Results: From 2014 to 2017, 21,993 SLE patients were identified. Women represented 87.4% of the cases, 5428 patients were selected to make up the sample of SLE patients. The number of patients without diagnosis of SLE was 19,419,540. From this population was drawn randomly a 10% size sample, to make up the potential control sample. To estimate the incremental cost of making the description analysis and calculation of prevalence, every patient was aged 18 or older on index date. Additionally, as the length of follow-up period was fixed to two years, all patients whose index date had been greater than first January 2016 were excluded from the study sample (Figure 1). The variables considered in this part of the study were demographic, clinical (Charlson Comorbidity Index) and cost-related variables, which was the outcome variable of the study, this cost was made up of the sum of all medical costs, regardless of whether they were related or not to SLE. Costs were adjusted for inflation, to values in 2017. To evaluate the effect of having SLE vs. not having, on the direct cost in health, propensity scores analysis was used to reduce differences in the baseline characteristics. Three groups were formed based on disease severity: high (patients who had renal failure), medium (patients in intensive care unit at least once but without renal failure) and low (remaining SLE patients) (See table 1).

Table 1. Incremental cost by degree of severity

<table>
<thead>
<tr>
<th>Degree of Severity</th>
<th>Average adjust incremental cost per year (in COP)</th>
<th>Confidence interval construction method</th>
<th>Confidence interval (95 %) (in COP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>$19,930,931.67</td>
<td>t-interval</td>
<td>$16,525,728.01</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bootstrap</td>
<td>$3,460,932.89</td>
</tr>
<tr>
<td>Medium</td>
<td>$7,248,201.04</td>
<td>t-interval</td>
<td>$11,688,205.25</td>
</tr>
<tr>
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<td>Bootstrap</td>
<td>$853,300.40</td>
</tr>
<tr>
<td>Low</td>
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<td>t-interval</td>
<td>$1,127,675.2</td>
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<tr>
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<td>$688,197.5</td>
</tr>
</tbody>
</table>

Methods: The present study was carried out with an administrative database that includes all the enrollees in the contributive health scheme for a period of 4 years. It was established an operative definition to identify individuals with the disease in order to make the descriptive analysis and calculation of prevalence. Every patient was aged 18 or older on index date. Additionally, as the length of follow-up period was fixed to two years, all patients whose index date had been greater than first January 2016 were excluded from the study sample (Figure 1). The variables considered in this part of the study were demographic, clinical (Charlson Comorbidity Index) and cost-related variables, which was the outcome variable of the study, this cost was made up of the sum of all medical costs, regardless of whether they were related or not to SLE. Costs were adjusted for inflation, to values in 2017. To evaluate the effect of having SLE vs. not having, on the direct cost in health, propensity scores analysis was used to reduce differences in the baseline characteristics. Three groups were formed based on disease severity: high (patients who had renal failure), medium (patients in intensive care unit at least once but without renal failure) and low (remaining SLE patients) (See table 1).

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Results: From 2014 to 2017, 21,993 SLE patients were identified. Women represented 87.4% of the cases, 5428 patients were selected to make up the sample of SLE patients. The number of patients without diagnosis of SLE was 19,419,540. From this population was drawn randomly a 10% size sample, to make up the potential control sample. To estimate the incremental cost of having SLE it was used multivariate regression through a GAM model. The estimated average annual total cost of a patient with SLE was $6,139,046 COP vs. non-SLE patient cost of $4,113,191 COP. Meanwhile, a patient in the low severity level, the estimate was $7,248,201.04. The annual cost of a SLE patient was $2,025,855 COP greater than the cost of a non-SLE patient. The adjusted incremental cost was estimated taking into account the levels of severity. In the Table 1 are presented the mean values of incremental costs and 95% confidence intervals.

Conclusion: Although the prevalence of SLE in Colombia is relatively low, the direct costs generated for this disease might be very high. The annual cost for a SLE patient was $2,025,855 COP greater than the cost of a non-SLE patient. When considering the severity levels of the disease, it was found a $19,930,931.67 incremental cost estimate for high level of severity. In the medium level, the estimate was $7,248,201.04. Meanwhile, a patient in the low severity level had a $853,300.40 incremental cost.

References:

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2020-eular.5785

SAT0651-HPR  BARRIERS IN DIAGNOSING RHEUMATOID ARTHRITIS – A FOCUS GROUP STUDY ON THE GENERAL PRACTITIONERS’ PERSPECTIVES
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1Aarhus University Hospital, Department of Clinical Pharmacology, Aarhus N, Denmark; 2Institute of Public Health, Research Unit of General Practice, Aarhus C, Denmark; 3Rigshospitalet, Copenhagen Center for Arthritis Research, Center for Rheumatology and Spine Diseases, Copenhagen, Denmark; 4Aarhus University Hospital, Department of Rheumatology, Aarhus N, Denmark; 5Aarhus University, Department of Clinical Medicine, Aarhus N, Denmark

Background: Early treatment, before three months from symptom onset of rheumatoid arthritis (RA), is essential to increase the likelihood of remission and to...
prevent permanent joint damage (1). However, it has been shown that only 20% of the patients are seen within the first three months, and the median delay in general practice has been estimated to 4 months (range 2–9) (2).

**Objectives:** To explore the barriers in diagnosing RA from the general practitioners’ (GPs) perspective.

**Methods:** We conducted a qualitative study based on focus group interviews. We recorded the interviews digitally and transcribed verbatim. The transcribed interviews were analyzed based on content analysis (3), by using Nivo 12. Sample size was determined by thematic saturation.

**Results:** In total ten GPs participated in three different focus groups. 40% were male, mean age was 53 years (range 37-64), and mean year since specialization authorization as GP was 16 years (range 5-23). 60% of the GPs worked in a practice located within the referral area of a university hospital; the remaining within the referral area of a regional hospital.

Four themes emerged in the analysis: 1) When the patient is not a text book example, referring to the difficulty of identifying relevant symptoms among all clinical manifestations from the joints as described by the patients, 2) The importance of maintaining the gatekeeper function, referring to the societal perspective, and the GPs responsibility to refer the right patients to secondary care, 3) Difficulties in referral of patients to the rheumatologist, referring to perceived differences in the collaboration with rheumatologists. The GPs experienced that it was sometimes difficult to be assisted by rheumatologists, especially when the clinical picture was not ‘clear cut’. Finally, (4) Para-clinical testing, can it be trusted? referring to challenges on the evaluation of especially biomarkers.

The overarching theme was: Like finding a needle in a haystack, covering the GPs difficulties in detecting RA among the many patients in general practice who may appear to be healthy and at the same time have symptoms very similar to RA.

**Conclusion:** The GPs experienced that RA was a difficult diagnosis to make. The immediate challenge was that RA patient’s initial symptoms often resembled those of more common and less serious conditions, and that investigative findings such as biomarkers can be negative at the early state of the disease. At the same time, the collaboration with rheumatologists was sometimes seen as a hurdle, when the clinical picture was not ‘clear cut.’

In order to facilitate earlier diagnosis of RA in general practice, the GPs and rheumatologists need to focus on these barriers by strengthening mutual information and collaboration.

Physicians should remain vigilant to patients who have conditions that do not resolve as expected with treatment, who have symptoms that persist, or who do not look well despite negative investigative findings.

**References:**


[3] Braun V. Qualitative research in psychology. 2006, 3(2), 77-101

**Disclosure of Interests:** None declared.

**SAT0852-HPR**

**CHRONIC DISEASE MANAGEMENT AND HEALTH CARE TECHNIQUES OF PATIENTS WITH SYSTEMIC SCLEROSIS IN SWITZERLAND – A CROSS-SECTIONAL STUDY**

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**Background:** People living with systemic sclerosis (SSc) often lack access to community-scheduled care and self-management support from qualified healthcare professionals. Such gaps lead to significant unmet health needs and inability to get preventive services. The Chronic Care Model (CCM) has been used to guide disease management across a wide range of chronic conditions. The CCM often uses e-health technologies to address self-management problems, connect patients with clinicians and reduce patient travel requirements.

**Objectives:** To evaluate current SSc care practice patterns and elicit patient health technology readiness to define relevant aspects and resources needed to improve SSc chronic disease management.

**Methods:** We employed a cross-sectional survey using the 20-item Patient Assessment of Chronic Illness Care (PACIC) instrument to assess how aspects of SSc care align with key components of the CCM. Six items drawn from the ‘SA (ask, advise, agree, assist, and arrange) model of behavioural counselling were included (all 26 items scored on 5-point scale, 1=never to 5=always). Acceptance of health technology was evaluated by adapting and combining questionnaires from vanRijn6 and Halwas7. German and French speaking SSc patients (<18 years) were recruited from university/cantonal hospitals and the Swiss scleroderma patients’ association. Participants completed anonymous paper/online questionnaires. Data were analysed descriptively.

**Results:** Of 101 SSc patients, most were female (76%), spoke German (78%) and had an median age of 60 years (IQR: 50-88). Median disease duration was 8 years (IQR: 5-16), spanning a range of severity (31% limited SSc, 38% diffuse SSc, 3% overlap syndrome). One-quarter (25%) did not know their disease subset.

The mean overall PACIC score was relatively low (2.91±0.95) indicating that care was ‘never’ to ‘generally not’ aligned with the CCM. Lowest mean subscale scores related to Follow-up/Coordination (2.64±1.02), Goal setting (2.68±1.07) and Problem-solving/Contextual Counselling (2.94±1.22). The single items ‘Given a copy of my treatment plan’ (1.99±1.38) and ‘Encouraged to attend programs in the community’ (1.89±1.16) were given the lowest ratings. The ‘SA summary score was 2.84±0.97.

In terms of technology readiness, 43% completed the survey online. Most participants owned a smartphone (81%), laptop (63%) and or desktop computer (46%).

The overwhelming majority of patients (91%) reported using the Internet in the last year – primarily for communication (e.g. emails, text messages). Participants indicated relatively little experience with e-health applications and participating in SSc online forums or self-help groups.

**Conclusion:** To improve chronic disease management of SSc patients in Switzerland, current care practices warrant reengineering taking CCM components into account. Specific unmet needs relate to self-management support, help patients set individualized goals, and coordinate continuous care. Web-based technologies incorporating user-centred design principles may be a reasonable option for improving care.

**References:**


**Disclosure of Interests:** Agnes Kocher Grant/research support from: Sandoz to support the development of an eLearning module for patients with rheumatic diseases,. Michael Simon: None declared, Carlo Chizzolino Consultant of: Boehringer Ingelheim, Roche, Oliver Distler Grant/research support from: Grants/Research support from Actelion, Basel, Boehringer Ingelheim, Competitive Drug Development International Ltd. and Mitsubishi Tanabe; he also holds the issued Patent on mi-29 for the treatment of systemic sclerosis (US20147398, EP2331143)... Consultant of: Consultancy fees from Actelion, Acceleron Pharma, AnaMar, Bayer, Baecoen Discovery, Blade Therapeutics, Boehringer, CSL Behring, Catenion, ChemomAb, Curziun Pharmaceuticals, Ergonex, Galapagos NV, GSK, GSK Global Pharmaceuticals, Inventiva, Italianmaco, IQvia, medac, Medscape, Mitsubishi Tanabe Pharma, MSD, Roche, Sanofi and UCB; Speakers bureau: Speaker fees from Actelion, Basel, Boehringer Ingelheim, Medscape, Pfizer and Roche, Andrew A. Dwyer: None declared, Peter Villiger Consultant of: MSD, Actelion, Roche, Pfizer, Sanofi, Speakers bureau: Roche, MSD, Pfizer, Ulrich Walker Grant/research support from: Ulrich Walker has received an unrestricted research grant from Abbvie, Consultant of: Ulrich Walker has act as a consultant for Abbvie, Actelion, Boehringer Ingelheim, Bristol-Myers Squibb, Celgene, MSD, Novartis, Pfizer, Phadia, Roche, Sandoz, Sanofi, and ThermoFisher, Paid instructor for: Abbvie, Novartis, and Roche, Speakers bureau: Abbvie, Actelion, Bristol-Myers Squibb, Celgene, MSD, Novartis, Pfizer, Phadia, Roche, Sandoz, and ThermoFisher, Dunja Nicca: None declared

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