Background. Advances in HIV treatment changed the landscape of the epidemic from a fatal to a chronic disease. The number of patients living with HIV is expected to increase as they are living longer. Compared with the general population, older HIV-infected patients suffer additional comorbidities and often take several medications, leading to polypharmacy and drug interactions. Besides that the HIV population is aging, more patients are living longer and may want to access care for prevention. Furthermore, the HIV workforce is aging and retiring without a new generation of providers to replace them. There is a fundamental concern about the readiness of future physicians to care for the HIV population. In response to this anticipated workforce shortage, a HIV training program was established without a preliminary core curriculum in 2012. 

Methods. Two to three residents were recruited into the HIV training track each year. Residents have their continuity practice in the institution’s HIV Clinic and rotate on the inpatient HIV team each year. Otherwise, residents participate in all of the core rotation and curricular activities of the Primary Care Residency. The authors will (i) display the process of building the infrastructure of the HIV training program, (ii) describe the curriculum, and (iii) share the 5 years experiences and outcomes.

Results. The program enrolled a cohort of 11 residents between 2012 and 2017. Residents managed a panel of 30–40 HIV patients with diverse demographics. A medical record review revealed high performance measures in HIV and non-HIV conditions. 100% of eligible patients were on ART, 92% of patients were retained in care and 92% of those on ART had HIV viral suppression. In addition, all residents completed an HIV knowledge assessment test and showed 26% increase in their score at 1 year. There was 100% retention of residents and faculty. Residents and patients demonstrated high satisfaction with the program.

Conclusion. A novel HIV training track is feasible and can be successfully implemented. Expanding HIV-specific curricula within primary care residency programs can build workforce of providers to meaningfully care for the aging HIV population.

Disclosures. All authors: No reported disclosures.

600. To Study the Status of HIV Disclosure in Children and Adolescents Alok hemat Sr, MBBS, MD, CCST(UK) and Meenu Singh, MD, Paediatrics; Pediatric; PCIMED; Narayana Multanof Loka Hospital, New Delhi, India

Session: 62. HIV: Management and Clinical Outcomes
Thursday, October 4, 2018: 12:30 PM

Background. Disclosure to HIV-infected children regarding their diagnosis is important as expanding numbers of HIV-infected children attain adulthood and may become sexually active. HIV disclosure is an important step toward long-term disease management and necessary for the transition from pediatric care into adolescent and adult care settings. Most studies on this topic have carried out in 144 caregivers of Children and adolescents aged between 6 and 16 years of age attending the pediatric ART clinic. The subjects were enrolled consecutively and were interviewed using a structured questionnaire after taking written informed consent. The questionnaire included information on the demographic details, the disclosure status of HIV infection in children and perceptions about disclosure of status to the child.

Results. The mean age of children was 11.40 ± 2.86 years. Although 93.8% of caregivers believed children should know their HIV status, the prevalence of disclosure to the child was only 33.3%. Disclosure had been done primarily by caregivers (72.9%). Disclosure had been done primarily by caregivers (72.9%). Among 1,558 respondents, 292 (18.7%) reported a history of PDM. Among 1,558 respondents, 292 (18.7%) reported a history of PDM. Among 1,558 respondents, 292 (18.7%) reported a history of PDM. Among 1,558 respondents, 292 (18.7%) reported a history of PDM. Among 1,558 respondents, 292 (18.7%) reported a history of PDM.

Conclusion. In our study prevalence of HIV disclosure was 33.3% there was increase in disclosure in children and perceptions about disclosure of status to the child.

Disclosures. All authors: No reported disclosures.
605. Loneliness Among Older Adults Living with HIV: A Study and Online Community

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Background. The population of people living with HIV (PLHIV) is aging. A new registry and online community, called Aging with Dignity, Health, Optimism and Community (ADHOC), has been launched to investigate how HIV impacts the lives of older PLHIV.

Methods. A cross-sectional analysis of ADHOC was performed on 208 PLHIV 50+ years of age. One hypothesis was that increasing age would be associated with greater loneliness. Loneliness was assessed using the UCLA Loneliness Scale (ULS-3). A score ≥ 26 was classified as lonely. The impact of aging on loneliness was analyzed by ANOVA and multiple linear regression.

Results. ULS-3 scores ranged from 3 to 94 and 48.6% of subjects were classified as lonely. Significant differences were found between the 50–59, 60–65 and 65+ age groups, with older age associated with decreased loneliness (P = 0.018) (Table 1). In the multiple linear regression model, these observations persisted even after controlling for gender, sexual orientation, race/ethnicity, relationship status, education, income, and number of comorbidities (Table 2). Decreases in loneliness were associated with female gender, being in a relationship, higher income, and fewer comorbidities (P < 0.05).

Conclusion. Among PLHIV over 50, loneliness is less severe in older age groups. Additional investigation is needed to better understand potential causes and to find ways to remediate loneliness among older PLHIV.

| Table 1: Comparison of ULS-3 Scores by Age |
|-------------------------------------------|
| Age          | ULS-3 Mean ± SD | n  | %   | P-value |
|---------------|-----------------|----|-----|---------|
| 50–59         | 5.8 ± 2.1       | 133| 54.3| Ref.    |
| 60–65         | 5.1 ± 2.0       | 40 | 19.2| −0.80  | 0.026 |
| 65+           | 4.8 ± 1.8       | 35 | 16.8| −1.41  | <0.001|

| Table 2: Multiple Linear Regression of ULS-3 Scores |
|-----------------------------------------------|
| n | % | Coef. | P-value |
|---|---|------|---------|
| Age |   |      |         |
| 50–59 | 113 | 54.3 | Ref.    |
| 60–65 | 40 | 19.2 | −0.80  | 0.026 |
| 65+  | 35 | 16.8 | −1.41  | <0.001|

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606. Risk Factors for Congenital Infection in the United States: Analysis of the Kids’ Inpatient Database (KID)

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