between SR and non-SR hospitals. We also identified isolate characteristics associated with AST reporting in SR hospitals.

**Results.** Among 242 and 185 hospitals reported ≥ 30 isolates, many showed patterns of SR (Figure 1). Of 437 and 425 hospitals reported ≥ 1 isolate, only 112 (26%) and 152 (36%) routinely reported AST results for all group A agents for EB and SA, respectively. For EB, 345 (79%) hospitals routinely reported AST results for ciprofloxacin or levofloxacin, although both are group B agents. For SA, 324 (76%) routinely reported vancomycin (Figure 2). Antibiograms for many agents differed between SR and non-SR hospitals (Figure 3, 4). In SR hospitals, non-susceptibility to narrower-spectrum drugs, patient location, age, and some species among EB were associated with AST reporting.

**Conclusion.** AST results reporting vary across hospitals and agents, and CLSI’s SR standards are used inconsistently. For AR surveillance, complete reporting calls for solutions that bypass SR. In the meantime, SR should be taken into account in national AR benchmarking.

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1609. Using a Novel Rapid Test to Investigate a Multistate Outbreak of Coccidioidomycosis Among US Residents Returning From Mission Trips in Baja California, Mexico, June–July, 2018

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**Background.** In August 2018, New York City health authorities notified CDC of two students with pneumonia and rash following mission trips to Mexico. Send-out Coccidioides serology tests took 7 days for results to return. Both students and five additional travelers from four states were diagnosed with coccidioidomycosis. A seroepidemiologic survey implicated soil-disturbing activities at a single site as a likely source. Given the time to diagnosis observed, we examined the use of a novel one-hour lateral flow assay (LFA).

**Methods.** We interviewed and collected sera from people who traveled with seven case-patients during June–July 2018 and performed LFA, enzyme immunoassay (EIA), and immunodiffusion (ID). We asked travelers about exposures and symptoms and compared test results with reports of ≥ 1 coccidioidomycosis symptom(s) within 6 weeks of travel.

**Results.** Of 133 travelers, we interviewed 108 (81%) and collected sera from 75 (56%). Majority were male teenagers. One-third (34%, 37/108) reported symptoms,
and of those, 43% (16/37) sought healthcare. Four were hospitalized, including one in intensive care, for a median of 7 days (range 3–12). Only six (6%) had previously heard of coccidioidomycosis. One-third (32%, 24/75) tested LFA positive, 10 (13%, 10/75) EIA positive, and eight (11%, 8/75) ID positive. Seventy-one percent (17/24) with positive LFA reported symptoms, compared with 83% (10/12) with positive EIA, 100% (10/10) with positive ID, and 31% (16/51) with negative LFA. Of 51 travelers with negative LFA, we observed one positive EIA and no positive ID.

Conclusion. In this outbreak that resulted in a high attack rate and prolonged hospitalizations, the rapid one-hour LFA appeared as a useful screening tool compared with a 24 hour CD test which took at least 7 days to return. The proportion of symptomatic LFA-positive travelers was nearly as high as for those with positive EIA, and we observed agreement with EIA and ID-negative results. Whether 12 people with positive LFA but negative EIA and ID truly had infection is unclear. Further evaluation to examine sensitivity and specificity of LFA are needed. Additionally, greater education is needed for groups traveling to coccidioidomycosis-endemic areas.

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1610. Implementation of Clinical Care Pathway Reduces Measles Exposures During Outbreak in New York
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Background. The United States is currently experiencing the largest measles outbreak since 1994. The New York outbreak started in October 2018 in several communities with low immunization rates for measles. Our institution is a referral center for the Hudson Valley and New York City. Failure to immediately recognize the disease early in the outbreak resulted in several exposure investigations and significant expenditure of time and resources. With evidence of ongoing transmission in local communities, we initiated a multi-pronged approach to recognize and limit potential measles exposures.

Methods. We developed a clinical pathway to alert Emergency Department (ED) staff and local Emergency Medical Service (EMS) agencies to the signs and symptoms of measles and provided steps for isolation, care, and testing for patients with possible measles. The ED staff and EMS personnel were educated in meetings and by posters, emails, and huddles. Reports of cases were made to infection control in real time, and local Departments of Health (DOH) were subsequently notified of suspected cases and exposures. We describe data pre- and post-pathway implementation. Chi-square was used to compare the number of patients requiring contact investigations for staff and patient exposures pre- and post-pathway implementation.

Results. From October 2018 through April 2019, 31 patients were evaluated for measles. Measles was diagnosed in 15 patients (1 adult, 14 children). Eight patients were admitted to the hospital, 3 required Pediatric ICU care. Pre-pathway implementation, 2 out of 9 (22%) evaluated patients resulted in exposure investigations; post implementation, 1 out of 22 (4.5%) evaluated patients required an exposure investigation (P = 0.18). The investigations conducted by our infection control department included 153 patients, 141 pre-pathway vs. 12 post-pathway. Nine patients required prophylaxis with immunoglobulin, and 10 patients received MMIR vaccine as prophylaxis. No exposures resulted in clinical cases of measles.

Conclusion. Implementation of a clinical pathway to recognize and isolate suspected measles cases and ED staff and EMS personnel resulted in reduced exposures and improvement in communication with Infection Control and local DOH.

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1611. Interventions to Decrease the Absolute Number of Individuals Not Immune to Measles at Princeton University (PU)
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Background. PU’s dormitories house ~100% of undergraduate and ~70% of graduate students. MMR is required for all students by NJ law, allowing for medical and religious exemptions (RE). Information on immunization requirements is widely available and accessible. If a student is found not compliant, measures include monetary fines, class registration holds, and contact by residential staff. Visiting short-term students are required to submit immunization records, but, due to rolling matriculation dates, enforcement measures may not be applicable. In the fall of 2018, a measles outbreak was reported close to campus. We sought to engage all students not immune to measles with proactive messaging.

Methods. Starting on December 3, 2018, the electronic health record (EHR) was used to generate a weekly report of active students not immune to measles following the CDC’s immunity criteria. Notifications and education material were sent via secure messengers and/or email to students with no immunization data were provided instructions on record submission. Reminders were sent to those due for second MMR. Students with RE were offered blood tests for measles immunity. Alerts were placed in the EHR of all non-immune students so every encounter would serve as reminder. Student travelers on PU sponsored trips were informed about measles outbreaks and, often, MMR became a trip requirement.

Results. On December 3, 2018, 84 students were measles non-immune: 2 with medical and 23 with RE; 59 lacking second MMR or with no immunization data. The 23 RE became 24 when a student in absentia returned. Since, 3 of the students with RE had blood tests revealing measles immunity; 2 received MMR to travel; 3 decided that their RE was not current. On 4/22/19, there were 18 students lacking second MMR or with no immunization data, most of them new visiting students. Overall, 57% reduction of absolute number of measles non-immune students.

Conclusion. This community intervention shows that students who remained measles non-immune despite the regular immunization compliance activities, could become compliant through active messaging, education and continued engagement. Additionally, greater education is needed for patients traveling to coccidioidomycosis-endemic areas. 

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