recommends for the role of the RNS which were recently updated (Beech et al., 2019). This framework maps all of these requirements.

**Objectives:** This work supports the development of roles, improve access for patients and reduce. This document will act as a foundation for building sustain-ability and a more robust education and role development strategy. This work will strengthen rheumatology nursing and support all 4 UK nation’s issues regarding recruitment, retention, sustainability, succession planning and benchmarking. Dissemination is key and we will work hard with stakeholders to ensure centrali-zation of a nationally adopted framework. This abstract submission will increase dissemination opportunities.

**Methods:** Online data sources were searched for the most relevant and cur-rent evidence. Where research evidence wasn’t available, existing and new knowledge was utilised from a consensus of clinical expert and patient opin-ions, several rounds of discussions took place virtually and face to face. RCN Rheumatology Nurse Forum Workshop attendees in June 2019 also answered a questionnaire to elicit views and demographic information regarding roles.

**Results:** The questionnaire results demonstrated 100% (n37) agreement with the development of the framework and that only 2 respondents had completed a competency process. 60% were RNS. Of these 52% (n13) were band 6, 47% (n9) were band 7, and 1% were band 8 consultant nurses. The questionnaire highlighted the need to develop the framework. Results were fed back to the working party to inform the domains to be included.

**Conclusion:** Document will be at ESR 2020 having successfully submitted a session proposal and abstract. Evaluation will begin later in the year to 12 months from launch. We will measure impact using a variety of methods includ-ing membership Facebook pages and the questionnaire at point of download request. We will measure where and how the competency is being used and adoption of the framework throughout the UK.

**References:**

**Disclosure of Interests:** Polly Livermore: None declared, Diana Finney Speak-ers bureau: Nordic Abbvie, Julie Begom: None declared, Ruth Wyllie: None declared, Trish Cornell Employee of: Consultant Nurse for Abbvie, Helen Smith: None declared, Lisa Howie: None declared, Louise Parker: None declared DOI: 10.1136/annrheumdis-2020-eular.6681

**AB1358-HPR**

**DIAGNOSIS OF AXIAL SPONDYLOARTHRITIS: A PRIMARY UNMET EDUCATIONAL NEED FOR RHEUMATOLOGISTS**

W. P. Maksymowych1, 2, L. Caplan1, A. Deodhar1, S. Dolatabadi1, M. Hwang2, A. Carlsson2, K. Steed2, A. Carapello2, J. Paschke2, L. S. Genel2, 1University of Alberta, Edmonton, Canada; 2CARE Arthritis, Edmonton, Canada; 3Rocky Mountain Regional VAMC, Aurora, United States of America; 4Oregon Health & Science University, Portland, United States of America; 5Harbor-UCLA Medical Center, Torrance, United States of America; 6McGovern Medical School at UTHealth, Houston, United States of America; 7University of Virginia, Charlottesville, United States of America; 8James J Peters VA Medical Center, New York, United States of America; 9University of California, San Francisco, San Francisco, United States of America

**Background:** Diagnosis of axial spondylarthritides (axSpA) is challenging because of absent physical findings in early disease and the limited diagnostic performance of laboratory markers. Considerable reliance is placed on imaging of the sacroiliac joints (SIJ) but specialty training is primarily focused on interpretation of plain radiographic abnormalities.

**Objectives:** We aimed to identify what might be the primary unmet educational needs of rheumatologists completing fellowship training by using clinical and imaging data from an inception cohort of patients presenting with undiagnosed back pain. We hypothesized that concordance would increase after imaging is reviewed after the clinical data.

**Methods:** The diagnosis of axSpA was compared between local rheumatolo-gists,axSpA experts and pF using clinical and imaging data from the multicenter Screening for Axial Spondyloarthritis in Psoriasis, Iritis, and Colitis (SASPIC) Study. In this inception cohort, patients ≤45 years of age with ≥3 months back pain undergo diagnostic evaluation by a local SASPIC rheumatologist, including imaging of the SIJ, who then records a global evaluation of presence/absence of axial SpA. This is done at 3 consecutive stages: 1.After the clinical evaluation. 2.After the results of labs (HLA-B27, CRP) and radiography. 3.After review of the local MRI. In this exercise, 20 cases were selected from the SASPIC cohort and the rheumatologist global evaluations were removed from the eCRFs. Four experts in axSpA reviewed the clinical and imaging data in each eCRF and provided their global evaluations for stages 1, 2, and 3 of these 20 cases. Subse-quently, 4 pF rheumatologists conducted the same exercise blinded to the assessments of the local rheumatologist and experts in axSpA. Concordance (% agreement) between the assessors was analyzed.

**Results:** Diagnosis of axSpA by the local SASPIC rheumatologist was made in 90%, 65%, and 75% of cases after stages 1, 2, and 3, respectively. Majority diagnosis of axSpA by experts was made in 84.2% (16/19), 57.9% (11/19), and 63.2% (12/19), after stages 1, 2, and 3, respectively. Majority diagnosis of axSpA by pF rheumatologist was made in 94.4% (17/18), 100% (16/16), and 93.8% (15/16). Concordance among experts and between experts and local SASPIC rheumatologists increased after review of imaging data. For pF-rheumatologists concordance with experts increased after review of imaging for 2 assessors and decreased for the other 2 assessors. For the latter, the primary reason for decrease in concordance with experts was false positive diagnosis of axSpA in 35% and 30% of the cases after review of the imaging.

**Conclusion:** A structured case-based and sequenced evaluation of clinical and imaging data suggests a gap in the training of recently graduated rheumatolo-gists, with over-interpretation of imaging leading to false positive diagnosis of axSpA.

**AB1359-HPR**

**PERCEPTION ABOUT FIBROMyalGIA AND ITS ACCOMPANYING SYMPTOMS AMONG MEXICAN PHYSICIANS**

R. I. Arvizu-Rivera1, N. Escobedo-Zuñiga1, J. I. Colunga-Pedraza2, G. Serna-Peña3, A. Cárdenas4, 1Hospital Universitario “Dr Jose Eleuterio Gonzalez”, Internal Medicine Department, Monterrey, Mexico; 2Hospital Universitario “Dr Jose Eleuterio Gonzalez”; Rheumatology Division, Monterrey, Mexico

**Background:** Previous studies showed that 93% of rheumatologists consider fibromyalgia (FM) as a clinical entity. However, accompanying symptoms such as fatigue, widespread pain, sleep disturbance and headache are underestimated among physicians. According to a previous study, most recognized symptoms by general practitioners are fatigue and widespread pain (72.6%), while about thirty percent of physicians recognize sleep disturbance and depression as symptoms.

**Objectives:** To investigate physicians’ point of view of FM accompanying symp-toms in northeastern Mexico.

**Methods:** We devised an electronic survey about physicians’ perceived impor-tance of depression, fatigue, widespread pain, sleep disturbances, headache and irritable bowel disease symptoms (pain and cramping) in patients with FM. Questions were answered using a 5-point Likert scale: 1, strongly disagree; 2, disagree; 3, neutral; 4, agree; 5, strongly agree. General practitioners, rheumatologists, neurologists, psychologists were included.

**Results:** A total of 236 physicians were included: general practitioners, 149 (69.3%); rheumatologists, 21 (8.9%); neurologists 18 (7.6%); psychiatrists 8

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(3.4%), and family physicians, 49 (20.8%). FM was considered a clinical diagnosis by 208 (88.1%) and most physicians think FM is both a physical and psychological condition, 190 (80.5%). Full results on physicians’ perceptions is shown in Table 1. Fatigue was the symptom which most physicians agreed or strongly agreed was important in FM, 219 (92.7%). Disagreement (any degree) was greater regarding abdominal pain/cramping being an important symptom in FM, 52 (22%). Complete results can be seen in Image 1.

Table 1. Perceptions of physicians about FM.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
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<tbody>
<tr>
<td>FM is a clinical diagnosis, n (%)</td>
<td>208 (88.1)</td>
</tr>
<tr>
<td>Unsure FM is a clinical diagnosis, n (%)</td>
<td>33 (14)</td>
</tr>
<tr>
<td>FM is a physical illness, n (%)</td>
<td>12 (5)</td>
</tr>
<tr>
<td>FM is a psychological illness, n (%)</td>
<td>11 (4.7)</td>
</tr>
<tr>
<td>FM is both physical and psychological, n (%)</td>
<td>190 (80.5)</td>
</tr>
<tr>
<td>FM has a negative impact on quality of life, n (%)</td>
<td>227 (96.2)</td>
</tr>
<tr>
<td>FM has a negative impact on life expectancy, n (%)</td>
<td>135 (57.2)</td>
</tr>
</tbody>
</table>

Conclusion: FM was considered a clinical diagnosis and an illness both physical and psychological by most physicians. Headache and abdominal pain/cramping are symptoms less likely to be perceived as important in patients with FM.

References:

Disclosure of Interests: None declared

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AB1361-HPR

A MODEL TO IMPROVE MINORITY PATIENT RECRUITMENT IN LUPUS CLINICAL TRIALS - THE AMERICAN COLLEGE OF RHEUMATOLOGY MIMICT PROJECT EXPERIENCE

S. Sheikhi1, N. Wento2, S. McCalla3, A. Santani1, S. Saxena Beem1, J. Walker1, D. Hoit4, A. Howell5, K. Holz5, S. Williams5, A. Anandarajah5, 1University of North Carolina, Chapel Hill, United States of America; 2KOH Research & Communication, Atlanta, United States of America; 3American College of Rheumatology, Atlanta, United States of America; 4University of Rochester, Rochester, United States of America

Background: In the US, African Americans and Latinos are underrepresented in lupus clinical trials (LCTs), despite experiencing the greatest lupus disease burden.2,3 Low participation in LCTs results in inadequate data on treatment effective-ness for minority patients, and fewer opportunities for better care and treatment options.2 Only one percent of minority patients are referred to clinical trials each year.4 Provider barriers to making referrals include limited time and unfamiliarity with lupus and LCT opportunities.5 Using US federal grant funds, the American College of Rheumatology (ACR) developed MIMICT, a two-part model with associated materials to address provider-side LCT referral barriers. The materials include a toolkit for clinical trial sites and an educational toolkit for providers.

Objectives: Our objectives are to:
- Describe the US LCTs disparities.
- Discuss the research methodology to evaluate the two-part MIMICT model.
- Assess the feasibility of the model to increase minority involvement in clinical trials.

Methods: We designed two studies to evaluate the MIMICT model. The first study used an online, pretest/posttest, two-group evaluation approach to assess the extent to which the educational toolkit increased providers’ knowledge, attitudes, self-efficacy, and behavioral intentions to refer minority patients to clinical trial. We conducted the study in 2018 with primary care providers (PCPs) and again in 2019/2020 with specialty providers. The second study used a longitudi-nal, mixed methods, case-study approach to explore the real-world use of the toolkits with clinical trial site teams at two university medical centers.

Results: In the first study, among MIMICT-exposed PCPs, mean scores indicated statistical significance at p<0.001 with more knowledge about referring [55.84 (sd=23.51) vs 41.76 (sd=19.98), more self-efficacy to refer [55.00 (sd=37.22) vs 37.99 (sd=34.42), and more intentions to refer [6136 (43.85) vs. 33.41 (41.16) American African patients to LCTs among the treatment group than the control group, respectively. This presentation will discuss additional data comparing the study in 2018 and the study in 2019/2020 and look comparatively at outcomes across provider type.

In the second study, we found that the driver for successful engagement of providers and their subsequent use of the educational toolkit was the development of a trusting relationship between the clinical trial site teams and providers in the community. The development of trust took repeated and varied modes of contact, which we will discuss in-depth.

Conclusion: The MIMICT educational toolkit increase knowledge, self-efficacy, and intentions to refer lupus patients to LCTs. However, building trust between LCT sites and local providers takes time and repeated outreach, but the potential benefits to medicine and minority health are substantial.

References:

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HPR Interdisciplinary research

AB1361-HPR

PRIMARY CARE PHARMACOLOGICAL TREATMENT FOR PATIENTS WITH HAND ARTHRITIS

M. M. Castañeda-Martínez1, G. Figueroa-Parrá1, D. Vega-Moralés1, J. M. Calderón Espinosa1, B. R. Vázquez Fuentes1, J. A. Equivel Valerio1, Y. G. Ordoñez Azuara1, D. A. Galaz-Ortiz2, J. Alarcón1, G. S. Alarcón1, G. S. Escudero1, S. Estel1, G. J. Ross-Estel1, G. J. Alarcon1, L. Reinlib1, G. S. Cooper1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Reinlib1, G. S. Cooper2, L. Re