

residual chlorine); 63.1% used specific tests for *Legionella*; and 35.6% performed heterotrophic plate counts (HPCs). We analyzed new, 2018 hospital survey data to assess further progress toward meeting CMS requirements for WMPs. **Methods:** We analyzed 2018 NHSN Annual Hospital Survey responses for facilities that reported on WMPs in 2017. Responses included information regarding risk assessments for *Legionella* and other waterborne pathogens as well as details regarding WMP teams and water-monitoring practices. WMP team members were categorized as administrative (hospital administrator, compliance officer, risk or quality management), epidemiology or infection control (epidemiologist or infection preventionist, other clinical), or environmental or facilities (consultant, facility manager or engineer, equipment or chemical supplier, maintenance). Statistical significance was assessed using the McNemar test, where appropriate. **Results:** Of hospitals reporting on WMPs in 2017, 4,087 of 4,929 (83%) responded again in 2018. The proportion of facilities that reported having a WMP increased from 3,258 of 4,087 (79.7%) in 2017 to 3,647 of 4,087 (89.2%) in 2018 ($P < .0001$). Of the 3,647 hospitals that reported having a WMP in 2018, 95.9% had conducted a risk assessment for waterborne pathogens; 67.3% of these facilities had most recently done so within 1 year of the survey. WMP teams had representation from environmental or facilities staff at 98.8% of hospitals, epidemiology or infection control staff at 89.8% of hospitals, and administrative staff at 71.7% of hospitals. Of facilities with WMPs in 2018, 90.5% reported regular monitoring of water temperature, 72.2% disinfectant, 67.4% tests for *Legionella*, and 48.8% HPCs. **Conclusions:** More hospitals reported having a WMP in 2018 than 2017. However, ~1 in 10 respondents lacked a WMP. Differences in water monitoring practices across facilities potentially reflect a lack of standardization in how WMPs are implemented. Some hospital WMPs do not incorporate routine monitoring of water temperature and disinfectant, which is a basic practice. CDC continues to develop tools, resources, and training to support facility WMP teams in meeting CMS requirements and protecting patients from water-associated pathogens.

Funding: None

Disclosures: None

Doi:[10.1017/ice.2020.577](https://doi.org/10.1017/ice.2020.577)

Presentation Type:

Late Breaker Poster

Communications and Screening for 2019 Novel Coronavirus at a Tertiary-Care Medical Center

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Background: In December of 2019, the World Health Organization reported a novel coronavirus (severe acute respiratory coronavirus virus 2 [SARS-CoV-2]) causing severe respiratory illness originating in Wuhan, China. Since then, an increasing number of cases and the confirmation of human-to-human transmission has led to the need to develop a communication campaign at our institution. We describe the impact of the communication campaign on the number of calls received and describe patterns of calls during the early stages of our response to this emerging infection. **Methods:** The University of Iowa Hospitals & Clinics is an 811-bed academic

medical center with >200 outpatient clinics. In response to the coronavirus disease 2019 (COVID-19) outbreak, we launched a communications campaign on January 17, 2020. Initial communications included email updates to staff and a dedicated COVID-19 webpage with up-to-date information. Subsequently, we developed an electronic screening tool to guide a risk assessment during patient check in. The screening tool identifies travel to China in the past 14 days and the presence of symptoms defined as fever >37.7°C plus cough or difficulty breathing. The screening tool was activated on January 24, 2020. In addition, university staff contacted each student whose primary residence record included Hubei Province, China. Students were provided with medical contact information, signs and symptoms to monitor for, and a thermometer. **Results:** During the first 5 days of the campaign, 3 calls were related to COVID-19. The number of calls increased to 18 in the 5 days following the implementation of the electronic screening tool. Of the 21 calls received to date, 8 calls (38%) were generated due to the electronic travel screen, 4 calls (19%) were due to a positive coronavirus result in a multiplex respiratory panel, 4 calls (19%) were related to provider assessment only (without an electronic screening trigger), and 2 calls (10%) sought additional information following the viewing of the web-based communication campaign. Moreover, 3 calls (14%) were for people without travel history but with respiratory symptoms and contact with a person with recent travel to China. Among those reporting symptoms after travel to China, mean time since arrival to the United States was 2.7 days (range, 0–11 days). **Conclusion:** The COVID-19 outbreak is evolving, and providing up to date information is challenging. Implementing an electronic screening tool helped providers assess patients and direct questions to infection prevention professionals. Analyzing the types of calls received helped tailor messaging to frontline staff.

Funding: None

Disclosures: None

Doi:[10.1017/ice.2020.578](https://doi.org/10.1017/ice.2020.578)

Presentation Type:

Late Breaker Poster

Effectiveness of Annual Flu Vaccination Until Week Four of the 2019–2020 Season

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