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Background: The use of quality-of-care indicators is an important strategy to measure and evaluate if the care provided in the standard clinical setting adheres to current evidence informed best practices. Achievement of quality indicators is often reported as a quality score (%). Quality indicators are often developed from guidelines, systematic literature reviews, or expert panel consensus using a systematic approach. The recently developed national guidelines for inflammatory arthritis [1, 2] provided the fundamentals of quality indicators of inflammatory arthritis.

Objectives: To evaluate quality indicators for inflammatory, their use in routine clinical practice reflecting the processes of clinical care and improvement in outcomes.

Methods: Quality measurement was carried out across 5 centers based on six domains of quality: 1. Structure (Describes the innate characteristics of providers and the system and the organisational aspects of care), 2. Process (Assesses actual healthcare service delivered to patients by healthcare providers), 3. Patient experience (Describes the patient's perception of quality of care)[3]. 4. Outcome (Assesses the end result or the final goals of the delivered care). 5. Access (Evaluates the provision of timely and appropriate healthcare), 6. Efficiency (Describes the relationship between clinical performance and resource use). Data were logged based on patients’ recorded data.

Results: Inflammatory arthritis services are provided in 100% of the centers. 88.3% of the participants voted that they do implement “Treat to Target” approach and quality indicators for the management of inflammatory arthritis in their standard practice. Patient experience was rated positive in 63% whereas Timely treatment target was recorded in 74%. Efficiency evaluation revealed constrains attributed to lack of insurance cover of cost of some recommendations (72.7%).

Conclusion: Irrespective of resource and infrastructure constraints, assessment of all the relevant domains of care, revealed improvement and strengths of all the other measures. Results revealed that the treating rheumatologists not only do adhere to quality indicators required for the management of inflammatory arthritis, but also provide timely and appropriate healthcare that has been well received by the patients. Such results are vital as quality measurement in rheumatology is focused primarily on processes of care, consequently, process measurement facilitates implementing actionable targets for improvement instead of focussing solely on outcomes of care.

REFERENCES:

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AB1146

PHYSICIAN ADHERENCE TO CLINICAL GUIDELINES IN RHEUMATOLOGY: CAN IT HELP PROVIDING EVIDENCE-BASED, STANDARDIZED CLINICAL DECISIONS.

Keywords: Rheumatoid arthritis, Remission, Psoriatic arthritis

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Background: Clinical practice guidelines serve many targets, including guiding clinical decision-making process based on best evidence, standardized patient care, improving provider performance, setting standards of practice, and reducing variability in practice. Despite their vital role in standard practice, adherence to guidelines has been reported to be suboptimal. Overall, no information is available of how rheumatologists would interact with recently published national clinical practice guidelines [1, 2].

Objectives: To answer three principal research questions: (i) how far do rheumatologists deviate from the recommended clinical guidelines (ii) What are the major barriers to guidelines adherence? and (iii) What are the factors that would improve guideline adherence?

Methods: This was Cross sectional multi-center, survey-based study. Rheumatologists in 12 centers, covering both the north and south of Egypt, were invited to participate in the study. All outcomes were measured using a validated survey tool. The primary outcome of interest was barriers to guideline adherence. Secondary outcomes included general attitudes toward guidelines and factors that could improve adherence to guidelines. Outcomes were measured by the survey tool. All outcomes were reported on a numerical visual analogue scale (0-100). 55% was defined as a priori as a threshold to infer strong association between physician responses and category of interest. P-value <0.05 was used for statistical significance.

Results: 77 rheumatologists participated in the survey. Analysis of the participants experience revealed a broad range of knowledge with 18.2% were still in training (residents), 10.4% have 1-3 years of experience, 14.3% have 3-5 years experience, 24.7% have 5-10 years of experience whereas 32.5% had more than 10-years of experience. The majority 65% have not been ever involved in clinical guidelines development (p < 0.001). 74% agreed/ strongly agreed that they were adequately trained accessing and applying guidelines in their standard practice, whereas 6.5% only disagreed (p<0.001). 58.4% rated their adherence to clinical practice guidelines as high/very high, whereas 38% rated it as average and 2.6% rated it as low (<0.001). Concerning, adherence, 88.3% of the participants voted that they do implement “Treat to Target” approach for the management in their standard practice (p<0.001). Major barriers to guidelines adherence were time constrains due to clinical documents (53.2%), access to relevant guidelines at the point of care (48.1%) as well as lack of insurance cover of cost of some recommendations (72.7%). Factors that would improve guideline adherence included: improved focus on guidelines during training (88.3%), access to relevant guidelines at the point of care (48.1%) as well as lack of insurance cover of cost of some recommendations (72.7%).

Conclusion: Guidelines have enhanced physician adherence to management recommendations and provide evidence-based, standardized clinical decisions. Results of the work revealed significantly less tendency to deviate from the national guidelines among rheumatologists. Few areas of improvement have been identified including implementing the guidelines in trainee’s education courses and consistent access to relevant guidelines at the points of care.

REFERENCES:

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Disclosure of Interests: None Declared.

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AB1147

THE COMPARATIVE PERFORMANCE OF THREE SCREENING QUESTIONNAIRES FOR PSORIATIC ARTHRITIS IN A PRIMARY CARE SURVEILLANCE PROGRAM

Keywords: Epidemiology, Non-pharmacological interventions, Psoriatic arthritis


Background: There are considerable delays in the diagnosis of psoriatic arthritis (PsA) and earlier diagnosis is likely to lead to better outcomes.

Objectives: The aim of this study was to compare the performance of three PsA screening questionnaires in a primary care psoriasis surveillance program.

Methods: Participants with psoriasis, and not known to have psoriatic arthritis (PsA), were identified from general practice databases and invited to attend a secondary care centre for a clinical assessment. The three patient-completed screening questionnaires (PEST, CONTEST, and CONTEST with a manikin CONTEST)) were administered along with other patient reported measures and...
a clinical examination of skin and joints was performed. Participants who demonstrated signs of inflammatory arthritis suggestive of PsA were referred, via their GP, for a further assessment in a secondary care rheumatology clinic.

**Results:** A total of 751 participants attended the screening visit and 165 participants were judged to have signs and symptoms of inflammatory arthritis, of which 150 were referred for assessment. Of these 126 were seen and 48 were diagnosed with PsA. The results for each questionnaire were as follows: PEST: Sensitivity 0.625 (95% CI 0.482 to 0.749), specificity 0.757 (0.724 to 0.787). CONTEST: Sensitivity 0.604 (0.461 to 0.731), specificity 0.766 (0.736 to 0.796). CONTEST+ Sensitivity 0.542 (0.401 to 0.676), specificity 0.834 (0.805 to 0.859).

There was no evidence of any significant difference in sensitivity between questionnaires, but CONTEST demonstrated marginally superior specificity to PEST. However, the area under the ROC curve was similar for all three instruments. PEST was better at identifying cases of peripheral arthritis, including those with axial involvement, but the CONTEST questionnaires were better at identifying cases of peripheral enthesitis, though numbers were small (Figure 1).

**Conclusion:** Minimal differences in discriminative ability between the three screening questionnaires were found in this study and no specific recommendation can be made based on these results. The choice of which instrument to choose will depend on other factors, such as simplicity and low patient burden.

References: n/i.

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**AB1148**

**PATIENT AND PHYSICIAN GLOBAL ASSESSMENT OF PSORIASIC ARTHRITIS: SIMILARITY IN AGREEMENT IN ARAB COUNTRIES THAN PREVIOUSLY REPORTED ELSEWHERE – AN INTERNATIONAL STUDY UNDER THE AEGIS OF ARLAR**

**Keywords:** Psoriatic arthritis

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**Background:** In patients with psoriatic arthritis (PsA), discordance between physicians and patients when assessing disease activity has been described as frequent, mainly in European and North American studies. This discordance may negatively impact treatment adherence and shared decision-making processes. Culture and beliefs influence patients’ perceptions of health.

**Objectives:** To evaluate the concordance between patient- (PGA) and physician-global assessment (PhGA) of PsA disease activity and its association with demographic and disease characteristics in a multinational group of patients from Arab countries.

**Methods:** This multicentric multinational cross-sectional study was conducted in thirteen Arab countries by the Arab League of Associations of Rheumatology (ArLAR) research group (ARCH). During a single routine visit, patients and physicians were requested to rate the PsA disease activity on a numeric scale from 0 (no activity) to 10 (worse activity). In addition, demographic and disease data were collected, as well as PGA and PhGA for psoriasis (PsO) activity, Health Assessment Questionnaire (HAQ), Fibromyalgia Rapid Screening Tool (FIRST), Patient Health Questionnaire (PHQ4) and Disease Activity in Psoriatic Arthritis (DAPSA). First, the correlation between PGA and PhGA for PsA and PsO disease activity was assessed statistically using the Spearman correlation coefficient (PsA and PsO) and graphically using the Bland and Altman method (PsA). Second, concordance between the PGA and PhGA PsA activity (defined as a difference between -2 and 2) was calculated and correlated with demographic and disease factors using multivariable logistic regression.

**Results:** The study included 564 patients from thirteen countries; mean age 45 years (SD 13), 57% females, median disease duration four years (IQR 2-9); 89.2% had skin PsO, and 43.5% had nail PsO. The disease was active overall: mean DAPSA was 19.3 (SD 16.1), HAQ 1.1 (SD 0.8), and PHQ4 3.3 (SD 2.9). The screening test for widespread pain was positive in 18.4% of patients. The mean PGA for PsA activity was 4.7 (SD 2.5), versus a PhGA of 3.9 (SD 2.4). Similarly, PGA for psoriasis activity was 4.0 (SD 2.8), and PhGA was 3.1 (SD 2.6). The correlation between PGA and PhGA was strong for PsA activity (r=0.738) (with good agreement on Bland and Altman (Figure 1)) and moderate for psoriasis activity (r=0.613). Among 554 patients’ measurements, 358 (84.2%) were in concordance with the physician’s global assessment. In the multivariable analysis, concordance was independently associated with a high CRP (OR 2.32 [95% CI 1.33; 4.02] and DAPSA category (better concordance in patients in remission (OR 10.92 [95% CI 1.01; 1.03]).

**Conclusion:** In this unselected sample of patients from Arab countries, there was a strong concordance between PGA and PhGA of PsA activity. This raises questions about patient expectations and pain perceptions in Arab countries. Concordance was stronger for PsA than PsO, indicating that rheumatologists may be more comfortable assessing joints than skin. The patient’s evaluation of disease activity needs to be taken into account when considering the disease management plan, especially in patients who are not in remission.

**Figure 1. Agreement between PGA and PhGA for PsA activity**

**Average PGA and PhGA for PsA activity**

No current disease includes those with no current peripheral disease (1 with pure axial, 3 with no current peripheral disease or axial disease, 2 with no current peripheral disease and axial disease status not known)

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