

with complete recovery in all cases. **Conclusions:** We concluded that timely detection of a norovirus outbreak in a healthcare facility is imperative for effective infection control, especially in a multibed-room setting, because of the extended viral shedding in children and the transmission route that included aerosolized viral particles in vomitus. Molecular methods offer a rapid and definitive way to establish etiology, but these tests may not be accessible. Direct contact with infected children and contaminated surfaces and patient-care items were relevant risk factors in this outbreak (which involved both patients and healthcare workers) and contributed with its length.

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Poster Presentation

Successful Diagnostic Stewardship for *Clostridioides difficile* Testing in Pediatrics

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Background: As many as 40% of infants aged ≤ 12 months and 10%–28% of children aged 13–24 months are colonized by *Clostridioides difficile*. The IDSA and the SHEA recommend that testing should never be routinely recommended for infants ≤ 12 months of age and should not be routinely performed for children 1–2 years of age unless other causes are excluded. We report implementation of *C. difficile* diagnostic stewardship at 2 children's hospitals. **Methods:** We implemented age-based restrictions for *C. difficile* testing at hospital A (~200-bed, free-standing, children's hospital) and hospital B (~100-bed children's hospital within a larger hospital). Both sites are part of the same multicampus institution, and both used nucleic acid amplification testing to detect *C. difficile* throughout the study. In May 2018, we implemented an electronic order set for *C. difficile* that provided alerts to avoid testing young infants and patients with recent use of laxatives, stool softeners, or enemas, but providers could order *C. difficile* testing at their discretion. In October 2018, we implemented a more restrictive diagnostic stewardship algorithm for *C. difficile*. No testing was allowed for infants aged ≤ 12 months. Approval pediatric infectious diseases staff was required to test children aged 13–24 months. Pathology resident approval was required to test children aged ≥ 24 months who had received laxatives, stool softeners, or enemas within ≤ 24 hours. Clinical microbiology laboratory supervisors reinforced rejection of nondiarrheal stool specimens for testing. Providers at both campuses were informed about the new testing guidelines by e-mail. We compared the number of tests sent and positive cases of healthcare facility-onset *C. difficile* (HO-CDI) by age strata before and after the implementation of the restrictive testing algorithm. **Results:** After the intervention, the number of tests in infants significantly declined; 2 infants aged ≤ 12 months and 4 infants aged 13–24 months were tested for *C. difficile* (Table). After the intervention, the number of tests per month

declined at hospital A, as did the number of HO-CDI cases at both hospitals. Rejections of nondiarrheal stools significantly increased after the intervention ($P < .001$). **Conclusions:** *C. difficile* diagnostic stewardship for children was successfully implemented using a rule-based alert system in the electronic health record. This intervention was associated with a reduced number of tests sent and cases of HO-CDI. This strategy was cost-saving and prevented misdiagnosis, unnecessary antibiotic therapy, and overestimation of HO-CDI rates.

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Successful Response to a Measles Exposure in a Pediatric Clinic Utilizing Measles, Mumps, and Rubella (MMR) Vaccine Prophylaxis

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Background: To be effective, postexposure prophylaxis (PEP) must be administered promptly after measles exposure. MMR vaccine is recommended within 72 hours of exposure. Immunoglobulin (IG) is recommended for infants aged < 6 –12 months, susceptible individuals, and severely immunocompromised people within 6 days of exposure. MMR vaccine is readily available, less expensive, and more easily administered than IG, and it provides long-term immunity. However, due to delays in diagnosis of measles cases, it is often not possible to administer MMR PEP to contacts within 72 hours. We describe an unvaccinated infant with fever and rash after recent international travel who presented to a pediatric outpatient clinic. Measles was promptly suspected, and specimens were collected for measles polymerase chain reaction (PCR) testing at the California Department of Public Health (CDPH) laboratory. PCR results confirming measles were obtained within 24 hours of the patient visit. **Methods:** A multidisciplinary team of medical, employee health, nursing, pharmacy and infection prevention staff was assembled. Electronic health records (EHRs) were used to identify exposed patients based on registration times, as well as to determine their MMR vaccination status and to identify any immunocompromising conditions. Exposed patients were notified either by e-mail or phone. Adult caretakers were interviewed to determine who accompanied the child to the clinic. Caretakers were questioned regarding their MMR vaccination status and the high risk to accompanying persons. The use of EHRs with data integration from other healthcare system helped validate and supplement vaccine statuses and medical histories of exposed family members. **Results:** In total, 128 persons were exposed; 31 staff (24%), 46 patients (36%) and 51 family members (40%). All 128 patients (100%) and family members were notified within 24 hours of case confirmation, and 44 of 128 (34%) required PEP. All staff had documentation of measles immune status. However, 1 of 31 staff (3%) needed PEP due to immunosuppression. MMR vaccine was given to 35 of 36 eligible persons (97%), except for 1 sibling who received IG due to delay in exposure identification. An additional 8 of 44 persons (18%) required IG due to age or immunosuppression. There were no secondary cases. **Conclusions:** MMR vaccine was used as primary PEP due to prompt suspicion for measles, early laboratory confirmation, and swift coordinated response using a multidisciplinary team. Leveraging EHRs helped rapidly