Table 2. Risk Factors for Adverse Outcomes

	Adjusted Odds Ratios (95% Confidence Interval)						
	Functional Decline From pre-covid/baseline to last follow-up observation (N patients with sufficient records)						Other adverse outcome
Risk Factor	Transferring (N=96)	Dressing (N=100)	Eating (N=106)	Toileting (N=106)	Bathing (N=103)	Continence (N=99)	New hospice status (N=99)
Case (COVID positive)	**5.65 (1.20-26.53)****	**3.51 (0.87-14.23)***	0.80 (0.32-1.98)	1.24 (0.37-4.21)	1.03 (0.37-2.87)	2.21 (0.86-5.71)	**7.12 (1.26-40.24)****
Number of follow-up visits	0.94 (0.51-1.72)	**2.41 (1.14-5.14)****	1.34 (0.93-1.94)	1.22 (0.74-2.01)	0.84 (0.56-1.27)	1.06 (0.72-1.58)	1.31 (0.67-2.58)
Age ≥ 80	**5.91 (0.92-37.91)***	**4.60 (0.83-25.39)***	1.50 (0.60-3.76)	**14.66 (1.73-124.03)****	**3.52 (1.07-11.59)****	1.56 (0.58-4.15)	1.89 (0.35-10.16)
Sex (male)	2.24 (0.52-9.75)	0.17 (0.02-1.63)	0.48 (0.16-1.45)	0.36 (0.07-1.88)	1.30 (0.43-3.95)	1.03 (0.34-3.12)	0.92 (0.16-5.42)
Race (White)	0.86 (0.07-10.09)	1.00 (omitted)	0.46 (0.08-2.51)	1.51 (0.13-17.75)	0.52 (0.08-3.37)	1.14 (0.18-7.33)	1.23 (0.10-14.88)
Short NF stay	11.37 (1.17-110.35)	10.93 (0.61-197.29)	2.41 (0.41-14.10)	3.48 (0.24-49.87)	0.53 (0.05-5.42)	2.68 (0.36-19.82)	1.00 (omitted)
Comorbidities (count)	0.90 (0.62-1.31)	0.74 (0.47-1.15)	1.10 (0.85-1.43)	**0.65 (0.42-0.99)****	1.09 (0.82-1.44)	0.79 (0.59-1.05)	0.65 (0.38-1.10)

* indicates p-value < 0.10
** indicates p-value < 0.05

specifically in the ability to transfer and dress. Larger studies are needed to further characterize our findings and to design interventions that can help overcome these long-term sequelae from COVID-19.

Funding: None
Disclosures: None

Antimicrobial Stewardship & Healthcare Epidemiology 2022;2(Suppl. S1):s41–s42
doi:10.1017/ash.2022.135

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

assessment of Vaccine Interest in Unvaccinated COVID-19–positive inpatients

Lisa Stancill; Lauren DiBiase and Emily Sickbert-Bennett Vavalle

Background: Although vaccine hesitancy has been an issue for many years, it has become a major point of contention in the effort to mitigate the COVID-19 pandemic. In August 2021, a large academic medical facility began capturing the vaccination status of admitted COVID-19–positive patients, as well as their interest in the COVID-19 vaccine. We performed a descriptive analysis on the characteristics of unvaccinated patients who contracted COVID-19 and their interest in receiving the COVID-19 vaccine. **Methods:** Patient history and physical (H&P) notes and demographic data were collected using the internal data warehouse sourced from the electronic medical record for all SARS-COV-2–positive inpatient admissions to UNC Medical Center and UNC Chatham from August 1, 2021, to January 11, 2022. Manual chart reviews of progress notes were completed for patients whose history was not recorded in the initial H&P. Demographic data were summarized by vaccine status overall and by interest in COVID-19 vaccine among unvaccinated patients. We performed χ^2 to determine demographic differences between the interested and uninterested unvaccinated groups. **Results:** In total, 536 patients were admitted with COVID-19 from August 1, 2021, to January 11, 2022. Of these, 15% were fully vaccinated (2 doses mRNA plus 1 dose J&J); 5.4% were partially vaccinated; 75.7% were unvaccinated; and 2.9% had an unknown vaccination status. Demographic characteristics are presented in Table 1. The most common demographics were consistent among the fully vaccinated and unvaccinated groups, with the exception of sex and age group (Table 1). For those whose interest data were available (n = 164), 34% were uninterested in receiving the COVID-19 vaccine. Importantly, race and age were statistically significantly different ($P <$ .05) between the unvaccinated interested and unvaccinated uninterested groups. **Conclusions:** Even after experiencing COVID-19 firsthand and being hospitalized, some people who remain uninterested in receiving the COVID-19 vaccine. This population had a statistically higher proportion of white and older individuals than the unvaccinated interested group. Recommendations from healthcare providers might not be effective in persuading this population to be vaccinated. Instead, grassroots alternatives might be more successful. Additional analysis should be considered on whether patients who expressed interest in COVID-19 vaccine received immunization.

Table 1.

	Fully Vaccinated (n=73)	Unvaccinated overall (n=349)	Unvaccinated uninterested (n=56)	Unvaccinated Interested (n=108)
White	71.20%	59.30%	80.40%	55.60%
Married	34.30%	55.90%	53.60%	50.90%
Female	58.90%	49.90%	58.90%	46.30%
Age 25-49	17.80%	40.40%	19.60%	42.60%
Age 65+	56.20%	24.60%	53.40%	16.70%
Hispanic/Latino	8.20%	18.60%	3.60%	22.20%

Funding: None
Disclosures: None

Antimicrobial Stewardship & Healthcare Epidemiology 2022;2(Suppl. S1):s42
doi:10.1017/ash.2022.136

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

Stay home, save lives: Characterizing sickness presenteeism and motives among healthcare personnel in the COVID-19 pandemic

Amanda Brown Marusiak; David Weber; Cynthia Culbreth; Erica Pettigrew; Lisa Stancill and Emily Sickbert-Bennett

Background: Working while ill, or presenteeism, has been documented at substantial levels among healthcare personnel (HCP) along with its consequences for both patient and HCP safety. Limited literature has been published on HCP presenteeism during the COVID-19 pandemic, and specific motivations for this behavior are not well described. Understanding both individual and systemic factors that contribute to presenteeism is key to reducing respiratory illness transmission in the healthcare setting. We characterized the frequency of and motivations for presenteeism in the workforce of a large academic medical center during the COVID-19 pandemic. **Method:** We deployed a voluntary, anonymous electronic survey to HCP at University of North Carolina (UNC) Medical Center in December 2021, which was approved by the UNC Institutional Review Board. We received 591 responses recruited through employee newsletters. Respondents recounted their frequency of presenteeism since March 2020, defined as coming to work feeling feverish plus cough and/or sore throat. In total, 24.6% reported presenteeism at least once, with 8.1% reporting twice and 5.3% 3 or more times. Asking more generally about any symptoms while working, the following were most common: headache (26%), sinus congestion (20%), sore throat (13%), cough (13%), and muscle aches (9.3%). **Results:** Motivations for presenteeism fell broadly into 4 categories: (1) perception of low risk for COVID-19 infection, (2) concerns about workplace culture and operations, (3) issues with sick leave, and (4) concerns about employment record and status. Among HCP reporting at least 1 instance, the most common motivations for presenteeism included feeling low risk for COVID-19 infection due to mild symptoms (59.9%), being vaccinated (50.6%), avoiding increasing colleagues' workload (48.3%), avoiding employment record impact (39.6%), and saving sick days for other purposes (37.9%). Asked to identify a primary motivation, 40.3% reported feeling low risk for COVID-19 infection due to mild symptoms or vaccination, 21.2% reported a workplace culture issue (ie, increasing colleague workload, perception of weakness, responsibility for patients), 20.6% reported sick leave availability and use (including difficulty finding coverage) and 17.8% reported employment record ramifications including termination. **Conclusions:** This survey coincided with the onset of the SARS-CoV-2 o (omicron) variant locally, and as such, risk perceptions and motivations for presenteeism may have changed. Responses were self-reported and generalizability is limited. Still, these results highlight the importance of risk messaging and demonstrate the many factors to be considered as potential presenteeism motivators. Mitigating these drivers is particularly critical during high-risk times such as pandemics or seasonal peaks of respiratory illness.

Funding: None
Disclosures: None

Antimicrobial Stewardship & Healthcare Epidemiology 2022;2(Suppl. S1):s42
doi:10.1017/ash.2022.137

https://doi.org/10.1017/ash.2022.136 Published online by Cambridge University Press