In general, patients identified problematic gaps in SoCs more frequently than rheumatologists did. These findings can help to evaluate quality of care and to work towards improvement of care for RA patients in Europe.

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OP0308

QUALITY OF CARE PREDICTS OUTCOME IN SYSTEMIC LUPUS ERYTHEMATOSUS – CROSS SECTIONAL ANALYSIS OF A GERMAN LONG-TERM STUDY (LULA COHORT, 2011–2015)

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Background: Systemic lupus erythematosus (SLE) is a chronic disease, which is still associated with significant morbidity and mortality¹. Recommendations for the management of SLE patients exist²⁻⁵, but information on its implementation and the resulting impact on long-term outcome remain unclear.

Objectives: Our aim was to study the quality of SLE medical care in Germany to understand gaps and to analyze the association to long-term outcome parameters.

Methods: In the LuLa-study information on demographics, clinical and medical care parameters are assessed annually by self-reported questionnaires among a representative sample of SLE patients in Germany (LuLa cohort, n=572). In 2013 additional questions on the management of care, as mentioned in current guidelines and recommendations, were surveyed. Ten items predicting a good clinical care (quality measures) were evaluated and an overall score with a minimum of 0 points and a maximum of 10 points was calculated. The ten items are taking antimalarials, osteoporosis protection at a dose above 7.5mg prednisolone equivalent per day or taking ≤ 7.5mg per day, vaccination, blood pressure, fat metabolism counseling, urine examination and blood test once a year, treatment of comorbidity fat metabolism disorder, osteoporosis and hypertension. Health related quality of life (Short Form Survey, SF-12/36), damage (Brief Index of Lupus Damage, BILD) and disease activity (Systemic Lupus Activity Questionnaire, SLAQ) were chosen as relevant proxies for long-term outcome.

Using linear regression, we examined the relationship between the quality measures and outcome parameters, adjusted for age, disease duration and gender.

Results: 65.5% of the patients consulted a rheumatologist as a main contact for their disease. On average 6.1 points of the 10 quality measures were met (SD 1.7). The fulfillment of these quality measures varied between 22.8% (fat metabolism counseling) and 97.6% (osteoporosis protection at a dose above 7.5mg prednisolone equivalent per day or ≤ 7.5mg per day). Fulfilling more clinical care items in 2013 was predictive for high disease-related quality of life (SF-36, p=0.004), low progress in disease-related damage (BILD, p=0.048) and low disease activity (SLAQ, p=0.046) in the subsequent years.

Conclusion: Our study illustrates a strong link between the quality of care and important SLE outcome parameters: quality of life, disease-related damage and disease activity assessed by a self-reported questionnaire. Consistent considerations of these care parameters, which are recommended in several management guidelines, yield a positive effect on outcome. An interdisciplinary approach with general practitioners and other specialists is certainly beneficial and warranted. German Clinical Trial Register, www.germanctr.de, DRKS00011052

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OP0309

OPTIMIZATION OF FLARE MANAGEMENT IN PATIENTS WITH RHEUMATOID ARTHRITIS: RESULTS OF A RANDOMIZED CONTROLLED TRIAL

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Background: Flares in rheumatoid arthritis (RA) are common [1]. The shortage of readily available specialized care may hinder early detection and timely management of RA flares. Engaging non-physician rheumatology providers in care of RA flares may be beneficial.

Objectives: To evaluate the effect of a nurse-led flare management intervention versus usual care between rheumatology visits on flare occurrence and RA disease activity in patients with RA.

Methods: Patients with established RA (2010 ACR criteria) were randomized to the intervention versus usual care. The Flare Assessment in Rheumatoid Arthritis (FLARE-RA) questionnaire was administered monthly during the 24-month follow-up to all patients in the intervention arm to assess flare status. The results of the FLARE-RA questionnaire and patient's response to the question "Are you currently in a flare of your RA?" were recorded. Telephone nurse-led counseling or a visit with a mid-level rheumatology provider within 7 days of detection of flare was offered to patients in the intervention arm who indicated they were in flare. Patients in the usual care arm were followed by their rheumatology providers according to standards of care. OMERACT9 definition of flare was used to compare flare occurrence between the study arms. All patients completed satisfaction surveys at baseline and at the end of the follow-up.

Results: 150 patients with RA were randomized to intervention (n=75) versus usual care (n=75). At baseline, the majority of patients in the intervention arm (51%) and in the usual care (60%, p=0.32) were interested in expedited appointments with a rheumatology provider if in RA flare. There were no differences between the study arms at baseline in age, sex, tender joint counts, pain intensity, patient and physician global assessments, C-reactive protein levels, DAS28-CRP, CDAI, or SDAI. Despite randomization, patients in the intervention arm had lower swollen joint counts (1.1±2.7 vs 2.4, p=0.003) and Health Assessment Questionnaire (HAQ) score (0.6±0.6 vs 0.9±0.6, p=0.005) than those in the usual care arm. The number of patients in the intervention arm who completed the FLARE-RA questionnaires at baseline, 6, 12, 18, and 24 months was 75, 37, 27, 13, and 23, respectively. Patients in the intervention arm completed a median of 8.5 (range 1–24) questionnaires. RA flare was reported on 122 (19%) of these questionnaires; average FLARE-RA score: 2.57. Patients agreed to have an expedited clinic visit with a rheumatology provider during 39 (32%) of flares. The majority of patients preferred to self-manage their flare (76, 62%) or receive nursing advice over the phone 7 (6%). There were no differences in DAS28-CRP, CDAI, SDAI, anti-rheumatic treatment change by rheumatology provider, RA flare by OMERACT9 definition, or remission by CDAI between the study arms over 24-month follow-up. At the end of the study, a higher proportion of patients in the intervention arm (44%) versus the usual care arm (21%, p=0.04) reported positive effect of participation in the study on the management of RA flares.

Conclusion: The majority of patients expressed interest in expedited rheumatology appointments for their RA flares on their baseline patient-satisfaction survey. However, during the study, patients in the intervention arm largely preferred self-management and/or over-the-phone counseling. The nurse-led flare