compared between the cohorts using a generalized linear model fit using a generalized linear model. 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 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 differences.

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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 58 years. Eighty-two percent were male, 66% were gay or lesbian, and 56% were white. Forty-seven percent were female, 66% were gay or lesbian, and 56% were white. The prevalence of multimorbidity was higher in Cohort 2 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 differences.

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

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

**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 epidemiologic characteristics were not significantly different from the UHP cohort (group 2) for age and sex. Prevalence of NAFLD was 51.6% in group 1 compared 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, 47% 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 median CD4 count, and a higher percentage of innate strand transfer inhibitors current users in group 1.

**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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355. Barriers for Hepatitis C Elimination in HIV/HCV Coinfected Patients

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Session: 45. HIV Complications: Hepatitis Co-Infections
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Background. Approximately 30% of people living with HIV are co-infected with Hepatitis C virus (HCV). HIV/HCV coinfection patients have faster progression to liver fibrosis, cirrhosis, and increased mortality, compared with monoinfected patients. Therefore, treatment in this population is a priority. The objective of this study was to develop an active program to reach HIV/HCV co-infected patients, with the goal to eliminate Hepatitis C in our local HIV clinic.

Methods. Beginning in December 2016, our clinic received State funds to support open access to treat HIV/HCV patients with direct antivirals (DAA). From December 2016 to May 2018, the process was based on primarily on physician referrals to treat HIV/HCV patients at our clinic, without an active intervention, and 50 patients were treated. Our active intervention during the second part was based on the identification of all untreated HIV/HCV patients and contacting them directly, to link them to care.

Results. A total of 462 HIV/HCV co-infected patients were identified who qualified for the state-sponsored treatment program. From June 1, 2018 to July 31, 2018, only 7 patients were linked to care and started on DAA. The four main identified reasons for not getting DAA therapy were: no show up to the clinic appointments, and their relationship to other STI screening and diagnosis in HIV+ MSM at an urban center.

Methods. Retrospective review of HCV and STI testing and diagnosis among HIV+ MSM outpatient sites. Demographics from local databases, clinical data from EPIC and chart review on select cases.

Results. 876 HIV+ MSM, median age 42, 80% virally suppressed. 850 (98.2%) had known HCV status. 36/850 (4.2%) HCV Antibody (Ab) at any point: 23 (2.7%) at baseline (6 dual MSM/IDU), 13 (1.5%) newly Ab+ (0 dual risk). 4/36 (11.1%) HCV RNA< 1 of baseline Ab+, 3 in newly Ab+. Among new Ab+’s, 7 asymptomatic, 6 symptomatic, most commonly high liver tests, 3/13 (15.4%) were persistently viremic requiring therapy: 614/827 (74.2%) HCV Ab- were retested 21, 260 (10.2%) >1x – average retetesting interval 13 months. Among 36 HCV Ab+’s, 0 had reinfection. Testing and new STIs by HCV status is in Table 1. 2/13 (15.4%) with new HCV were not tested for gonorrhea or chlamydia (G/C) at any site. Acute syphilis was more common in new HCV+ than HCV-’s (P > 0.02). HCV rescreening was higher in those tested for extragnatinal (EG) G/C vs. those not tested (Table 2), but up to 18.8% were not HCV retested despite EG testing done. 304/876 (34.7%) were ≤35 years of age. Testing and positive results for all four STIs were greater in those ≤35 (Table 3). Non-Hispanic (NH)-Black was the largest race/ethnicity and had the highest rate of new STIs except pharyngual chlamydia, rectal gonorrhea and acute syphilis (Table 4).

Conclusion. We found significant risk of HCV among HIV+ MSM in our cohort, with a prevalence of 2.7% and a 34-month incidence of 1.5%, with no reinfections. HIV+HCV Ab- MSM were frequently retested for HCV but missed opportunities among sexually active individuals lead to delayed diagnoses of acute infection. Unexplained elevation of liver tests in sexually active HIV+ MSM should prompt immediate HCV testing, and more HCV Ab testing is indicated as part of STI screening in this group. Awareness should be raised about risk of acute HCV with new syphilis, and there is room to improve EG G/C testing.