compared between the cohorts using a generalized linear model fit using a generalized estimating equation that accounted for repeated measures. Within each cohort, multi-variable 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 2, multimorbidity was less likely for those with private insurance (9%; 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.

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

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

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**Session:** 44. HIV Complications: Cardiovascular, Metabolic, and Other Complications

**Thursday, October 3, 2019: 12:15 PM**

**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 female, incomes < 100% FPL and female sex were associated with increased likelihood of multimorbidity. Future research will need to assess the reasons for these disparities.

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

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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**Session:** 45: HIV Complications: Hepatitis Co-Infections

**Thursday, October 3, 2019: 12:15 PM**

**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 patients with mono-infection. Although little is known about the direct acting antiviral (DAA) era, we have anecdotal 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-infected without cirrhosis and mono-infected patients with cirrhosis as it relates to cure of HIV treated with DAA.

**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 96%. 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 DAA. 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 DAA. Whether coinfected patients with cirrhosis should be managed differently will require additional study.

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