Patients who were not recommended for MMA based on DISE findings were excluded. Retrospective chart review included VOTE classification, DISE findings, and referrals for MMA to the OMFS clinic. Other data included age, BMI, past medical history, sleep study data including AHI and oxygen nadir, and if MMA or other OSA treatments were done.

Results: Out of 408 DISE performed, 58 patients (14.2%) were referred to our OMFS for MMA. Patients' demographics were: male (48; 82.8%); average age: 51; average BMI: 32.5; 39 (67.2%) with comorbidities. Sleep studies included: 32 HSATs, 22 PSGs, 4 missing. 41 patients (75.9%) had severe OSA. Average O2 nadir was 75%. On DISE, most patients had some level of obstruction at all anatomic subsites (94.8%). All patients had complete obstruction at the level of the palate or velum. 41 (70.7%) also had additional anatomic abnormalities noted including maxillary constriction, midface hypoplasia, retrognathia or micrognathia. From 58 patients recommended for MMA, 35 (60.3%) followed up in OMFS clinic and 11 (31.4%) underwent MMA surgery. Five patients (14.3%) received OATs. 11 patients (19%) had CPAP re-evaluation. 27 patients (46.6%) were lost to follow-up.

Conclusion: Of patients referred by ENT to OMFS following DISE, only 60% were seen at OMFS clinic and only half of these patients underwent MMA. While some received other treatments, nearly half were lost to follow-up altogether. We propose a revised workflow to improve patient education, acceptance, and coordination of OSA care and follow-up.

Support (If Any):

0594

FUNCTIONAL LIMITATIONS AND WELL-BEING THROUGHOUT THE ADULT LIFESPAN: THE MODERATING ROLE OF SLEEP

Claire Williams[1], Natalie Dautovich[2], Joseph Dzierzewski[2]

Virginia Commonwealth Unviersity [1] Virginia Commonwealth University [2]

Introduction: Functional limitations represent individuals' difficulty with completing essential activities of daily living, such as sitting, stooping, and walking. Though functional limitations have been linked to lower well-being outcomes, less is known about potential protective factors for well-being in the lived experience of functional limitations. This study aimed to examine the potential moderating effect of sleep quality on the association between functional limitations and life satisfaction, a common indicator of well-being, across the adult lifespan.

Methods: The present study used archival data from the Midlife in the United States Refresher study. Participants included 696 individuals (50.6% female, Mage=51.58 years, SD=13.61 years) who completed measures of functional limitations (Functional Status Questionnaire), global sleep quality (Pittsburg Sleep Quality Index), and life satisfaction (single-item measure). A moderated moderation analysis was conducted to examine the moderating role of sleep quality on the association between functional limitations and life satisfaction. Age was included as a secondary moderator in the analysis to determine differences between age groups (younger, middle-aged, elders). Demographic variables of gender and racial identity were used as covariates in study analyses.

Results: Participants' global sleep score was a significant moderator of the association between functional limitation status and life satisfaction ($B = 0.16$, $p < .001$). Overall better global sleep quality buffered the association between higher functional limitations and worse life satisfaction. A significant three-way interaction between age, global sleep, and functional limitations was detected ($\beta = -0.003$, $\Delta R2 = .02$, $F(1, 686) = 12.25$, $p < .001$). The effect of global sleep on the association between life satisfaction and functional limitation status was significant for younger adults ($B = 0.07$, $p < .001$) and middle-aged adults ($B = 0.02$, $p = .0224$), but not for elders ($B = -0.02$, $p = .2223$). Better global sleep quality buffered the negative association between functional limitations and life satisfaction specifically for younger and middle-aged adults.

Conclusion: The current study provided evidence for the importance of sleep quality in the lived experience of functional limitations, particularly for younger and middle-aged adults. This study contributes to a rapidly growing body of literature that seeks to identify protective factors for individuals experiencing lower functioning. In the future, clinicians should integrate sleep quality screeners in medical and mental health care settings in order to identify at-risk individuals who are experiencing functional limitations, and potentially consider establishing preventative, education-based interventions concerning sleep in the experience of functional limitations.

Support (If Any):

0595

INFLAMMATORY PLASMA BIOMARKER CLUSTER ASSOCIATIONS WITH SLEEP IN PEOPLE WITH AND WITHOUT HIV

Nicholas Bakewell[1], Patrick Mallon[2], Caroline Sabin[1], Alan Winston[3], Frank Post[4], Memory Sachikonye[5], Nicki Doyle[3], Susan Redline[6], Ken Kunisaki[7]

University College London [1] University College Dublin [2] Imperial College London [3] King's College London [4] UK Community Advisory Board (UK-CAB) [5] Brigham and Women's Hospital [6] University of Minnesota and Minneapolis VA Health Care System [7]

Introduction: Sleep problems are commonly reported in people with HIV (PWH) and may be exacerbated by HIV-induced inflammation. We determined associations between systemic inflammation and objective/subjective sleep measures in PWH and demographically/lifestyle similar HIV-negative controls.

Methods: Objective sleep measures from 7-day actigraphy (e.g. mean/standard deviation (SD) of wake after sleep onset [WASO], sleep duration/efficiency), overnight oximetry (oxygen desaturation index [ODI]), and patient-reported measures (Insomnia Severity Index [ISI] and Patient-Reported Outcomes Measurement Information System [PROMIS] sleep questionnaires) were assessed in participants in the multicenter POPPY-Sleep Study in the UK and Ireland. Principal Component Analysis using 31 plasma inflammatory biomarkers followed by cluster analysis previously identified 3 distinct inflammatory clusters: 1 (low inflammation), 2 (immune activation) and 3 (systemic inflammation). Baseline characteristics and between-cluster differences in sleep outcomes were assessed using Kruskal-Wallis or logistic regression/Chi-squared tests.

Results: The 465 participants (74% PWH, median [interquartile range] age 54 [50-60] years) were mainly male (80%), men having sex with men (71%) and white (88%). Among PWH, most (98%) were on antiretroviral therapy, 92% had viral load ≤50 cps/mL and CD4 cell count was 610 [470-785] cells/mm3. Overall, 18% met ISI criteria for insomnia (ISI≥ 15), and other sleep measures suggested generally good sleep (e.g., ODI 3.1/hr [1.5-6.4]). Clusters 1 (n=209), 2 (n=47) and 3 (n=209) differed significantly for HIV status (73%, 60%, 78%, p=0.03); BMI (24.8, 25.9, 26.2 kg/m2, p=0.002); systolic blood pressure (126, 135, 126 mmHg, p=0.002); cardiovascular