Results: During the pilot testing phase the automated system processed 516 notes and identified 489/516 (94.8%) as successful loads, and 27/516 (5.2%) were flagged as problematic since one or more data elements were missing. Misapplication of the template occurred in 21/27 (77.8%) of notes flagged by the monitoring system and corrected with addendums. An additional NLP run produced 510/516 (98.8%) completed assessments with calculated DAS28 scores. Specific elements recovered using this process are presented in table below.

Total notes processed (n = 516)	Number (%)	
Elements investigated	Missing data elements	Elements Corrected
Tender Joint Count	1/516 (99.8%)	1/1 (100%)
Swollen Joint Count	2/516 (99.6%)	2/2 (100%)
Patient Global Assessment	11/516 (97.8%)	8/11 (72.7%)
Physician Global Assessment	9/516 (98.2%)	7/9 (77.8%)
Modified Health Assessment Questionnaire	15/516 (97.1%)	10/15 (66.7%)
Pain Score	11/516 (97.8%)	9/11 (81.8%)
Total notes with ≥1 missing elements	27/516 (94.8%)	21/27 (77.8%)

Conclusions: The addition of this error monitoring system provides an efficient data correction system and is expected to motivate and reinforce the use of RA templates. The implications of which may be profound as we transition from traditional epidemiological research to a more active learning healthcare enterprise. This pilot study established "proof of concept" and the next challenge is to adapt the technology to other VARA and non-VARA sites. This technology and framework could enable collaborative clinical research networks that are committed to large-scale pragmatic and observational effectiveness studies.

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AB1090 IS THERE AN ETHNIC VARIATION IN ACCEPTANCE OF BIOLOGIC THERAPY? A UNIVERSITY HOSPITAL EXPERIENCE

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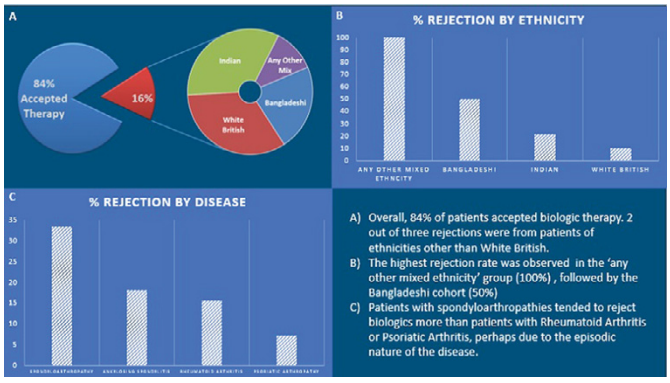
Background: Ethnic variation in drug adherence & preference is well documented (1). While usually a reflection of patient autonomy, the issue takes significance if it impedes the provision of effective evidence based care. Indeed, race affects rheumatological disease outcomes (2), likely for both biological & psychosocial reasons. Studies from United States of America found ethnic minorities were less likely to be on a biologic for a rheumatological disease compared to Caucasians, even after adjustment for education & insurance (3). Studies in the United Kingdom found similar results (4), although few investigated the disparity in the acceptance of biologics between ethnicities. Leicester, a midland UK city has an ethnically diverse population, where identifying and addressing such disparities is crucial in delivering effective & equal care.

Objectives: To determine any disparity in acceptance of biologic therapy, when offered in person, in a healthcare system free at the point of access, between White British and other ethnicities.

Methods: Data was collected from nurse led Biologics therapy clinics, from October 2016 to December 2016. All patients referred were deemed suitable for a biologic as per NICE guidlelines by a Rheumatologist, and were attending the clinic for counselling, assessment & consenting. Proformas were piloted, and improved proformas with information including demographic, disease & treatment details, as well the outcome of the consultation (biologic accepted or rejected) was used to collect data. The collated data were then analysed using EXCEL spread sheet.

Results: Data was collected from 55 patients. Interestingly, sex distribution was nearly equal (54% female). 57% of the total sample was White British (WB). The remaining 43% included; Indian, Bangladeshi, Pakistani, White Other, Asian other, African Caribbean & Any other mixed race. The most common disease necessitating referral for a biologic was rheumatoid arthritis (53%).

16% of patients rejected a biologic drug, of which 66% were ethnic minorities. The rejection rate among ethnic minorities was thus 24% compared to 10% in the WB cohort. The highest rejection rate was within the Any Other Mixed Ethnicity cohort (100%), followed by the Bangladeshi cohort (50%). Of note, all patients who rejected biologic therapy from an ethnic minority background did not speak English as their first language. Rejection rates were highest in the Spondyloarthropathies (21%).



Conclusions: Our results demonstrate a disparity between the White British population and other ethnicities in the acceptance of biologics, despite one to one counselling. This can have detrimental impacts on treat to target concept and disease progression, and thus will be further investigated & addressed.

References:

[1] Katz J. Patient Preferences and Health Disparities. JAMA. 2001;286(12):1506.
[2] Jordan J. Effect of race and ethnicity on outcomes in arthritis and rheumatic conditions. Current Opinion in Rheumatology. 1999;11(2):98–103.
[3] Lee at al. Treatment disparity related to race/ethnicity and education in rheumatoid arthritis patients: Comment on the article by Constantinescu et al. Arthritis Rheum. 2009;61(8):1141–1142.
[4] Kumar, K. et al. FRI0166 Ethnicity Is Associated With Biologic Treatment Persistence In Rheumatoid Arthritis. Annals of the Rheumatic Diseases 74.Suppl 2 (2015): 483.2–483. Web.

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AB1091 HIGH ACCEPTANCE RATE IN RA, AS AND PSA PATIENTS WHEN BEING STARTED ON BIOSIMILAR TNF OR BEING SWITCHED FROM THE ORIGINAL TNF MAB (REMICADE, ENBREL) - A SINGLE CENTER EXPERIENCE

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Background: Biiosimilar TNF Mab (BioTNF) have become available in most of the European countries in the last few years. They are labeled to be used in the most common rheumatic diseases, like RA, AS and PsA. Controlled studies have shown comparable efficacy and safety of BioTNF and original TNF (Remicade, Enbrel). BioTNF are allowed to be used in TNF naive patients as well as in TNF pretreated patients (switchers). Prescriptions in different countries may vary due to local most often cost driven restrictions.

So far, little is known about the awareness, acceptance and possible obstacles which may influence patients willingness to accept therapy with BioTNF instead using the original compounds

Objectives: The study was conducted and designed to get a deeper insight in what may influence patients decision making and willingness to accept treatment with BioTNF firsthand or accept switching.

Methods: Between February 2015 and December 2016 41 patients (BioINF n=29, BioETA n=12) were introduced to BioTNF therapy. 9 Patients (Bio-INF n=3, Bio-ETA n=6) received TNF therapy the first time, in 32 patients (Remicade n=23, ETA n=8) werde switched from the originator TNF compound to BioTNF. All patients received comprrehensive information on BioTNF in verbal and written form.

A standardised questionaire was used to ask patients on their awareness, acceptance and about possible obstacles for the usage of BioiTNF Mab.

Results: 6 out of 9 TNF naive patients agreed after their first information on BioTNF to start therapy with BioINF (n=3) or BioETA (n=3). Another 2 patients accepted BioETA therapy on their second visite. Only one patients asked to be started on the originator TNF Remicade. In patients being ask to switch from Remicade to BioINF 19 patients accepted promptly to be switch and in patients with Enbrel therapy 6 out of 9. Finally only 1 patient on Remicade TNF therapy denied even after a third visit to be switched. Mayor concern to deny the use of BioTNF were possible lack of efficacy (30%), safety (32%) and missing longterm experience (35%). The main motivation to switch was patients believe to save money and that they were ask to switch to BioTNF Mab on short notice from their health care insurance company.

Conclusions: There is a high acceptance rate in patients with chronic inflammatory rheumatic disease to be started on or switched to BioTNF (>90%). Their are little concerns in patients accepting BioTNF with regard to safety or efficacy of BioTNF. Patients are aware of BioTNF as a less costly way to treat their rheumatic condition. Physicians should be aware of this willingness and offer BioTNF therapy were it is appropriate. Using BioTNF is a cost saving way to use biologics in rheumatic therapy with equal efficacy and safety compared to the originiator compounds.

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