SAT0345 QUALITY INDICATORS IN THE CARE OF PSORIATIC ARTHRITIS

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Background: In 2016, members of GRAPPA in collaboration with KPMG LLP (UK) conducted a study to benchmark care in psoriatic arthritis (PsA). Challenges in the care of patients with PsA were identified but a key finding was that centres do not usually have processes in place to measure the impact of improved quality of care.[1]

Objectives: To identify quality of care indicators to enable PsA caregivers to assess and monitor the outcomes of specific initiatives aimed at improving care in four focus areas. The focus areas are aligned to key patient pathway challenges: 1) Shorten time to diagnosis, 2) Improve multi-disciplinary collaboration, 3) Optimise disease management and 4) Improve disease monitoring.

Methods: 1. Structured review literature to obtain a longlist of 100 potential indicators across 4 focus areas. Search strategy used specific terms related to quality measures in PsA, adjacent and other chronic diseases. 80+publications were reviewed and rated based on relevance to four focus areas. 2. Survey expert rheumatologists and dermatologists representative of different healthcare systems to review the longlist and identify the most meaningful and feasible indicators for use in day to day practice. 3. Consensus discussion among the experts to identify shortlist of indicators based on pre-defined selection criteria. Key criteria for the Indicators were:[1] support improvement of patient care[2] evidence-based,[3] measurable, and[4] feasible. 4. Electronic group discussion among the experts to refine definitions of shortlisted indicators and targets.

Results: The expert group arrived at a consensus with a shortlist of 8 quality indicators across each focus area.

Domain (Indicator, Target). 1. *Shorten time to diagnos*is (a) Average duration from presentation to HCP to confirmed PsA diagnosis. Less than 6 months[2] (b)% of patients with Psoriasis who receive a PsA screening test Annually[3]). 2. *Improve multidisciplinary collaboration* (a) Multidisciplinary PsA assessment is available (Y/N)[4] (b) Does the centre provide suitable training for HCPs, nurses etc. to increase awareness of PsA disease symptoms (Y/N)[5] 3. *Optimise disease management* (a) Average number of PsA evaluations done by HCP per patient in a year[6]1–2 annually (b)% PsA patients on whom T2T strategy is applied[7] 4. *Improve disease monitoring* (a)% of PsA patients who received full disease assessment for co-morbidities, e.g. co-morbidity index at least once every year[8] (b) Availability of short-term unscheduled appointments (Y/N)?[9] Max. 2 weeks.

Conclusions: 8 quality indicators in 4 areas of practice have been defined. The respective targets are evidence based, feasible, measurable and meaningful for patients.

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SAT0346 CLINICALLY MEANINGFUL IMPROVEMENT IN SKIN AND NAIL PSORIASIS IN BIO-NAÏVE ACTIVE PSORIATIC ARTHRITIS PATIENTS TREATED WITH INTRAVENOUS GOLIMUMAB: RESULTS THROUGH WEEK 24 OF THE GO-VIBRANT STUDY

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Background: GO-VIBRANT was a Ph3 trial of IV golimumab (GLM) in adult pts w/active PsA.

Objectives: To evaluate improvement in skin, nail psoriasis and Dermatology Life Quality Index (DLQI) w/IV GLM.

Methods: Adult bio-naïve PsA pts w/active disease(≥5 swollen and tender joints, CRP ≥0.6 mg/dl, active plaque PsO or documented history, and despite treatment w/csDMARDs and /or NSAIDs)were randomised to IV GLM 2 mg/kg at wks0, 4, and q8wks thereafter or PBO at wks0, 4, 12, and 20 w/crossover to GLM at wk24. Pts w/≥3% body surface area(BSA)PsO at baseline (BL) were assessed using Psoriasis Area and Severity Index(PASI,0–72) 75/90/100% and modified Nail Psoriasis Severity Index(mNAPSI,0–130) at BL, wks14 and 24(in pts w/ mNAPSI>0 at BL). DLQI was assessed at BL, wks8, 14 and 24.

Results: 394 pts(PBO:n=198;GLM:n=196) had ≥3% BSA PsO at BL; 76.5% had mNAPSI >0 at BL(mean 18.6).Pts on GLM achieved a greater PASI75 response vs PBO(59.2% vs 13.6%,p<0.001) at wk14 and wk24(64.8% vs 13.1%,p<0.001). At wk14, pts on GLM achieved greater PASI 90/100 responses vs PBO(39.3/16.8% vs 6.6/4.5%;p<0.001 for all) and at wk24(42.9/25.5% vs 7.6/5.6%;p<0.001 for all) (table 1). At wk14, similar proportions of pts in GLM grps, regardless of BL MTX use, achieved PASI 90/100 responses. At wk24, greater proportions of pts on GLM+MTX and GLM only achieved PASI100 vs PBO(+MTX:30.5% vs 7%, p<0.001;–MTX:15.4% vs 1.8%,p<0.010) (table 1).Mean decrease(improvement) from BL in mNAPSI score was greater in GLM vs PBO(−9.6 vs −1.9,p<0.001) at wk14 and wk24(−11.4 vs −3.7,p<0.001). At wk8, mean decrease(improvement) from BL in DLQI was greater in GLM vs PBO(−7.2 vs −1.7,p<0.001),at wk14 (−7.7 vs −1.8,p<0.001) and wk24(−8.1 vs −1.9,p<0.001). At wk14, 55.1% of pts treated w/GLM achieved a PASI50 response and improvement in DLQI≥5 vs 7.1% treated w/PBO(p<0.001) and at wk24, 59.2% vs 8.1%(p<0.001).

Abstract SAT0346 – Table 1. Change from Baseline in PASI 90/100 Through Wk24

	Wk14		Wk24	
	PBO	GLM	PBO	GLM
Pts evaluable for improvement fr/BL in PASI, n	198	196	198	196
PASI 90 (%)	6.6	39.3	7.6	42.9
% Diff (95% CI)		32.7 (25.10, 40.40)*		35.3 (27.52, 43.16)*
PASI 100 (%)	4.5	16.8	5.6	25.5
% Diff (95% CI)		12.3 (6.34, 18.30)*		20.0 (13.22, 26.85)*
+BL MTX, n	142	131	142	131
PASI 90 (%)	7.7	41.2	9.2	45.8
% Diff (95% CI)		33.5 (23.97, 42.98)*		36.6 (26.88, 46.41)*
PASI 100 (%)	5.6	17.6	7.0	30.5
% Diff (95% CI)		11.9 (4.39, 19.46)**		23.5 (14.55, 32.43)*
- BL MTX, n	56	65	56	65
PASI 90 (%)	3.6	35.4	3.6	36.9
% Diff (95% CI)		31.8 (19.21, 44.41)*		33.4 (20.65, 46.05)*
PASI 100 (%)	1.8	15.4	1.8	15.4
% Diff (95% CI)		13.6 (4.17, 23.03)***		13.6 (4.17, 23.03)***

*p<0.001; **p=0.002; ***p=0.010

Abstract SAT0346 – Table 2. Change from Baseline in mNAPSI Through Wk24

	Wk14		Wk24	
	PBO	GLM	PBO	GLM
Pts (mNAPSI>0) evaluable for change fr/BL, n	170	197	170	197
Mean (SD)	−1.9 (13.05)	−9.6 (15.71)	−3.7 (14.45)	−11.4 (16.38)
LS Mean diff (95% CI)		−8.4 (-10.71,–6.05)*		−8.4 (-10.82,–6.01)*

*p<0.001