potent in vitro and in vivo activity against B. anthracis. This project evaluated the in vitro activity of omadacycline against a larger set of B. anthracis strains across two laboratories.

**Methods.** Methods: Antibiotic susceptibility testing followed Clinical Laboratory Standard Institute methods to construct a collection of 53 B. anthracis strains at the University of Florida (UF) and 50 B. anthracis strains at MRIGlobal, representing human and animal isolates from North America, Africa, Europe, Asia, and Australia. Minimum inhibitory concentrations (MICs) for omadacycline and comparator at both sites (doxycycline, ciprofloxacin, levofloxacin, moxifloxacin) were determined by broth microdilution.

**Results.** Results: In the UF study, omadacycline demonstrated an MIC50 of 0.015 mg/L and an MIC90 of 0.03 mg/L against B. anthracis. Omadacycline MIC values were equal to or lower than doxycycline. In the MRIGlobal study, omadacycline demonstrated an MIC50 of 0.06 mg/L and an MIC90 of 0.06 mg/L (Table 1). All comparator MIC values were within ranges previously observed against these strains. Against a ciprofloxacin-resistant strain (MIC = 2 mg/L), omadacycline had an MIC value of 0.015 mg/L against a doxycycline-resistant strain (MIC = 4 mg/L), omadacycline had an MIC value of 0.06 mg/L. Reproducibility was observed between the 2 laboratories for omadacycline in vitro activity against B. anthracis (Table 2).

**Conclusion.** Based on the in vitro activity in both studies, omadacycline has the potential to be effective in treating anthrax infection. Reproducibility of omadacycline in vitro activity against B. anthracis was observed at 2 independent study sites.

**Disclosures.** Alisa W. Serio, PhD, Paratek Pharmaceuticals, Inc. (Employee, Shareholder) Diane M. Anastasiou, BA, Paratek Pharmaceuticals, Inc. (Consultant)

### 1209. The Evolving Nature of Syndromic Surveillance During the COVID-19 Pandemic in Massachusetts

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**Session:** P-71. Public Health

**Background.** We developed a syndromic algorithm for COVID-19-like illness (CLI) to provide supplementary surveillance data on COVID-19 activity.

**Methods.** The CLI algorithm was developed using the Electronic Medical Record Support for Public Health platform (eshealth.org) and data from five clinical practice groups in Massachusetts that collectively care for 25% of the state’s population. Signs and symptoms of CLI were identified using ECD-10 diagnosis codes and measured temperature.

The algorithm originally included three categories: Category 1 required codes for coronavirus infection and lower respiratory tract infections (LRTI); Category 2 required an LRTI-related diagnosis and fever; Category 3 required an upper or lower RTI and fever.

The three categories mirrored statewide laboratory-confirmed case trends during spring and summer 2020 but did not detect the increase in late fall. We hypothesized this was due to the requirements for fever and LRTI. Therefore, we added three new categories defined by milder symptoms without fever: Category 4 requires LRTI-related diagnoses only; Category 5 requires upper or lower RTI or olfactory/taste disorders; and Category 6 requires at least one sign of CLI not identified by another category.

**Results.** The six-category algorithm detected the initial surge in April 2020, the summer lull, and the second surge in late fall (see figure). Category 1 cases were not identified until mid-March, which coincides with the first laboratory-confirmed cases in Massachusetts. Categories 2 and 3, which required fever, were prominent during the initial surge but declined over time. Category 5, the broadest category, declined during February and March 2020, likely capturing the end of the influenza season, and successfully detected the spring surge and fall resurgence.

**Conclusion.** A syndromic definition that included mild upper RTI and olfactory/taste disorders, with or without fever or LRTI, mirrored changes in laboratory-confirmed COVID-19 cases better than definitions that required fever and LRTI. This suggests a shift in medically attended care and/or coding practices during initial vs subsequent surges of COVID-19, and the importance of using a broad definition of CLI for ongoing surveillance.

**Disclosures.** Michael Klompas, MD, MPH, UpToDate (Other Financial or Material Support, Chapter Author)

### 1210. Recommendations for Screening and Diagnosis of Chagas Disease in the United States

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**Session:** P-71. Public Health

**Background.** Over 300,000 people in the United States are infected with Trypanosoma cruzi, the protozoan parasite that causes Chagas disease (CD). Only about 1% of estimated U.S. cases have been identified, usually through blood donor screening, and most people are unaware they have the infection. Screening is critical for increasing case detection and ensuring patients receive appropriate and timely care, but awareness of CD management strategies among healthcare providers is low. Diagnostic guidelines for CD in the United States are needed to increase provider-directed screening and diagnosis.

**Methods.** Screening recommendations were prepared by the U.S. Chagas Diagnosing group, which consists of clinicians, researchers, and public health experts involved in CD programs. The group agreed on six main questions based on the PICO method (Population, Intervention, Comparison, and Outcome). Subgroups discussed each and proposed initial recommendations, which were then shared and validated within the larger group. The recommendations used the GRADE methodology, assigning two sets of ratings: 1) strength of the recommendation, and 2) quality of the evidence.

**Results.** The group recommended screening anyone who was born or lived for >6 months in South America, Central America and Mexico (Figure 1). Recent community-based studies found a prevalence of 1-3.8% in this population. Within this population, having a family member with CD, or having clinical conditions suggestive of CD, including electrocardiographic abnormalities, suggest an elevated risk. Screening women of childbearing age and infants born to seropositive women is important for preventing congenital transmission. Test performance may vary depending on several factors, including whether patients are from South America, Central America or Mexico. Confirmation therefore requires positive results on at least two serological tests based on different antigens or formats, in line with Pan American Health Organization (PAHO) recommendations. Once CD is confirmed, patients should receive an electrocardiogram and echocardiogram to monitor for de

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### 1211. Incidence of All-Cause Community-Acquired Pneumonia in Ontario and British Columbia, Canada, 2002-2018: a Canadian Immunization Research (CIR) study

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Community-acquired pneumonia (CAP) causes substantial morbidity and mortality. There is a lack of data on the comprehensive burden of CAP across the life span in Canada. We estimated the incidence of all-cause CAP in all age groups in Ontario and British Columbia (BC), Canada.

Methods. We identified hospitalized and outpatient CAP episodes from the Discharge Abstract Database (DAD) and physician billing claims databases (Ontario Health Insurance Plan in Ontario and Medical Services Plan in BC) in both provinces. The National Ambulatory Care Reporting System was used to identify CAP episodes from emergency department visits in Ontario. CAP recorded with a primary or secondary diagnosis was identified using International Classification of Diseases 9 (480–486), 10 (100, 110), 11, 12–18, 136, 137, 138, 139, 140, 141, 142, 143, 144) • Abstracts

Results. Ontario had 3,607,186 CAP episodes from 2005–2015 with a mean annual incidence of 2,801 (95% confidence interval [CI]: 2,748, 2,854) per 100,000 population; incidence declined from 3,077/100,000 in 2005 to 2,604/100,000 in 2010 before increasing to 2,843/100,000 in 2018. BC had 1,146,172 CAP episodes from 2002–2008, with a mean annual incidence of 2,146 (95% CI: 2,105, 2,189); the incidence increased from 2,065/100,000 in 2002 to 2,189/100,000 in 2008. A high incidence of CAP was observed in children aged 0–4 years and older adults, particularly in adults aged ≥85 years in both provinces across all PCV program periods (Figure 1).

Conclusion. CAP continues to be a public health burden in Canada despite publicly funded pneumococcal vaccination programs. Ontario seems to have higher CAP burden than British Columbia that warrants further investigation. The youngest cohort (children aged 0–4 years and older adults, particularly in adults aged ≥85 years) according to routine childhood pneumococcal conjugate vaccine (PCV) immunization programs from 2005–2018 in Ontario and from 2002–2018 in BC. Poisson regression models were fitted with population denominators from Statistics Canada to estimate the incidence rates.

Disclosures. No reported disclosures

1213. Vaccine Uptake Amongst Participants in the North Carolina COVID-19 Community Research Partnership Who Were Initially Receptive or Hesitant to Receive a COVID-19 Vaccine

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Methods. The Community COVID-19 Research Partnership (CCRP) is a large prospective study exploring COVID-19 epidemiology and heterogeneity in participants from mid-Atlantic and Southern States. All participants complete an online daily survey where they are asked questions about COVID-like symptoms, infections, and their vaccination status. In addition to the daily survey, in December 2020, we implemented a short online cross-sectional survey questioning NC participants on whether they intended to be vaccinated. After completing the cross-sectional survey, we used daily survey data through 15 May 2021 to see if participants reported receiving vaccine. Unvaccinated participants who did not complete the daily survey 30 days or more prior to 15 May 2021 were excluded.

Results. 18,874 participants completed the cross-sectional survey and reported vaccination status. Of these participants, 90% were white, 68% were female, 26% were healthcare workers, and 2% self-reported COVID-19 diagnosis. The median age was 54 years (IQR: 41 – 65), 79%, 13%, and 2% answered yes, unsure, no, and prefer not to answer, respectively, about intention to be vaccinated (Table). 99% of the participants who intended to receive the COVID-19 vaccine reporting being vaccinated. Those who were unsure or intended not to get vaccinated had vaccination rates of 86% and 53%, respectively. 78% of the participants who preferred not to answer were vaccinated.

Table. Vaccine intent versus vaccination status – COVID-19 Community Research Partnership, North Carolina, December 2020 – May 2021

| Vaccine Intent | Vaccinated (n=17,461, % row) | Non-vaccinated (n=4,413, % row) | Overall (N=21,874, %) |
|---------------|-------------------------------|-------------------------------|-----------------------|
| Yes           | 14,582 (89.5%)                | 228 (1.5%)                    | 14,810 (78.5%)        |
| Unsure        | 1,909 (80.3%)                 | 474 (17.9%)                   | 2,383 (12.7%)         |
| No            | 715 (52.7%)                   | 643 (47.3%)                   | 1,358 (7.2%)          |
| Prefer not to answer | 235 (17.6%)               | 68 (22.4%)                    | 303 (1.4%)            |