be addressed by clinical teams to improve adherence and clinical outcomes.

Table 1. Multivariate analysis. Factors associated to non-adherence behaviors of patients with rheumatic diseases.

	OR (95% CI)	p-value
Age (1-year increment)	1.00 (0.98 – 1.02)	0.984
Gender (female versus male)	1.04 (0.57 – 1.90)	0.892
Need of taking medication 3-4 times per day (versus 1-2 times per day)	1.40 (0.74 – 2.66)	0.306
Number of different medicines (1-unit increment)	1.00 (0.89 – 1.14)	0.967
IEXPAC overall score (1-unit increment)	1.04 (0.90 – 1.21)	0.581
BMQ overall score (1-unit increment)	0.95 (0.91 – 1.00)	0.052

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THU0624

UNDERSTANDING ETHNIC DIFFERENCES IN THE UTILIZATION OF NONSTEROIDAL ANTI-INFLAMMATORY DRUGS FOR OSTEOARTHRITIS

Ernest Vina¹, Michael Hannon², Jazmin Dagnino¹, C. Kent Kwok¹. ¹University of Arizona, Rheumatology, Tucson, United States of America; ²Pinney Associates, Pittsburgh, United States of America

Background: The prevalence of arthritis-attributable activity limitation, work limitation and severe pain are significantly higher among Hispanics than among non-Hispanic Whites (NHWs) in the US. While Hispanics are less likely to report regular use of nonsteroidal anti-inflammatory drugs (NSAIDs), reasons for this decreased NSAID use are unknown. It is also unclear whether there are ethnic differences in the use of both over-the-counter (OTC) and prescription NSAIDs.

Objectives: To determine: 1) if there are ethnic differences in the use of OTC and prescription oral NSAIDs for knee/hip osteoarthritis (OA); 2) if there are differences in familiarity with and perceptions of efficacy and risk of NSAIDs between Hispanics and NHWs; and 3) if patient attitudes/beliefs about NSAIDs mediate observed ethnic differences in the use of NSAIDs for OA.

Methods: Participants ≥50 years of age with chronic frequent pain due to knee/hip OA completed structured interviews. Data on sociodemographic characteristics, clinical information, actual use of oral NSAIDs for OA treatment (last 6 months), and familiarity with NSAIDs (3 items, yes/no response) were collected. Perceptions of efficacy (4 items) and risk (3 items) of NSAIDs were evaluated using five-category ordinal response scale questions. Responses were averaged, with higher values indicating higher perception of efficacy/risk. Fisher's exact or Wilcoxon-Mann-Whitney tests were conducted to determine if knowledge and perceptions about NSAIDs differed by ethnicity. Multivariable logistic regression models were built to determine if ethnic differences in NSAID use were mediated by knowledge and perceptions about the medication.

Results: Among knee/hip OA patients, Hispanics (n=130), in comparison to NHWs (n=204), were younger (mean age 61.8 vs. 65.7) and less likely to have an annual income of ≥\$40K (21.6% vs. 56.5%). Hispanics, compared to NHWs, had lower odds of using an OTC NSAID (OR 0.57, 95% CI 0.36-0.90) but greater odds of using a prescription NSAID (OR 1.66, 95% CI 1.04-2.64) for OA. Hispanics, compared to NHWs, were also less likely to ever hear about OTC and prescription oral NSAID to treat OA or have a good understanding of either oral NSAID type as a treatment for OA (Table 1). Mean [SD] perceived efficacy of OTC and prescription oral NSAIDs were slightly lower among Hispanics than NHWs (2.91 [0.98] vs. 3.12 [0.88], p=0.0565; 3.03 [1.02] vs. 3.34 [0.87], p=0.0047; respectively). Mean [SD] perceived risk of prescription NSAIDs was lower among Hispanics than NHWs (2.44 [1.03] vs. 2.82 [1.01], p=0.0012). After adjustment for all familiarity with OTC NSAIDs questions, and perceived efficacy and risk of OTC oral NSAIDs scores, the association between OTC NSAID use and ethnicity was attenuated and no longer significant (OR 1.01, 95%CI 0.54-1.89). After adjustment for familiarity with and perceptions of efficacy and risk of prescription NSAIDs, the

association between prescription NSAID use and ethnicity remained significant (OR 2.62, 95%CI 1.51-4.54).

Conclusion: Among patients with knee or hip OA, Hispanics were less likely than NHWs to utilize an OTC oral NSAID as treatment for arthritis. They were also less familiar with the use of NSAIDs for OA treatment and less likely to believe in their efficacy. Patient familiarity and perceptions of OTC oral NSAIDs may mediate ethnic differences in the use of NSAIDs for knee/hip OA.

Table 1. Familiarity with NSAIDs

	Hispanics (n = 130)	NHWs (n = 204)	p-value*
OTC NSAIDs, n (%)			
Heard About It	100 (78.13)	192 (95.05)	< .0001
Family/Friends Received It	67 (52.76)	127 (62.25)	0.1080
Have Good Understanding	79 (63.20)	168 (83.58)	< .0001
Prescription NSAIDs, n (%)			
Heard About It	92 (74.80%)	173 (85.22)	0.0274
Family/Friends Received It	56 (45.16%)	107 (52.45)	0.2120
Have Good Understanding	78 (62.90%)	148 (74.00)	0.0462

*Fisher's exact

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CAN WE IMPROVE INPATIENT REFERRALS TO RHEUMATOLOGY IN A TEACHING HOSPITAL IN THE UK?

Arani Vivekanantham, Zenab Sarwar Mateen, Roseanna Wheatley, Rachael Myers, Pippa Watson, Jayne Little. Manchester University NHS Foundation Trust, Manchester, United Kingdom

Background: Inpatient referrals to rheumatology vary nationally from paper/electronic methods to phone conversations with the rheumatology registrar. In our Trust, which includes two large teaching hospitals in the UK, rheumatology referrals were hand written, faxed to secretaries and then given to the rheumatology registrar. This method was time consuming and referrals often lacked vital information. The referrer would also not know when the registrar had received the referral. A quality improvement project (QIP) in another UK hospital has shown an electronic referral system to be more efficient and safer for patients [1].

Objectives: This QIP aimed to evaluate the current system for inpatient referrals to two rheumatology departments within one large UK NHS trust and to identify aspects for improvement.

Methods: Two hundred and ten inpatient rheumatology referrals received between January 2018 - January 2019 were analysed retrospectively for inclusion of important information such as, patient location and referrer's contact details.

Results: The review of current referrals identified several areas for improvement. The results are summarised in Table 1. The reasons for referrals ranged from swollen, painful joints to new rashes and medication reviews.

Table 1. Inclusion of important items in inpatient rheumatology referrals

Item	Inclusion of item in referral n (%)		
	Wythenshawe Hospital (n=105)	Manchester Royal Infirmary (n=105)	Combined (n=210)
Date of referral	78 (74)	95 (90)	173 (82)
Time of referral	26 (25)	7 (7)	33 (16)
Name of referrer	102 (97)	92 (88)	194 (92)
Referrer's contact details	38 (36)	13 (12)	51 (24)
Patient's name, hospital number	104(99)	102 (97)	206 (98)
Patient location	95 (90)	101 (96)	196 (93)
Past medical history	62 (59)	75 (75)	137 (65)

A process mapping session was undertaken to identify how the referral system could be improved. An electronic referral system, via the local electronic patient record (EPR), was created. As well as ensuring that there is an audit trail and referrals are received in a timely manner, referrers are provided with a proforma to direct them to supply the