median pre-SB4 switch DAS score for patients with RA who were switched to a 3rd biologic agent was 4.23 (Range: 2.59–7.65), whilst that of those switched back to ETN was 4.08 (Range: 3.35–4.81).

Abstract AB1267 – Table 1

Demographics (n=56)	No. of patients remaining on SB4 at 8 months (n=47)	No. of patients switched to a 3rd biologic agent at 8 months (n=7)	No. of patients switched back to ETN at 8 months (n=2)
Mean Age	57.2	55.4	39.5
% Female	64%	71%	100%
% Disease	70%	71%	100%
RA	15%	14%	0
AS	15%	14%	0
PsA			
% Etanercept	43%	71%	100%
Monotherapy			
Median Time on SB4 prior to switch (days)	N/A	251 (Range: 79–357)	122.5 (Range: 114–131)

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 clinical 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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AB1268

NO DIFFERENCES BETWEEN HOSPITAL AND CLINIC IN PATIENTS WITH RHEUMATOID ARTHRITIS BASED ON REAL-WORLD DATA FROM THE AORA OBSERVATIONAL COHORT STUDY IN JAPAN

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Background: In Japan, orthopaedic surgeons, rather than internists, are often involved in the management of rheumatoid arthritis (RA), including drug treatment. However, the paradigm shift in the RA management has changed, and orthopaedic surgeons have often faced challenges in treating RA. The proportion of RA patients treated by orthopaedic surgeons is high in Akita Prefecture, located in Tohoku region in Japan. Akita Prefecture has the 6th largest area in Japan and the highest ageing rate. As many elderly patients have difficulty commuting to distant clinics or hospitals, specialised centres are desirable for advanced treatment of RA. However, in Akita Prefecture, the focus has been on improving treatment of RA by orthopaedic surgeons in the community. In 2010, the Akita Orthopaedic Group on RA (AORA) was established. Currently, 18 hospitals and 10 clinics are participating in the group, and cover all medical districts throughout the prefecture. In addition to a regular study meeting, a workshop on joint ultrasonography and a

case conference with internists have been held. We established a case registration system (AORA registry) 8 years ago. This system has enabled us to share treatment experiences.

Objectives: This study examined whether the AORA clinics have provided consistent community-based care comparable to that provided by hospitals.

Methods: Data from the 2017 AORA registry (including 2238 registrations [1300 in hospitals and 938 in clinics]) were used.

Results: Patients treated in clinics were younger (68.1 years in hospitals vs. 64.4 years in clinics), and had shorter duration of disease (157.4±4.0 months in hospitals vs. 143.5±4.5 months in clinics). The frequency and amount of methotrexate use were not significantly different between the two groups, while those of prednisolone use were greater in patients treated in hospitals than in those treated in clinics. There were no significant differences in the frequency or amount of biological disease-modifying antirheumatic drug use (19.9% in hospitals vs. 18.9% in clinics). There were also no significant differences in disease activity (Disease Activity Score-28-erythrocyte sedimentation rate) in the total cohort (2.91±0.04 in hospitals vs. 2.90±0.04 in clinics) or in patients aged 80 years or older (n=341) (3.35±0.08 in hospitals vs. 3.37±0.11 in clinics). The frequency and amount of drug use for treatment of osteoporosis were significantly higher in patients treated in hospitals than in those treated in clinics.

Conclusions: The results of this study showed that RA treatment outcomes were not significantly different between hospitals and clinics, indicating that the treatment level provided at orthopaedic clinics in the community was high and in accordance with the treat-to-target strategy. Given that orthopaedic surgeons are better able to examine joints and are able to treat osteoporosis, they are expected to treat more RA patients. We believe that the AORA plays an important role in maintaining the quality of clinical services for RA patients in Akita Prefecture.

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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 organise and evaluate 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 Report¹); 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=6); 2) optimising the management of the disease (n=26); 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 APs patients.