4, 2019: 12:15 PM

Background. Each year influenza causes between 12,000 and 56,000 deaths, and over half a million of hospitalizations in the United States. Despite the widespread availability of vaccination, immunization coverage is low. Less than half of American adults receive the influenza vaccine, and there is a disparity between Hispanic and non-Hispanics, with only 35.9% of Hispanic compared with 45.9% of white non-Hispanics receiving the vaccine. In Miami, South Florida, over two-thirds of the population is Hispanic, and rates of influenza vaccination are low. This study aims to quantify the knowledge and attitudes toward influenza vaccination among members of the adult Hispanic community in Miami, and to identify barriers to vaccination in this population.

Methods. This is a cross-sectional study conducted during the influenza season in 2017 and 2019 (October to December). A survey was administered in the waiting rooms of participating Latin American Consulates (Argentina, Colombia, Ecuador, Guatemala, Honduras, Mexico, Peru, and Uruguay) in Miami. Participants included were older than 18 years, Hispanic, and with residence in the United States for more than 6 months. The participants accepted the inform consent orally. The survey was voluntary and anonymous.

Results. We enrolled 970 adults. The median age was 43 years, 50% were male, 60% had health insurance, and 67% had completed education of high school or higher. Knowledge regarding influenza and vaccination was low (78% believed asymptomatic individuals could transmit influenza, 14% knew that vaccination is recommended during the winter months, 50% felt not everyone should be vaccinated, 25% believed the vaccine causes influenza, and 7% autism). About one quarter (27%) received the influenza vaccine annually, 35% sometimes, and 38% never. On the logistic regression, we identified age χ2(2) = 19.38, P < 0.001, consulate χ2(6) = 160.21, P < 0.001, and influenza status χ2(2) = 23.04, P < 0.001 as predictors of receiving vaccination. Neither gender, nor education level found to be associated with vaccination behavior.

Conclusion. Immunization rates in the adult Hispanic population are low. Interventions to improve vaccination among Hispanics who are older and lack of health insurance are urgently needed in the diverse Hispanic community.

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1651. The Impact of the 2017–2018 Influenza Season on Acute Care Hospitals in the United States: A Qualitative Evaluation of Immediate Responses and Future Preparedness
Gavin H. Harris, MD;1 Kimberly J. Rak, PhD;1 Jeremy M. Kahn, MD, MSc;1 Derek C. Angus, MD, MPH;1 Erin A. Caplan, MPH;1 Olivia Mancing, BA;1 Julia Driesen, PhD;2 David J. Wallace, MD, MPH;1 University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania;1 Critical Care Medicine - University of Pittsburgh, Pittsburgh, Pennsylvania;2 University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania

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Background. The 2017–2018 influenza season was characterized by high illness severity, wide geographic spread, and prolonged duration compared with recent years in the United States – resulting in an increased number of emergency department evaluations and hospital admissions. The current study explored how US hospitals perceived the impact of influenza during this time period, including effects on patient volumes, ways in which hospitals responded, and how lessons learned were incorporated into future influenza preparedness.

Methods. We conducted semi-structured phone interviews with capacity management personnel in short-term acute care hospitals across the United States. A random hospital sample was created using Centers for Medicare and Medicaid Services annual reports. Hospitals self-identified key informants who were involved with throughput and capacity. The interview guide was developed and pilot tested by a team of clinicians and qualitative researchers, with interviews conducted between April 2018 and January 2019. We performed thematic content analysis to identify how hospitals experienced the 2017–2018 influenza season.

Results. We achieved thematic saturation after 53 interviews. Responses converged to three thematic domains: impacts on staff and patient care, immediate staffing and capacity responses, and future preparedness (Table 1). Hospitals almost universally reported increased emergency department volumes, and inpatient volumes that frequently resulted in strain across the hospital. Strain was created by both increased patient volume and staff shortages due to influenza illness. As strategies to address strain, respondents reported the use of new protocols, new vaccination policies, additional staffing, suspected influenza treatment areas, and more frequent hospital and staff monitoring meetings. Many hospitals reported increased diversion time. Despite experiencing high levels of strain, some hospitals reported no changes to their future influenza preparation plans.

Conclusion. Acute care hospitals experienced significant strain as a result of the 2017–2018 influenza season. Hospitals implemented a range of immediate responses to seasonal influenza, but generally did not report future planning specific to influenza.

Disclosures. All authors: No reported disclosures.
Table 1. Respondents’ Perspectives on Infancy Capacity Strain

| Domain | Representative Quotations |
|---|---|
| **Perception of Strain** | |
| | “This is the highest influx of flu that was admitted that I’ve seen in probably 10, 12 years. We were really hit hard, and that again put more strain on the resources because they had to be isolated. So that means they had to have a private room.” |
| | “This strain on the entire hospital just because of the sheer volume of patients...And so it really came to light that we needed an improved flow process. So that we hadn’t started it already but it really did bring to light our inability to deal.” |

**Impact of Influence**

| Staff | |
|---|---|
| | “The increased patient volumes ended up becoming a physician capacity issue. Our hospital staff group became overwhelmed with the influx of patients and them being at capacity and not being able to see additional patients. I don’t think the emergency department was capable of handling it.” |
| | “You have multiple meetings and calls throughout the day to see how you are going to maintain or diminish the capacity. So at an administrative level, it’s very tiring. Pressure, constantly thinking of solutions for the team.” |

**Immediate Response**

| Staff | |
|---|---|
| | “We ended up needing [...] mandatory overtime. We had staff sign up. We asked everyone to work one extra shift per pay period. So that kind of its toll on staff as well. It wasn’t really a big seller but we needed to do that in order to make sure all the patients were cared for safely.” |
| | “We had a 10-bed overflow unit, and that open all fall, all winter long to help with increased patient load. We did utilize some temporary staff agency, contractual staff to help meet the need of our increased patient volume.” |

**Capacity**

| Staff | |
|---|---|
| | “We have a surge plan that we use that changes [...].” |
| | “The implementation of that number of times during that period to try to get discharges out sooner, to get tests done more quickly, to triage a little bit differently, to try to reduce the amount of time people are waiting to come into the hospital. I can’t say that it was 100% successful.” |
| | “We have our hospital system’s ambulance service [...] actually taking patients out of the ED [...] off the floors as well because that were going to be discharged.” |

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1653. Strong Partnership and Effective Communication Between a Tertiary Hospital and a County Health Department Were Critical in Controlling a 2019 Measles Outbreak in Southeast Michigan (SEM)

Trinn Mathew, MD, MPH, FACP, FIDSA; Paul Johnson, MD; Diane Kamerer; Amber Jones, MPH, CIC; Jeffrey Diok, MF; James Zadeh, MD; Christopher Carpenter, MD, MHA; Beaumont Hospital - Royal Oak, Royal Oak, Michigan

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**Background.** Measles, declared eliminated in the US 2000, is a reemerging vaccine-preventable airborne disease. The 2019 case count (704 as of April 30, 2019) has surpassed the number of 2014 cases (667), the highest since 1994. Many healthcare personnel (HCP) have not seen a case of measles, and this lack of clinical experience may contribute to missed or delayed diagnoses leading to its spread. We describe the processes and measures implemented at Beaumont Hospital, Royal Oak (B-RO) Michigan in collaboration with the Oakland County Health Department (OCHD) to prevent secondary spread during an outbreak.

Soon after the initial report of the index case in Oakland County in March, the B-RO epidemiology team connected with OCHD. As both exposed and suspected cases were expected to seek care at B-RO, a one-page informational document was sent to B-RO providers. This document detailed isolation precautions and testing methods, post-exposure prophylaxis (PEP), and contact information. During subsequent days, as measles cases increased, frequent calls between B-RO and OCHD addressed numerous issues, including: media notifications, contact of exposed persons, vaccine and immunoglobulin supply for PEP, safe referral of cases to the EC, and the process of measles specimen submission for testing. As needed, these communications occurred after business hours and during week ends. Serologic testing to confirm measles immunity was ramped up.

**Results.** As of April 30, 41 cases have been confirmed in MI associated with the index case. OCHD facilitated the exposure control for 40 patients, of which 6 came to B-RO during their infectious period (Figure 1). To date, there have been no secondary cases developing in B-RO patients, HCPs or visitors, which may be related to successful engineering controls, appropriate protective equipment, mandatory measles immunity confirmation as condition of Beaumont employment since the late 1980s, institution of furlough procedures, PEP for hospitalized patients, and widespread communications with patients, visitors and HCWs (Figure 2).

**Conclusion.** During an outbreak, close healthcare facility and local health department collaboration is essential in rapidly limiting an airborne disease outbreak.

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