Africa and is transmitted to humans through the bites of the infected female mosquitos, found in the endemic forest zones. The vaccine is produced with attenuated viruses and represents an essential prevention method. It confers prolonged immune protection and is considered to be safe in the general population. For the immunosuppressed condition under which many patients with immunomediated rheumatic diseases (IMRD) are submitted, little is known about its efficacy and safety in this group.

Objectives: The aim of this study is to analyse the effects of the vaccine in patients with IMRD.

Methods: The methodology of this research consisted of the application of a form-based interview, the analyses of the vaccine card and medical records, if existent. The requirement to take part as a volunteer was to be an IMRD patient that was vaccinated against yellow fever.

Results: 60 ambulatorial patients, unadvisedly vaccinated or not, were evaluated. Of those, 40 (66.7%) were female and 20 (33.3%) were male, with an age range varying from 8 to 48 years. It was observed that 52 (86.7%) presented no adverse effects from the vaccine, while 7 (11.7%) presented at least one side effect and 1 (1.7%) exhibited a severe reactivation of the underlying rheumatic disease. In the group of 7 patients that registered any side effects, it was described 1 case of bilateral optic neuritis with temporary vision loss, initiated three weeks after the vaccination. The other side effects registered were mild and included: 3 occurrences of headache and 1 record of each of the following: fever, local pain, arthralgia, myalgia, nausea, coryza and diarrhea.

Conclusion: Our data suggested that the vaccine exhibits a relative degree of safety in these patients. The benefits of the immunization should be evaluated by the rheumatologist, taking in account the risk of infection and lethality of yellow fever in patients who live or are visiting the endemic areas. The recommendations are that the vaccination in this group must always be planned, done under medical orientation and order. It should preferably be applied in patients under disease remission, without immunosuppression treatment or in those who, under immunosuppressors, it is possible to temporarily suspend this treatment in order to the vaccine to be administered.

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AB1198

EVALUATION OF THE WAITING TIME AND QUALITY OF RHEUMATOLOGY REFERRAL AT A TERTIARY CARE CENTER OF PORTO ALEGRE – RS, BRAZIL

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Background: To improve waiting time for a first consultation with a rheumatologist has become an important challenge in many countries [1, 2]. In 2008, a previous survey [3] evaluating the referrals to our Service, we observed long waiting times (median 3.8 months, interquartile range (IQR) =1.5-10.0, ranging from 3 days to 8 years) and that only 31% of consultations were related to hypothesis of systemic inflammatory rheumatic diseases (SIRD), which should be properly managed at a resourceful tertiary care center. In 2015, a new process of triage for referrals (based on a protocol recording relevant information and judgment by a rheumatologist) was introduced in our state health system aiming to improve quality of referrals and reduce waiting lists [4]. However, this system is applied only for patients from cities other than the capital (Porto Alegre, RS).

Objectives: To evaluate the waiting time and quality of referral for first Rheumatology consultations at a tertiary care center of South Brazil, comparing the present results with those obtained 10 years ago in a similar survey [3].

Methods: In a cross-sectional study, information regarding all first consultations at the Rheumatology Service of Hospital Nossa Senhora da Conceição were prospectively collected from Oct 2017 to Mar 2018. Referred patients were characterized in terms of demographic features, diagnostic

hypothesis formulated by the rheumatologist and time from initial referral. For analytical purposes, patients with adequate referrals were considered to be those that presented high probability of SIRD, needing assistance at secondary or tertiary level of care. The results were compared with data collected in the same way in 2008 [3]. Chi-square test was used for statistical analysis.

Results: Of 444 appointments for scheduled for new patients, 87 (19%) did not attend. The features of the remaining 357 patients were: female=85%, mean (SD) age= 53 (15) years. The waiting time for consultation ranged from 7 days to 63,8 months (median 12.7, IQR= 4.4-14.1). Diagnostic suspicion of SIRD occurred in 186 (52%). Among SIRD, rheumatoid arthritis (23,5%) was the most frequent, while among non-SIRD, osteoarthritis (21,0%) and fibromyalgia (20,7%) were the most common diagnostic hypotheses. A SIRD was the main hypothesis in 75/193 (38,9%) patients from the capital, comparing with 111/174 (67,7%) among those from other cities (P<0,001), indicating better selection of the latter group of patients. A reanalysis of data collected in 2008 revealed that, at that time, the prevalence of suspected SIRD was not significantly different between patients from capital (76/262, 29,0%) and those from other cities (74/225, 32,9%; P=0,354).

Conclusion: We observed improvement in the quality of referrals from other cities comparing to those from the capital of our state, suggesting a better selection process in the former [4]. Despite the efforts to reduce the waiting time for Rheumatology consultations, we observed an increase when compared to 2008. We believe that the delay is secondary to an increase of the demand without a proportional increase in the number of rheumatologist in the public health system. The elaboration of guidelines with standardized information required for referral and triage process seems to be promising to improve access to consultations in Rheumatology.

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AB1199

BARRIERS AND FACILITATORS TO THE IMPLEMENTATION OF A STRATIFIED MODEL OF CARE FOR LOW BACK PAIN PATIENTS IN PRIMARY CARE IN PORTUGAL

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Background: The results of a recent study have suggested that the current clinical practice is not in line with clinical guideline recommendations and may not be delivering the best outcomes to Low Back Pain (LBP) Portuguese patients. Since the stratified primary care approach has demonstrated clinical and cost-effectiveness in the UK and other countries, the SPLIT project aimed to introduce a similar approach that involves general practitioners (GPs) and physiotherapists (PTs) in the triage and targeted treatment for LBP patients, in Portugal. In order to facilitate the implementation of this project a training program for GPs and PTs was delivered by rheumatologists and PTs. Considering the specific organization of the Portuguese primary care, it was important to explore the perceptions of the GPs and PTs, who attended to the training, regarding the implementation of the SPLIT stratified model of care in the Portuguese context.

Objectives: Identify and understand the potential barriers and facilitators to the implementation of the SPLIT stratified model of care.

Methods: After obtaining ethical approval, two focus groups (one for each professional group) were carried out. The focus groups were based on a semi-structured interview schedule, audio-recorded and transcribed verbatim. A thematic analysis was conducted. Firstly, two researchers independently coded the transcripts. Secondly, these researchers discussed the codes and examined their scope and relevance. Thirdly, the researchers developed a coding scheme that included the main themes and sub-themes, as well as the connections among them.

Results: The potential barriers were identified and explored by both professional groups. The introduction of change into the routine delivery care was identified as one of the most important barriers. According to the GPs' perspective, the possibility of inadequate referral was considered as an issue. The PTs highlighted the challenges inherent to the psychosocial informed physiotherapy treatment of patients classified with high risk of developing persistent and disabling pain. More specifically, they emphasized the need to receive mentoring sessions in clinical practice, in order to develop competences for the management of psychosocial issues.

In what concerns to the potential facilitators to the implementation of the model, the participants' personal motivation was considered as one of the most important factors. The alignment of the SPLIT model with the mission and goals of the health care units where the project was going to be piloted was also identified as an important facilitator. Finally, both professionals groups considered that the SPLIT model may facilitate the interdisciplinary approach to the management of this condition, as it clarifies the specific contribution of GPs and PTs in the approach to LBP patients

Conclusion: The knowledge about the potential barriers and facilitators to the implementation of the SPLIT stratified model of care may contribute to the successful implementation of stratified care for LBP patients in Portugal.

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AB1200

IMPROVEMENT IN THE QUANTITY AND QUALITY OF OBSERVATIONAL DATA COLLECTED FOR US VETERANS ENROLLED IN THE VETERANS AFFAIRS RHEUMATOID ARTHRITIS REGISTRY USING AN ELECTRONIC AUDIT, FEEDBACK, AND DATA CORRECTION SYSTEM

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Background: The Veterans Affairs (VA) Rheumatoid Arthritis (RA) (VARA) registry is an observational cohort study of US Veterans with RA at 11 VA Medical Centers. VARA investigators capture clinical and laboratory disease activity measures (DAMs) during clinic visits via standardized templates in the electronic health record (EHR). Six clinical (tender/swollen joints, patient/provider global, MD-HAQ, pain) and 2 laboratory (ESR,

CRP) DAMs are extracted post-visit using natural language processing (NLP).

Objectives: This analysis determined the impact of an audit, feedback and data correction system on the quantity and quality of DAMs collected in the VARA registry.

Methods: After September 2017, VARA site investigators were provided monthly feedback reports of incomplete/missing DAMs for the prior month to allow sites to correct data entry errors. Updated and/or corrected data were entered into the EHR via note addendums and then automatically re-extracted by NLP to complete the capture of DAM data. DAMs from October 1, 2016 to September 30, 2017 (pre-feedback implementation – Pre-IMP) was compared to October 1, 2017 to September 30, 2018 (post-feedback implementation – Post-IMP).

Patients and Notes	Pre-IMP	Post-IMP	Increase (%) †
Unique patients	1,116	1,208	92 (8.2%)
Total Notes	2,411	2,873	460 (19.1%)
Average notes per patient	2.2±1.1	2.4±1.1	0.2 (10.1%)
Disease Activity Measure (DAMs)	Impact of Feedback/Corrections		
Total DAMs	15,709	20,688	5,355 (34.1%)
Number Clinical DAMs per note	4.9±1.5	5.5±1.2	0.7 (14.6%)
Notes with 6 Clinical DAMs	1,267 (52.5%)*	2,195 (76.4%)*	2,332 (81.1%)*
Notes with 4 DAMs for DAS28	1,526 (63.3%)*	2,038 (70.9%)*	2,873 (74.5%)*
Notes with 6 clinical and 2 lab DAMs	1,055 (43.8%)*	1,794 (63.4%)*	1,857 (64.7%)*

* Percent of total notes during the pre-implementation period.

† Percent of total notes during the post-implementation period.

‡ Percent change from pre-implementation baseline to post-implementation after corrections.

VARA registry goal is to collect the following Disease Activity Measures (DAMs) at each visit.

Six Clinical DAMs

Joint Tender Count of 28 joints
Joint Swelling Count of 28 joints
Patient Global Assessment of Disease Activity
Physician Global Assessment of Disease Activity
Modified Health Assessment Questionnaire
Patient Pain Score

Two Laboratory DAMs

Westergren Erythrocyte Sedimentation Rate
C-Reactive Protein

Composite DAM

Disease Activity Score for 28 joint count (DAS28)

Table 1

Results: During the pre-IMP period, there were 2,411 notes with DAMs collected on 1,116 unique patients compared to 2,873 notes on 1,208 unique patients in the post-IMP period - an increase of 92 (8.2%) unique patients and 460 (19.1%) notes. Enrollment in the VARA registry only increased by 121 (6.5%) during post-IMP period. During post-IMP period, there were 541 notes identified with deficiencies in clinical DAMs and monthly audit and feedback reports were provided to VARA sites to allow corrections. Individual site review resulted in 376 additional DAMs in 225 notes, with complete resolution of all error in 137 (25.3%) notes. The quantity of DAMs collected increased from 15,709 to 21,064, a 34.1% increase with the average number of DAMs collected per note rising from 4.9 to 5.6. The quality of data improved as demonstrated by the proportion of notes with all 6 clinical DAMs increasing from 52.5% to 81.1% and other improvements in quality/completeness as noted in table.

Conclusion: An audit, feedback, and efficient data collection system improved both the quantity and quality of DAMs collected. The improvement in the collection of DAMs in RA patients will further enhance epidemiologic and outcomes studies of RA and provide higher quality longitudinal data to enhance the care of RA patients.

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