(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.

Variable	
FM is a clinic diagnostic, n (%)	208 (88.1)
Unsure FM is a clinical diagnostic, n (%)	12 (5)
FM is a physical illness, n (%)	33 (14)
FM is a psychological illness, n (%)	11 (4.7)
FM is both physical and psychological, n (%)	190 (80.5)
FM has a negative impact on quality of life, n (%)	227 (96.2)
FM has a negative impact on life expectancy, n (%)	135 (57.2)

Conclusion: FM was considered a clinical diagnostic 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.

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Figure 1. Image 1. Perception of accompanying symptoms of fibromyalgia (FM)

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AB1360-HPR A MODEL TO IMPROVE MINORITY PATIENT RECRUITMENT IN LUPUS CLINICAL TRIALS - THE AMERICAN COLLEGE OF RHEUMATOLOGY MIMICT PROJECT EXPERIENCE

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Background: In the US, African Americans and Latinos are underrepresented in lupus clinical trials (LCTs),¹ despite experiencing the greatest lupus disease burden.^{2,3} Low participation in LCTs results in inadequate data on treatment effectiveness for minority patients, and fewer opportunities for better care and treatment options.¹ 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.⁴ 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 longitudinal, 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 $p \leq 0.001$ 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 [61.36 (43.85) vs. 33.41 (41.16)] African American 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.

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HPR Interdisciplinary research

AB1361-HPR PRIMARY CARE PHARMACOLOGICAL TREATMENT FOR PATIENTS WITH HAND ARTHRALGIA

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Background: Primary care physicians (PCP) are the first point of contact for patients with a new-onset inflammatory rheumatic disease, like rheumatoid arthritis (RA). Consequently, primary care is crucial to the early diagnosis and prompt treatment of such individuals. The first three months following the onset of RA symptoms represent an important therapeutic window. Historically, patients with inflammatory arthritis received first-line treatment with non-steroidal anti-inflammatory drugs (NSAIDs), moving to synthetic disease-modifying anti-rheumatic drugs (DMARDs) relatively late in the disease process. As synthetic DMARDs are usually initiated in secondary care by rheumatologists, PCP focus on alleviation of patient's discomfort. Documented problems in primary care practice include accuracy of diagnosis, test ordering, medication use and delays in referral.

There is no evidence of which is the pharmacological treatment more commonly used for hand arthralgia in Family Medicine patients of a university hospital on their first or second visit.

Objectives: To examine the primary care physicians' pharmacological treatment prescribed for hand arthralgia in a Family Medicine Consultation.

Methods: In a period of a year and two months, eligible patients were recruited on their first or second visit to the Family Medicine Consultation of the Hospital Universitario "Dr. José Eleuterio González" in Monterrey, Nuevo León, México. Eligible patients were adults (aged ≥ 18 years) with hand arthralgia as their chief complaint, who had not rheumatologic diagnosis and wasn't caused by trauma. Ninety patients were recruited, data were collected by capturing the prescription made by PCP.