Table 1. Potentially achievable vs. reported vaccination coverage and 95% confidence intervals for ≥2 doses Hepa by age 24 months, by selected socio-demographic factors, for children born in 2015, National Immunization Survey-Child, United States

| Factors                          | Reporting Coverage % | Potential Achievable Coverage % (95% CI) |
|---------------------------------|----------------------|----------------------------------------|
| **National**                    |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Children health insurance status** |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Children race/ethnicity**     |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Residence in a metropolitan statistical area** |                  |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Mother’s education level**    |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Mother’s marital status**     |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Mother’s age**                |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Child’s birth order status**  |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Vaccination provider type**   |                      |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Number of vaccination providers for child** |                |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |
| **Number of children in household** |                    |                                        |
| Any Medicaid                    | 68.2 (67.4–68.7)     | 83.7 (82.9–84.6)                       |
| Any Other                       | 76.3 (75.5–77.1)     | 86.6 (85.8–87.5)                       |

Note: All comparisons between potentially achievable vs. reported vaccination coverage are significant at P < 0.001.

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284. Using Epidemiologic Investigation and Viral Sequencing to Describe and Provide Public Health Response to an Outbreak (OB) of Acute Hepatitis A Virus Infection (HAV) in the San Fernando Valley (SFV), California

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**Session:** 41. Hepatitis

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**Background.** California (CA) experienced a large hepatitis A OB in 2017–2018 associated with genotype IB strains, primarily among persons experiencing homelessness and/or using drugs. In October and November 2018, we identified a cluster of three HAV cases among persons linked by drug use and homelessness in the San Fernando Valley (SFV), CA. We describe how molecular epidemiologic methods linked an additional four OB cases that lived or were associated with a senior housing facility (SHF) and guided hepatitis A vaccine outreach.

**Methods.** Suspect HAV cases were reported to DPH through provider and electronic lab reports with positive serum HAV IgM and in a 2 mile area in SFV. A case report and extended interview were completed on suspects to assess risk factors associated with HAV transmission and contacts. HAV IgM positive serum specimens were sent to the CA DPH Viral and Rickettsial Disease Laboratory for HAV RNA detection and molecular sequencing. Extracted nucleic acids were amplified using nested, RT-PCR targeting the VP1-P2B region, and a 315 nt fragment was sequenced using Sanger sequencing. Contacts to cases received HAV prophylaxis and HAV vaccine outreach occurred in at-risk settings.

**Results.** We identified 7 HAV cases with symptom onsets from October 2018 to January 2019. All 7 cases had positive serum HAV IgM, ≥ALT 3 X normal or had a specimen matching the OB strain and were epi-linked to a case previously identified. Of 3 homeless cases, 2 had genotype IB, CA cluster A; one specimen was unavailable. Four additional SHF cases were 2 residents, one male, and one visitor. Among the 4 cases associated with the SHF, three had genotype IB, CA cluster A; one specimen was unavailable. Two elderly residents reported severe fatigue, without nausea, diarrhea and vomiting. Among the 3 homeless individuals, no direct link to the SHF was established. In total, 948 HAV vaccines were provided at the SFH, homeless shelters and other settings. HAV vaccine coverage for SHF residents and food handlers was 70% and 62%, respectively.

**Conclusion.** Two clusters of HAV cases were identified among homeless persons and individuals associated with an SHF were linked through a common HAV genotype. Two elderly cases had atypical symptoms that may not have been confirmed as HAV without viral sequencing and prompted vaccine campaign to prevent additional HAV cases.

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285. Fibrosis Progression and Clinical Outcomes in HCV/HBV Coinfected Persons in the ERCHIVES Cohort

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**Background.** Progression of liver disease and clinical outcomes in HCV/HBV coinfected persons and how they differ from HCV monoinfected persons and HCV infected persons with resolved HVB infection are not well characterized. We compared incidence of cirrhosis, hepatic decompensation and overall mortality in these three groups.

**Methods.** Using the Electronically Retrieved Cohort of HCV-infected Veterans (ERCHIVES), we identified those with HCV infection only, HCV/HBV coinfection (HbsAg or HBV DNA or both positive) or HCV with resolved HBV (HbsAb+ in absence of HbsAg or HBV DNA positivity). We excluded those with HCV coinfection or hepatocellular carcinoma at or before baseline, and those who received any HCV or HBV treatment. Incident rates (95% CI) were determined for cirrhosis, first hepatic decompensation event and overall mortality in these three groups.

**Results.** We identified 60,368 HCV monoinfected (Gp A), 151 HCV/HBV coinfected (Gp B) and 19,802 HCV infected with resolved HBV infection (Gp C). Mean age was 61.0, 60.9 and 63.0 years in the three groups and 96.5%, 96.0%, and 97.9% were males. Median baseline FIB-4 index was 2.0, 2.2, and 2.1, respectively. Incident cirrhosis (among those without cirrhosis at baseline) was increased 2- to 2.5-fold in HCV/HBV coinfected persons with baseline FIB-4 of 1.46–3.25. Hepatic decompensation and mortality were also increased several-fold in the HCV/HBV coinfected who had minimal or mild/moderate fibrosis at baseline. However, among those with cirrhosis at baseline, the difference was small among HCV/HBV coinfected and the other groups.

**Conclusion.** HCV/HBV coinfected persons with minimal or mild/moderate fibrosis at baseline have a much higher risk of developing cirrhosis, hepatic decompensation and mortality. However, once cirrhosis has is established, the difference is diminished. This underscores the need to intervene early when HCV/HBV coinfected persons still have minimal or mild/moderate fibrosis.

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