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VIRTUAL VISITS IS THE FUTURE COMING? TELEREUMATOLOGY. PILOT PROJECT: REVIR PROGRAM, RHEUMATOLOGY SERVICE. BARCELONA, SPAIN

Fabiola Ojeda^{1,1}, Manel Ciria¹, Carolina Perez-Garcia¹, Eric Sitjas², Elena Martinez³, Daniel Martinez-Laguna⁴, Montserrat Pimienta⁵, Jordi Monfort¹.
¹Hospital del Mar, Rheumatology, Barcelona, Spain; ²Hospital del Mar, Direction, Barcelona, Spain; ³Institut Català de la Salut, CAP Vila Olímpica, Barcelona, Spain; ⁴Institut Català de la Salut, CAP Sant Martí, Barcelona, Spain; ⁵Institut Català de la Salut, CAP Ramon Turró, Barcelona, Spain

Background: The prevalence of rheumatic diseases in the Spanish population is estimated at 22.6% according to the EPISER 2000 study. A new epidemiological study is currently underway, EPISER 2016 and its preliminary results point towards a higher prevalence. Within the national health system, primary care is the first level of access to the health system and is provided at primary care centers (CAP). The rheumatology at primary care centers at Spain has been a pioneer in the application from the team at Parc de Salut Mar (Hospital del Mar), with the physical presence of rheumatologists in the 14 centers belonging to the CAP network of the SAP Litoral. The high prevalence of the medical pathology of the musculoskeletal system and the aging of the population, can condition an increase in visit requests in rheumatology, and with it, the increase in the waiting lists of patients.

Objectives: The main objective of this study is to know the resolutive possibility of virtualization, measured in the number of visits resolved telematically, as well as its impact on the resolution capacity of the primary care physician and the reduction of the waiting list of first face-to-face visits.

Methods: Prospective experimental study, started on December 1, 2017 and ended on May 31, 2018. Four primary care centers were selected according to population and waiting list: Sant Martí Nord, Sant Martí Sud, Ramón Turró and Villa Olímpica. The REVIR program proposes the creation of a circuit for the assessment of referrals to rheumatology from primary care physicians (MAP).

Results: 726 first visit requests were received during the REVIR program. The most common categorized pathology was mechanical pathology, representing about 70% of the first visits requested. Metabolic bone disease ranked second with 16%, and inflammatory pathology ranked third (SLE, RA, SA, SPA, PsA). Chronic musculoskeletal pain ranked fourth (including fibromyalgia) and lastly soft tissue pathology. The number of first visit requests was multiplied by two in all the participating primary care centers of the project. Despite this increase, the telematic resolution of the visits created was stable, with a value greater than 40%.

Conclusion: The implementation of a system of assessment of the first visits in rheumatology requested from Primary Care is effective in decreasing the waiting list to make face-to-face visits, as well as to detect early serious pathology that requires hospital control. It has been achieved, therefore, that the patient is treated at the level of attention that corresponds to him. Guaranteeing the adequate use of hospital resources and reducing the waiting list for a first in-person visit in rheumatology in primary care is one of the most important goals fulfilled, given that it is directly related to maintaining the accessibility and equity of the public health system.

REFERENCES:

- [1] Kataria, S., & Ravindran, V. (2018). Digital health: a new dimension in rheumatology patient care. *Rheumatology International*. <https://doi.org/10.1007/s00296-018-4037->

Tabla 1: Resolution of the first virtual visits to 6 months of REVIR project

CAP	Total	First CAP	First Hospital	Virtual resolution
Ramón Turró	193 (26,4%)	94 (49%)	22 (11,3%)	77(40%)
Villa Olímpica	96 (13,2%)	36 (37,5%)	13(13,5%)	47(49%)
Sant Martí (1 y 2)	437 (60,2)	216 (49,5%)	53(12,1%)	168(38,4%)
Total	726 (100%)	346 (47,6%)	88(12,1%)	292(40,2%)

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HIGH LEVELS OF DAMAGE IN INFLAMMATORY RHEUMATIC DISEASES: A CLUE TO LOW RATES OF REMISSION AND LOW DISEASE ACTIVITY

Isabel Castrejon, Sarah Everakes, Joel Block, Sonali Khandelwal, Ailda Nika, Padmanabhan Raghu, Theodore Pincus. *Rush University Medical Center, Rheumatology, Chicago, United States of America*

Background: Despite introduction of powerful biologic medications over the last 2 decades, rates of remission and low disease activity rates in RA remain less than 50%. One possible basis is that measures and indices such as disease activity score 28 (DAS28) and clinical disease activity index (CDAI), while sensitive primarily to disease activity in clinical trial patients selected for high inflammatory activity, may also reflect clinically important joint damage and patient distress in unselected patients in routine care. Similar considerations may pertain to systemic lupus erythematosus disease activity index (SLEDAI), Bath ankylosing spondylitis disease activity index (BASDAI), and other measures and indices initially designed to assess disease activity. Levels of organ damage and patient distress, as well as inflammation, may be quantitated according to 3 physician (0-10) visual analog scales (VAS), in addition to physician global assessment VAS (DOCGL), scored in fewer than 10 seconds in routine care.

Objectives: To test a hypothesis that damage and distress may be prominent in patients with inflammatory conditions, according to mean VAS for inflammation or reversible findings (DOCINF), damage or irreversible findings (DOCDAM), and distress (DOCSTR), e.g., fibromyalgia.

Methods: All patients at one site complete a multidimensional health assessment questionnaire (MDHAQ), which includes patient global VAS (PATGL), at each visit in routine care. Physicians complete four 0-10 (none-highest) VAS for DOCGL, DOCINF, DOCDAM, and DOCSTR, and a query to estimate the proportion of clinical decisions (total=100%) attributed to each of the 3 findings. Patients were classified into various diagnostic groups, in which scores were analyzed according to mean and standard deviation.

Results: Analyses included 563 patients (Table). Mean levels of DOCGL ranged from 3.2 to 5.2, and PATGL from 3.6 to 6.5, which might be interpreted to indicate high disease activity. Highest mean DOCINF scores were seen in patients with RA, SLE, vasculitis, polymyalgia rheumatica (PMR), spondyloarthropathy (SpA), and gout (2.2-2.8), while highest mean DOCDAM was seen in OA (4.9) and DOCSTR in FM (6.2) (Table). However, in RA, mean DOCDAM was 3.7 vs 2.4 for DOCINF. DOCDAM also was almost as high or higher than DOCINF in SLE, SpA, vasculitis, and gout. Mean estimates of distress were also ≥ 1.5 in patients with all inflammatory diagnoses.

Diagnosis (per ICD code)	N (%)	Global Estimates (0-10)		Physician subscales (0-10)		
		PATGL	DOCGL	DOCINF	DOCDAM	DOCSTR
RA	64	4.9 (2.9)	4.5 (2.4)	2.4 (2.2)	3.7 (2.8)	1.9 (2.7)
SLE	47	4.1 (3.1)	3.7 (2.8)	2.2 (2.4)	1.5 (1.7)	1.8 (2.5)
SpA and psoriatic arthritis	34	4.1 (2.9)	3.9 (2.4)	2.4 (2.5)	2.7 (2.3)	1.9 (2.8)
Vasculitis and PMR	23	3.6 (2.6)	3.4 (3.0)	2.6 (1.8)	2.3 (2.2)	1.7 (2.6)
Gout	21	4.4 (2.9)	4.2 (2.7)	2.8 (2.5)	3.2 (2.8)	1.5 (1.9)
Osteoarthritis	135	5.8 (2.9)	4.9 (2.2)	1.2 (1.9)	4.9 (2.5)	2.2 (2.7)
Fibromyalgia	84	6.5 (2.6)	5.2 (2.2)	0.9 (1.2)	1.7 (2.0)	6.2 (2.6)
Other diagnosis	155	4.0 (3.0)	3.2 (2.2)	1.6 (2.0)	2.4 (2.3)	1.6 (2.1)
TOTAL	563	4.8 (3.0)	3.9 (2.4)	1.6 (2.0)	2.9 (2.5)	2.4 (2.9)

Conclusion: Rheumatologists estimated high levels of damage in patients with RA and other inflammatory rheumatic diseases, similar or higher than inflammation, as well as recognizable distress which may elevate measures such as tender joint count and PATGL. These findings may explain in part low rates of remission and low disease activity noted in RA and other inflammatory diseases, as index scores used to document improvement are not affected by anti-inflammatory therapy. Most rheumatology clinical quantitative measurement is directed to inflammatory activity. However, an estimate of damage and distress may clarify why many patients may appear to have suboptimal control of inflammatory activity despite aggressive treatment, including treat to target in RA.

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