compared between the cohorts using a generalized linear model fit using a generalized estimating equation that accounted for repeated measures. Within each cohort, multivariable binary logistic regression was used to assess the association between participants' characteristics and multimorbidity.

Results. Cohort 1 had 198 participants, and Cohort 2 had 378 participants. Cohort 1 represented 33% of the 2006 clinic population, and Cohort 2 represented 54% of the 2016 clinic population. Less Cohort 2 participants were uninsured (5% vs. 22%, $P < 0.001$) and more had private insurance (44% vs. 26%, $P < 0.001$). The prevalence of multimorbidity was higher in Cohort 2 (28% vs 21%, $P < 0.001$). For Cohort 1, multimorbidity was less likely for those with private insurance (8%, adjusted Odds Ratio [aOR] 0.81, 95% Confidence Interval [CI] 0.69–0.90) compared with those with Medicare (32%). For Cohort 2, multimorbidity was more likely for those with incomes < 100% Federal Poverty Level (FPL; 34%) compared with those with incomes 101–250% FPL (27%, aOR 0.86, 95% CI 0.74–1.00) and 251–500% FPL (21%, aOR 0.78, 95% CI 0.64–0.95). For Cohort 2, multimorbidity was associated with female sex (40%, aOR 1.21, 95% CI 1.01–1.45) compared with male sex (24%).

Conclusion. Older PLWH represented an increasing proportion of the studied Southeastern clinic population. Multimorbidity prevalence was higher in 2016 compared with 2006. Insurance status was associated with multimorbidity for Cohort 1. For Cohort 2, incomes < 100% FPL and female sex were associated with increased likelihood of multimorbidity. Future research will need to assess the reasons for these disparities.

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352. Characteristics Associated with Pre-Frailty in Older People Living with HIV

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Background. Frailty is a concern among older people living with HIV (PLHIV). There is a paucity of research characterizing PLHIV who are at risk of becoming frail (pre-frailty). To investigate how HIV impacts older PLHIV in the United States, a new study called Aging with Dignity, Health, Optimism and Community (ADHOC) was launched at ten sites to collect self-reported data. This analysis uses data from ADHOC to identify factors associated with pre-frailty.

Methods. Pre-frailty was assessed using the Frailty Index for Elders (FIFE), where a score of zero indicated no frailty, 1–3 indicated pre-frailty, and 4–10 indicated frailty. A cross-sectional analysis was performed on 262 PLHIV (age 50+) to determine the association between pre-frailty and self-reported sociodemographic, health, and clinical indicators using bivariate analyses. Factors associated with pre-frailty were then included in a logistic regression analysis using backward selection.

Results. The average age of ADHOC participants was 59 years. Eighty-two percent were male, 66% were gay or lesbian, and 56% were white. Forty-seven percent were classified with pre-frailty, 26% with frailty, and 27% with no frailty. In bivariate analyses, pre-frailty was associated with depression, low cognitive function, depression, multiple comorbidities, low income, low social support and unemployment (Table 1). In the multiple logistic regression analysis, pre-frailty was associated with having low cognitive function (Odds Ratio [OR] 8.56, 95% Confidence Interval [CI]: 3.24–22.63), 4 or more comorbid conditions (OR 4.00, 95% CI: 2.23–7.06), and an income less than $50,000 (OR 2.70, 95% CI: 1.56–4.68) (Table 2).

Conclusion. This study shows that commonly collected clinical and sociodemographic metrics can help identify PLWH who are more likely to have pre-frailty. Early recognition of factors associated with pre-frailty among PLHIV may help to prevent progression to frailty. Understanding markers of increased risk for pre-frailty may help clinicians and health systems better target multi-modal interventions to prevent negative health outcomes associated with frailty.

Table 1. Factors associated with pre-frailty (independent risk ratios)

Variable	Risk Ratio	95% C.I.	
Depressed	3.88	1.57	9.61
Low cognitive function	3.53	1.54	8.07
Lonely	1.70	1.25	2.34
4 or more comorbid conditions	1.53	1.24	1.90
Live alone	1.50	1.04	2.17
Income less than $50,000	1.50	1.15	1.94
Low social support	1.62	1.05	2.50
Not close to friends	1.65	1.15	2.37
Not employed	1.35	1.02	1.78

Table 2. Factors associated with pre-frailty (logistic regression analysis)

Variable	Odds Ratio	95% C.I.	P-value
Low cognitive function	8.56	3.24 - 22.63	<0.001
4 or more comorbid conditions	4.00	2.23 - 7.06	<0.001
Income less than $50,000	2.70	1.56 - 4.68	<0.001

Pseudo $R^2 = 0.20$
n = 262

Disclosures. **All authors:** No reported disclosures.

353. A Comparison Study of Prevalence and Risk Factors for Nonalcoholic Fatty Liver Disease (NAFLD) and Nonalcoholic Steatohepatitis (NASH) by Transient Elastography (TE) in HIV-Infected Patients

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Background. There are limited data on the prevalence and risk factors of NAFLD and NASH in HIV-infected individuals receiving ART. A large study on this subject was presented at Glasgow 2018, from the University Hospital of Palermo (UHP).

Methods. We prospectively collected data on epidemiology, comorbidities, CD4, HIV virus load and ART from November 2017 to September 2018 in patients undergoing TE examination with Controlled Attenuation Parameter (CAP) in our HIV clinic at Saint Michael's Medical Center in Newark, NJ. We used the same parameters to define NAFLD and fibrosis severity that were used for the UHP (CAP >248 dB/m and TE > 7.1 Kpa). We present comparative data between those 2 cohorts.

Results. We enrolled 624 consecutive HIV-infected individuals (group 1) their baseline epidemiologic characteristics were not significantly different from the UHP cohort (group 2) for age and sex. Prevalence of NAFLD was 51.6% in group 1compared with 42.7% in group 2, and the prevalence of significant fibrosis in those with NAFLD was 31% in group 1, and 23% in group 2. The main differences we found between those 2 cohorts were race: group 1, 68% black and group 2, 87% White, incidence of Diabetes mellitus was 20% in group 1, and 6% in group 2, despite the fact that BMI was not significantly higher in group 1. Other important differences were the mean time on ART, it was 5 years longer for group 1. Finally, there was a trend for a higher incidence of hypertension, a lower percentage of patients with Virus load < 20 c/mL, a lower mean CD4 count, and a higher percentage of integrase strand transfer inhibitors current users in group1.

Conclusion. NAFLD prevalence is alarming high in patients with HIV disease, it is of utmost importance to understand its natural history, in order to prevent the potentially severe consequences of NASH. Our study suggests that a longer duration on ART might correlate with higher incidence of NAFLD, which would suggest better monitoring of liver health with new ART.

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354. Efficacy of Second-Generation Direct Acting Antivirals in the Setting of HCV/HIV Co-infection and Cirrhosis: A Review of Real-World Treatment Experiences

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Background. Patients co-infected with HIV and HCV represent a unique subpopulation with specific high-risk characteristics including increased transmission efficiency of HCV, higher HCV viral load and more rapid progression of liver disease when compared with mono-infected patients. Although virologic failure is rare in the direct acting antiviral (DAA) era, we have anecdotally observed a high rate of failure in our patients who are co-infected and have cirrhosis. Our objective was to evaluate the impact of cirrhosis on co-infected patients compared with co-infection without cirrhosis and mono-infected patients with cirrhosis as it relates to cure of HCV treated with DAAs.

Methods. A retrospective chart review was performed. Patients from UConn Health Infectious Diseases and Gastroenterology clinics and Hartford Hospital Comprehensive Liver Center treated January 1, 2014 through December 31, 2017 were included. Patients were grouped as follows: (1) HCV/HIV coinfected without cirrhosis, (2) HCV/HIV coinfected with cirrhosis, (3) HCV infected with cirrhosis. Data were analyzed in SAS, variables were compared by chi square analysis and Fishers Exact test to determine statistical significance.

Results. No differences in baseline characteristics were noted (Table 1). Cirrhotic patients were 63% of the total cohort. There was no statistical difference in the rates of sustained virologic response (SVR) among the 3 groups. The overall rate of SVR was 95%. SVR for patients with cirrhosis (co- and mono-infected) was 92%. All treatment failures ($n = 3$) in this cohort had cirrhosis. Among the 38 cirrhotic patients, 3 (8%) had treatment experience with DAAs. In contrast, none of the non-cirrhotic patients had prior DAAs. The use of protease inhibitors or ribavirin had no impact on cure; ribavirin was evenly distributed between the two groups with cirrhosis. SVR rates were lower with genotypes 2–4 as compared with genotype 1. No immunologic or virologic factors were correlated with SVR.

Conclusion. We found no differences in rates of SVR in coinfected patients with or without cirrhosis. However, all treatment failures were noted in patients with cirrhosis, and cirrhotic patients tended to have treatment experience with DAAs. Whether coinfected patients with cirrhosis should be managed differently will require additional study.