Table 1. Characteristics of study participants

| Characteristics | Study participants (n=435) |
|-----------------|--------------------------|
|                 | Na  | %   |
| **Vitamin D Status (ng/ml)** |     |     |
| Normal          | 91  | 21  |
| Insufficient    | 219 | 50  |
| Deficient       | 125 | 29  |
| Median Vitamin D|     |     |
| Gender          |     |     |
| Male            | 271 | 62  |
| Female          | 164 | 38  |
| CDC staging     |     |     |
| A               | 166 | 38  |
| B               | 186 | 43  |
| C               | 74  | 17  |
| MRSA            | 9   | 2   |

Table 2 Multivariate analyses by GEE on eGFR outcome

| Characteristics | GEE OR (95% CI) | p-value |
|-----------------|----------------|---------|
| **BMI categories** |               |         |
| 2.076–2.344     | 0.42–1.958    | 0.29   |
| 3.133–3.755     | 0.45–3.837    | 0.088  |
| **Vitamin D Status** |             |         |
| Serum Vitamin D  | 0.106–1.738   | 0.06–3.652 | 0.33–3.511 |
| Insufficient F2 | 0.81–1.558    | 0.42–6.751 | 0.61–2.585 |
| Deficient F3    | 0.56–2.062    | 1.49–7.257 | 0.47–3.579 |
| **Vitamin C**    |               |         |
| Baseline Vitamin C | 0.55–2.269   | 0.04–1.95-8 | 0.98–1.087 |
| Serum Vitamin C  | 0.22–2.067    | 1.04–10.65 | 0.21–2.272 |

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349. Implementation of a Multidisciplinary HIV-Pulmonary Clinic Subhashini A. Sellers, MD; Amy Dunn, MSN, FNP; Aarti Sanghani, MPH; Jonah Pierce, RN; Hannah D. Little, MHA and Claire E. Farel, MPH; University of North Carolina at Chapel Hill, Chapel Hill, North Carolina; University of North Carolina Hospitals, Chapel Hill, North Carolina

Session: 44. HIV Complications: Cardiovascular, Metabolic, and Other Complications Thursday, October 3, 2019: 12:15 PM

Background. Among people with HIV (PWH), pulmonary comorbidities are a leading cause of morbidity and mortality. As PWH live a near-normal lifespan with ART, the focus has shifted from opportunistic infections to chronic disease. This includes chronic obstructive pulmonary disease (COPD) and lung cancer, for which PWH with and without concomitant tobacco use are at high risk. We sought to improve access to and quality of pulmonary care for PWH by instituting a pulmonary clinic co-located within a Ryan White-funded HIV clinic in the Southeastern United States.

Methods. A pulmonologist with expertise in lung disease in PWH began seeing patients one half-day twice monthly beginning in 2017. Longitudinal demographic, clinical, and appointment information was collected on each patient.

Results. Fifty patients were referred to the HIV-Pulmonary clinic. Of the 32 patients seen for an initial visit, the mean age was 55, 63% were male, and all were on ART. The majority were current (52%) or prior smokers (31%) with a mean pack-year history of 42. Over 40% of the patients had a COPD diagnosis and 25% had no prior pulmonary diagnosis. The majority of patients had not engaged in pulmonary care within the past year, as 63% had never seen a pulmonologist and another 28% did not follow-up with a prior provider. After the first visit, 69% either followed up or had a pending follow-up. Of the 17 current smokers, all were offered assistance with smoking cessation and 59% engaged. Of the 10 patients who were eligible for lung cancer screening (LCS) by current guidelines, all engaged in shared decision making and 40% pursued annual screening CT scans.

Conclusion. Chronic pulmonary diseases are increasing relevant comorbidity in PWH on ART. Our HIV-pulmonary clinic demonstrates the utility and feasibility of integration of sub-specialty consultative care in comprehensive care of PWH. By introducing a general pulmonary clinic within the existing infrastructure of the HIV clinic at our institution, we were able to engage PWH with and at risk for lung disease in treatment and care. Future goals of this interdisciplinary design include increased compliance with current COPD treatment guidelines and LCS, improved rates of smoking cessation, and continued collaboration between the ID and pulmonary providers.

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350. Outcomes for Joint Arthroplasty in Persons Living with HIV Charles L. Mandimika, MD; Lydia A. Barakat, MD and Marjorie Golden, MD; 1Yale New Haven Hospital, Milford, Connecticut; 2Yale School of Medicine, New Haven, Connecticut

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Background. Persons living with HIV (PLWH) now have dramatically improved life-expectancy with age-related morbidities requiring total joint arthroplasties. We present here an institutional review of PLWH who underwent total joint arthroplasty and prosthesis-related adverse outcomes at one year.

Methods. This was a retrospective chart review in a large academic medical center. Inclusion criteria were adult PLWH undergoing total joint arthroplasty between 2013 and 2017. Arthroplasty-related adverse outcomes within the first year post-surgery were recorded. Patients were identified using ICD-10 codes and classified as having a PJI using Infectious Diseases Society of America (IDSA) criteria.

Results. A total of 40 patients met the criteria. The median age was 59 years and 53% of patients were male. The median CD4 count and RNA viral load were 587 (range 90–920) cells/mm³ and 0 (range 0–180,000) copies/mL, respectively. The most common procedure was hip replacement (55%) and the most common indication for arthroplasty was avascular necrosis (43%). Adverse outcomes including PJI, dislocation, prosthesis loosening, seroma and chronic pain were identified in 28% of patients. PJI occurred in two patients and both required surgical revision. Modifiable risk factors present in both patients were active smoking, history of substance use disorder, chronic pulmonary disease, depression and hepatitis C antibody positivity. Both patients had CD4 counts >600 cells/mm³. Both were on atazanavir containing antiretroviral regimens. Neither patient was screened for MRSA carriage, and both were MRSA positive. The most common organisms were MRSA and MSSA respectively and each patient received 6 weeks of antimicrobial therapy.

Conclusion. This study supports that when medically optimized, PLWH have favorable outcomes. The two patients who developed PJI had multiple non-HIV modifiable risk factors predisposing them to PJI. In one case, the patient's isolated organism was MRSA, for which the patient did not receive appropriate pre-operative antimicrobial prophylaxis. This highlights the importance of routine screening for appropriate pre-operative prophylaxis in patients undergoing joint arthroplasty. Failure of PJI prophylaxis is independent of HIV status.

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351. HIV and Aging: Multimorbidity in Older People Living with HIV in One Southeastern HIV Clinic Elizabeth Crowder Arant, MD; Cesar Harding, BS; Paul V Fargenosi, MD, PhD and Kathleen A. McManus, MD, MSCR; 1University of Virginia School of Medicine, Charlottesville, Virginia; 2University of Virginia, Charlottesville, Virginia

Session: 44. HIV Complications: Cardiovascular, Metabolic, and Other Complications Thursday, October 3, 2019: 12:15 PM

Background. While morbidity and mortality related to HIV are decreasing, age-related chronic conditions are becoming more common in people living with HIV (PLWH). We hypothesized that multimorbidity prevalence among PLWH would increase from 2006 to 2016 and that multimorbidity would be associated with demographic and healthcare system-level factors.

Methods. Cohorts included PLWH aged 45–89 who received care at the University of Virginia (UVA) Ryan White HIV clinic in 2006 (Cohort 1) and 2016 (Cohort 2). Multimorbidity was defined as the co-occurrence of ≥2 age-related chronic diseases. Demographics, HIV-specific clinical characteristics and multimorbidity were

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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 1, multimorbidity was less likely for those with private insurance (OR 0.81, 95% 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%, OR 0.86, 95% CI 0.74–1.00) and 251–500% FPL (21%, OR 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 (ADHOOC) was launched at ten sites to collect self-reported data. This analysis uses data from ADHOOC 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 ADHOOC participants was 59 years. Eighty-two percent were male, 66% were gay or lesbian, and 56% were white. Forty-seven percent were male, 66% were gay or lesbian, and 56% were white. Forty-seven percent were male, 66% were gay or lesbian, and 56% were white.

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