Background: The increasing availability of biosimilars (bsDMARDs) has created a financial incentive to encourage switching to cheaper products ("non-medical switch") leading to different switching scenarios. While the clinical efficacy and safety of multiswitching seems to be established (1), limited data on patients’ knowledge about bsDMARDs and satisfaction with care are available.

Objectives: The aim of our study was to learn more about the outcome of mono- and multiswitching scenarios in routine care with respect to patients’ attitudes towards bsDMARDs in chronic inflammatory rheumatic diseases (CIRD) such as rheumatoid arthritis (RA), axial spondyloarthritis (axSpA) and psoriatic arthritis (PsA).

Methods: Consecutive patients with CIRD who were planned to switch treatment of one adalimumab biosimilar (ADA-bsDMARD) to another ADA-bsDMARD were recruited. The number of previous ADA-bsDMARD categorized the patients into: monoswitch = 1 and multiswitch >1. Demographics and standard assessments using validated outcome parameters for disease activity, physical function, and patient satisfaction with care (Leeds Satisfaction Questionnaire (LSQ)) were documented. LSQ contains items on five subscales (provision of information; empathy with the patient; attitude to the patient; access to and continuity with the care giver; and technical competence) and a general satisfaction scale. Knowledge about bsDMARDs was recorded using a structured questionnaire.

Results: Out of 90 patients in total, there were 42 with a monoswitch and 48 with a multiswitch scenario (Table 1). Patients were satisfied with care irrespective of the switching scenario. However, the knowledge about bsDMARDs was generally rather low (Figure 1). Less than one third of patients was able to identify correct answers about manufacturing, efficacy/safety issues, approval status and costs of bsDMARDs. However, when comparing the two switch scenarios, no differences in disease characteristics nor in satisfaction with care were found. Also the number of switches had not increased the knowledge about bsDMARDs.

Conclusion: This study shows that multiswitching did not lead to reduced satisfaction with care in patients on treatment with bsDMARDs. Especially, the number of switches did have no negative impact on patients satisfaction. The observation that patients who underwent multiple switches had no more knowledge about bsDMARDs than patients who just had one switch may just be explained by the positive experience most patients had with switching.

REFERENCES:

Table 1. Patients and disease characteristics stratified by switch scenario

<table>
<thead>
<tr>
<th>Variables*</th>
<th>Monoswitch (n=42)</th>
<th>Multiswitch (n=48)</th>
<th>P-Wert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex, male, n (%)</td>
<td>23 (54.7)</td>
<td>26 (54.2)</td>
<td>-</td>
</tr>
<tr>
<td>Age, years</td>
<td>44 (11)</td>
<td>51 (11)</td>
<td>-</td>
</tr>
<tr>
<td>Rheumatoid Arthritis, n (%)</td>
<td>14 (33.3)</td>
<td>7 (14.6)</td>
<td>-</td>
</tr>
<tr>
<td>Axial Spondyloarthritis, n (%)</td>
<td>23 (54.8)</td>
<td>31 (64.6)</td>
<td>-</td>
</tr>
<tr>
<td>Psoriatic arthritis, n (%)</td>
<td>5 (11.9)</td>
<td>10 (20.8)</td>
<td>-</td>
</tr>
<tr>
<td>Disease duration, years</td>
<td>9.2 (2.5)</td>
<td>10.6 (6.7)</td>
<td>0.48</td>
</tr>
<tr>
<td>HAQ</td>
<td>12.0 (6.0)</td>
<td>12.0 (5.0)</td>
<td>0.91</td>
</tr>
<tr>
<td>ASDAS</td>
<td>2.1 (1.2)</td>
<td>1.6 (1)</td>
<td>0.70</td>
</tr>
<tr>
<td>BASFI</td>
<td>4.6 (2.9)</td>
<td>3.7 (2.9)</td>
<td>0.87</td>
</tr>
<tr>
<td>Patient satisfaction LSQ-General (1-5) #</td>
<td>3.7 (0.7)</td>
<td>3.9 (0.6)</td>
<td>0.58</td>
</tr>
<tr>
<td>LSQ-information (1-5)</td>
<td>3.7 (0.6)</td>
<td>3.6 (0.4)</td>
<td>0.20</td>
</tr>
<tr>
<td>LSQ-Empathy (1-5)</td>
<td>3.6 (0.6)</td>
<td>3.5 (0.5)</td>
<td>0.57</td>
</tr>
<tr>
<td>LSQ-Technical (1-5)</td>
<td>4.1 (0.5)</td>
<td>4.1 (0.5)</td>
<td>0.51</td>
</tr>
<tr>
<td>LSQ-Attitude (1-5)</td>
<td>3.8 (0.7)</td>
<td>3.9 (0.5)</td>
<td>0.62</td>
</tr>
<tr>
<td>LSQ-Access (1-5)</td>
<td>3.7 (0.6)</td>
<td>3.8 (0.6)</td>
<td>0.70</td>
</tr>
</tbody>
</table>

*values in mean (SD)# values of 1 indicate dissatisfaction

Disclosure of Interests: None declared

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POS0303

PREVENTION OF CHRONIC DISEASES DUE TO INFLAMMATION IN INFLAMMATORY ARTHRITIS: RESULTS OF A DELPHI PROCESS TO SELECT CARE RECOMMENDATIONS FOR AN ELECTRONIC MEDICAL RECORD (EMR) INTERVENTION

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Background: Inflammatory arthritis (IA) predisposes patients to several chronic conditions including cardiovascular diseases (CVD), diabetes (DM), osteoporosis (OP) and infections, likely due to systemic effects of inflammation. Studies have found that patients with IA often receive suboptimal care for screening and managing these conditions.

Objectives: This is the first phase of a study which will develop and pilot test automated EMR reminders for family physicians. The reminders will prompt family physicians to screen for and address risk factors for these conditions. We conducted a Delphi process to select care recommendations to be addressed by the EMR reminders.

Methods: We conducted a review of current BC, Canadian and international guidelines for screening and addressing risk factors for CVD, DM, OP and infection. A list of 22 care recommendations, including their level of evidence and risks/benefits of implementation, was reviewed by a panel of six family physicians, three rheumatologists and three IA patients, in a three-round online modified Delphi process. Panelists rated each care recommendation, using 9-point scales, on 1) their clinical importance, 2) their likelihood of improving outcomes, and 3) implementation feasibility. Results were discussed in an online forum. Panelists then rated slightly revised care recommendations, modified based on feedback from the discussion. Care recommendations were retained if the median rating was ≥ 7 with no disagreement as defined by the RAND/UCLA Method handbook.

Results: A list of 15 care recommendations was selected by the Delphi process for EMR integration, including recommendations that address CVD risk assessment (1), hypertension screening (1), DM screening (2), fracture risk assessment (1), BMD testing (1), osteoporosis prevention (1) and treatment (1) with bisphosphonates, preventing infections through immunization (2), minimizing steroids (1) and hepatitis screening (1), screening for hydrochloroquine retinal toxicity (1), and counselling for lifestyle modifications (2). We excluded 7 recommendations which addressed lipid testing (1), BMD testing in steroid users (1), immunizations (2), weight management (1), and DMAF/AF laboratory test monitoring (2). Recommendations were excluded on the basis of importance (1) or feasibility (6).

Conclusion: The results of the Delphi process will inform the development of reminders, integrated in EMRs, that will support family physicians in their efforts to engage IA patients in addressing risk factors for chronic diseases related to inflammation. We hope to improve the prevention of these diseases, which represent an important cause of morbidity and mortality for people with inflammatory arthritis.

Acknowledgements: Iman Sheriff’s work on this project was funded by the CRA summer studentship programme. Dr. Lacaille is supported by the Mary Pack Chair in Arthritis Research from UBC and The Arthritis Society of Canada. Thank you to all who participated in the Delphi survey.

Disclosure of Interests: None declared

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POS0304

EPIDEMIOLOGY AND ECONOMIC BURDEN ASSOCIATED WITH MENTAL HEALTH COMORBIDITIES IN SYSTEMIC LUPUS ERYTHEMATOSUS AND LUPUS NEPHRITIS PATIENTS

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Background: Systemic lupus erythematosus (SLE), a multisystem autoimmune disease, is associated with mental health (MH) disorders. There is scarce information on the epidemiology and economic burden associated with MH comorbidities and the impact on SLE as well as the subpopulation with lupus nephritis (LN).

Objectives: Examine the incidence and prevalence rate of MH, healthcare resource utilization (HCRU), and costs associated with MH comorbidities in SLE/LN patients.

Methods: Adult SLE and LN patients with ≥ 1 inpatient or ≥ 2 outpatient diagnosis claims for SLE/LN (ICD-9 code: 710.0; and ICD-10 codes M32.10–19, M32.8, M32.9) were identified between 01JAN2013–30JUN2019 from two large US commercial databases. Inclusion required continuous enrollment benefits 12 months pre/post-index date. Patients were divided into two groups: those with (WMH) vs. those without (NMH). WMH was defined as a MH diagnosis of depression, anxiety, bipolar disorder, or psychosis. Index date for the WMH group was first MH diagnosis claim. For the NMH group, a random index date was assigned between 01JAN2014–30JUN2018. The groups were then matched with a 1:1 ratio based on age, sex, and region within their respective databases. Incidence and prevalence rate of MH in the SLE/LN population were determined. All-cause healthcare costs and HCRU per patients per year (PPPY) were examined with generalized linear models.

Results: A total of 7,760 SLE and 336 LN patients were identified. The majority of patients were female (SLE=93.5%; LN=95.2%) with a mean age of 55.1 years (SLE) and 44.5 years (LN). The prevalence rate of MH was 35.7% for SLE and 28.8% for LN patients and the incidence rate was 18.5% and 15.3%, respectively. Anxiety and depression were the most common MH comorbidities (Figure 1). WMH inpatient stays averaged an additional 2.6 and 7.2 days longer than NIM in SLE and LN, respectively. In addition, WMH patients averaged 10.4 (SLE) and 18.4 (LN) significantly more outpatient visits PPPY than NIM. Overall healthcare costs and HCRU per patients per year (PPPY) were examined with generalized linear models.

Conclusion: This real-world study shows that MH comorbidities have a high incidence and prevalence rate in SLE and LN patients. Healthcare costs and utilization for SLE and LN patients with MH comorbidities were significantly higher than patients without MH comorbidities. This study highlights not just the high prevalence of MH comorbidity but its large contribution to SLE healthcare costs.

Figure 1. Incidence and Prevalence Rate of Mental Health Comorbidities in the SLE and LN Populations

Disclosure of Interests: None declared

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