median pre-SB4 switch DAS score for patients with RA who were switched back to ETN was 4.08 (Range: 3.35–4.81).

Conclusions: This switch back rate to ETN is considerably lower than what has been reported in the literature.1–3 There appears to be a preference for switching patients to an alternative biologic agent, rather than switching patients back to the bio-originator. This could be explained by inadequate disease control on etanercept, which has been unmasked under the scrutiny of the biosimilar switch process. An alternative explanation could be that our local commissioning group offers financial incentives if the department maintains a high percentage of etanercept treated patients on SB4. Hence, as prescribing practice can be influenced by both clinical factors and external targets, utilizing the switchback rate from biosimilar drugs to bio-originators is not a reliable indicator of the quality of biosimilar switch process.

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AB1269 QUALITY STANDARD FOR THE MANAGEMENT OF PATIENTS WITH PSORIATIC ARTHRITIS: QUANTUM PROJECT

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Background: In the context of complex diseases like psoriatic arthritis (PsA), in which patients are often followed by different professionals, it is important for health professionals, providers and patients to have tools for delivering and demanding optimal care. One way to evaluate and understand health care quality is by the use of validated standards of care and quality indicators.

Objectives: To develop nationally accepted standards of care and quality indicators for care in PsA.

Methods: Qualitative methodology was followed that included: 1) Two focus groups (one with patients with PsA and another with non-rheumatologists specialists involved in the care of patients with PsA); 2) A narrative literature review of published documents related to the quality of care in PsA (including the QUANTUM Report); 3) A nominal group meeting in which 15 expert rheumatologists generated and consensuated, a series of quality criteria as well as formulas or quantifiable objective measures to evaluate them; 4) A Delphi to establish the feasibility, priority and agreement with the quality criteria; 5) A final generation of standards of care and their attributes (including quality indicators). A descriptive analysis of the results was carried out.

Results: A total of 59 standards of care were generated, 19 of mandatory compliance, grouped into 4 blocks according to specific objectives: 1) Early diagnosis (n=8); 2) Optimising the management of the disease (n=28); 3) Multidisciplinary collaboration (n=9); 4) Monitoring improvement (n=18). To assess the compliance of these standards of care, in many cases the medical records will be reviewed. Other sources will be the memory of the service and hospital and bibliographic databases. Regarding to the level compliance, for some of the standards of care this is yes/no, for others the compliance will range from 50% to 100%, and in this range for many this will be by 80%.

Conclusions: This set of standards of care should help improve quality of care in PsA patients.