According to ICD-10 codes, 9 deaths were reported, so the YLL were 124. The YLDs were 264,658. Finally, the DALYs were 264,782 for a rate of 808.82 per 100,000, which is higher than the GBD 2016 results (647 per 100,000).

Conclusion: The main cause of burden disease of rheumatic disease in Colombia is due to LBP. The burden is because of the YLD, related to the frequency of cases in people younger than 50 years of age. It is necessary for an early detection and development of intervention strategies.

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AB1205 BURDEN DISEASE OF OSTEOARTHRITIS IN COLOMBIA, 2015

Francy Cuervo¹, Ignacio Angarita¹, Ana María Santos¹, Eugenia-Lucía Saldarriaga¹, Juan Camilo Rueda¹, Jesús G. Ballesteros², Rodrigo Giraldo¹, Ingris Peláez-Ballestas³, Diana Díaz-Jiménez⁴, Pedro Santos-Moreno⁵, Diana Padilla-Ortiz¹, Viviana Reyes¹, Carlos Castañeda-Orjuela⁴, John Londono¹. ¹Universidad de La Sabana, Rheumatology, Chía, Colombia; ²Central Military Hospital, Rheumatology, Bogotá, Colombia; ³Universidad Nacional Autónoma de México, Faculty of Medicine, Ciudad de México, Mexico; ⁴National Institute of Health, Colombian National Health Observatory, Bogotá, Colombia; ⁵Biomab, Rheumatology, Bogotá, Colombia

Background: Osteoarthritis (OA) is the most prevalent rheumatic disease in Colombia, as reported by the COPCORD 2015 study. The prevalence is 10.81% (IC 95, 9.68-12.06) (1).

Objectives: To estimate the disease burden of OA for 2015

Methods: A descriptive study was developed. The reference data of the population was taken by DANE (Departamento Administrativo Nacional de Estadística) and the WHO (World Health Organization). It was necessary to develop an algorithm to determine the distribution in percentages of severity levels, according to the GBD definitions. A Markov model was elaborated to calculate the years of life lost due to premature mortality (YLL), years lived with disability (YLD) and Disability-Adjusted Life Year (DALY).

Results: Figure 1 shows the distribution of cases by age of OA, with the highest frequency of cases over 50 years in both sexes.

Abstract AB1205 Figure 1. Distribution of cases by age and sex

Figure 2 describes the distribution of the severity levels of the disease, with most cases being moderately severe.

Abstract AB1205 Figure 2. Distribution of severity levels of rheumatoid arthritis

The YLLs were 781 and the YLDs were 245,626. Finally, the DALYs calculated were 246,408 for a rate of 752.69 per 100,000.

When compared with that reported data by the GBD 2016, the burden of disease for OA was 204 (IC95% 143-278). The results of the present study show that the burden of the disease is higher, and the conditional factor is the YLDs.

Conclusion: Osteoarthritis is a frequent and disabling rheumatic disease that confers a large burden of rheumatic disease affecting people over 50 years of age. The treatment of OA should be focused on reducing disability and holistic intervention strategies to promote good quality of life.

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AB1206 SELF-REPORT OF FRACTURE HISTORY COMPARED TO FRACTURE CODES FROM AN ELECTRONIC HEALTH RECORD DATASET

Maria Danila¹, Amy Mudano¹, Elizabeth Rahn¹, Andrea Lacroix^{2,3}, Jeffrey Curtis¹, Kenneth Saag¹. ¹University of Alabama at Birmingham, Birmingham, United States of America; ²Group Health Cooperative, Seattle, United States of America; ³University of California San Diego, La Jolla, United States of America

Background: Self-reported fracture history data is frequently used in epidemiological studies of osteoporosis. Self-reported fracture data may differ from fracture history coded in electronic health records (EHR) due to imperfect patient recall, incomplete communication with clinicians, or lack of a universal EHR. Because both self-reported fracture history and EHR data can define phenotypes for clinical research studies, it is important to understand how these 2 data sources compare.

Objectives: To compare self-reported fracture history using survey data with fracture codes from an available EHR dataset.

Methods: Self-reported fracture data was derived from the Activating Patients at Risk for Osteoporosis (APROPOS) trial, which recruited participants from the Global Longitudinal study of Osteoporosis in Women (GLOW) cohort. Prior fracture data was collected using a survey deployed June - August 2015. Women were asked if they ever had a fracture and for each fracture type the date of the most recent one. Data on fractures recorded in the EHR September 2011 - June 2015 was obtained from Kaiser Permanente Washington Health Research Institute. We excluded skull, toes and fingers fractures. We defined concordance between the EHR and self-reported data if the location of a fracture was reported to be the same and if the reported dates were within 1 year of each other. Kappa (κ) statistic described the concordance between the 2 sources of fracture history. Descriptive statistics

evaluated potential factors associated with discordance between the self-reported and EHR-coded fracture history.

Results: A total of 133 fractures from 360 women (91% white, mean [SD] age 74.5(7.5) years, 82% had some college education) were included. There were 35 fractures reported on the survey but not in the EHR and 39 fractures coded in the EHR but not in the survey. Agreement between self-reported and EHR fractures was κ 0.48. Of the discordant fractures, we were more likely to find claims for fractures in EHR referent to self-report among whites (OR=5.5, 95%CI 1.1-27.9), for major osteoporotic fractures (OR=2.8, 95%CI 1.1-7.1), and for fragility fractures that typically require hospitalization (vertebral, hip, femur, pelvis) (OR=3.8, 95%CI 1.3-10.7). Discordance between EHR codes and self-reported fractures did not vary by age, formal education, or health literacy.

Conclusion: There was only modest correlation between self-reported fracture history and EHR fracture codes. This discrepancy may have implications for clinical and epidemiological studies of fractures suggesting that combining both types of data may be optimal.

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AB1207

ASSESSMENT OF RHEUMATIC DISEASES PATIENTS EXPERIENCE WITH THEIR HEALTHCARE USING IEXPAC. FACTORS ASSOCIATED AND AREAS OF IMPROVEMENT:

Javier de Toro-Santos¹, L. María. García Vivar², Lucía Pantoja³, Cristina Lerín Lozano⁴, Silvia García-Díaz⁵, Yvonne Mestre⁶, Sabela Fernández⁶, Luis Cea-Calvo⁶. ¹Hospital Universitario A Coruña, A Coruña, Spain; ²Hospital Universitario de Basurto, Bilbao, Spain; ³Hospital del Bierzo, Ponferrada, Spain; ⁴Hospital de Manacor, Manacor, Spain; ⁵Hospital de Sant Joan Despí Moisès Broggi, Barcelona, Spain; ⁶Merck Sharp and Dohme, Madrid, Spain

Background: The experience of patients with healthcare has been associated to important outcomes.

Objectives: We describe the experience with healthcare of patients with rheumatic diseases from Spain self-reported through IEXPAC, a validated questionnaire, and the influence of demographic and health care-related factors.

Methods: The IEXPAC scale (*"Instrument to Evaluate the EXperience of PATients with Chronic diseases"*, <http://www.iemac.es/iexpac/>) was developed and validated in Spain by health care professional and social organizations, experts in quality of healthcare and chronic patients (1). It consists of 12 items with Likert responses from "always" to "never" and yields an overall score from 0 (worst) to 10 (best experience). Three factors with sub-scores derive from the scale: Factor 1 (productive interactions, average of items 1, 2, 5 and 9, on patient-health care professionals relationship), Factor 2 (new relational model, average of items 3, 7 and 11, on the use of new technologies and contact with other patients) and Factor 3 (self-management, patients' ability to self-care, average of items 4, 6, 8 and 10). Data were obtained through an anonymous survey to patients from 25 Spanish hospitals. Bivariate comparisons and a multivariate analysis were made to explore the association between scores and demographic and health care-related characteristics.

Results: 625 patients received the survey, 359 (57.4%) returned it (mean age 55 years, 67% women). The percentage of patients who responded

"always" or "nearly always" to the different statements is displayed in table 1. Mean overall IEXPAC score was 5.5 (SD 2.0), sub-scores were: productive interactions: 7.5 (2.5); new relational model: 1.7 (2.1); self-care: 6.5 (2.5). Overall score was higher (better experience) in men ($p=0.022$), in those needing follow-up in a different region ($p=0.004$), seen by a lower number of physicians ($p=0.025$), seen by the same physician each time ($p<0.001$), treated with lower number of medicines ($p=0.039$) or with subcutaneous or intravenous (SC/IV) drugs ($p=0.083$). Multiple linear regression models (table 2) showed that being followed up by the same physician, being seen by lower number of specialists, and being treated with SC/IV drugs were associated to better overall experience scores. Associations were similar for the productive interactions and self-management factors.

Conclusion: Through IEXPAC, patients with rheumatic diseases identified areas of improvement in healthcare, especially those related with access to reliable information and services, interaction with other patients and continuity of health care after hospital discharge. Better experience was associated to being seen by lower number of specialists or being followed-up by the same physician each time, and also with treatment with SC/IV drugs, maybe in relation to the more personalized care these patients receive.

Table 1. Word-for-word IEXPAC items. Percentage of patients who responded "mostly" or "always" to each item

IEXPAC item	Percentage (%) who responded "mostly" or "always"
1. They respect my lifestyle The professionals who care of me listen to me and ask me about my needs, habits and preferences to adapt my treatment and care plan	76.5
2. They are coordinated to offer good health care to me Health and social care services are coordinated to improve my wellbeing and quality of life in my environment (family, neighbourhood, town).	60.6
3. They help me to get information from the Internet The professionals who care for me inform me about trustful webpages and internet forums that I can consult to better know my disease, its treatment and the consequences they may have on my life.	12.8
4. Now I can take care of me better I feel that my confidence in my ability to take care of myself, manage my health problems and keep my autonomy has improved.	74.3
5. They ask me and help me to follow my treatment plan I regularly review the adherence to my treatment and care plan with the professionals who care for me.	73.5
6. We set goals for a healthy life and better control my illness I've been able to agree with the professionals who care for me on specific objectives regarding diet, physical exercise and medication to get better control of my health problems.	63.4
7. I can use Internet and my mobile phone to consult my medical records I can consult my clinical record, tests results, programmed visits and access to other services through the internet or the mobile app of my health service.	7.3
8. They make sure that I take medication correctly The professionals who care for me review with me all of the medication I take, how I take it and how it suits me.	72.4
9. They worry about my welfare The professionals who care for me are concerned with my quality of life and I feel they are committed to my wellbeing	79.1
10. I have been informed on the health and social resources that can help me The professionals who care for me inform me about the health and social resources available in my neighbourhood or town that I can use to improve my health problems and take better care of myself.	33.8
11. They encourage me to talk to other patients The professionals who care for me invite me to participate in patients groups to share information and experiences on how to care for ourselves and improve our health.	10.3
Respond to the following statement only if you have been admitted to the hospital in the last 3 years. 12. They care about me when I come home after being in the hospital After hospital discharge, they have called or visited me at home to see how I was and what care did I need.	25.7