J. Braun[13], U. Kiltz[13]. [1]*German Rheumatism Research Center Berlin (DRFZ), Epidemiology and Health Services Research, Berlin, Germany*; [2]*University Medical Center and Faculty of Medicine Carl Gustav Carus at the TU Dresden, Division of Rheumatology, Department of Medicine III, Dresden, Germany*; [3]*Charité – Universitätsmedizin Berlin, Institute for Social Medicine, Epidemiology and Health Economics, Berlin, Germany*; [4]*Rheumatology Practice, Berlin, Berlin, Germany*; [5]*Rheumatology Practice, St. Bonifatius, Munich, Germany*; [6]*Johannes Wesling Klinikum Minden, Universitätsklinik für Geriatrie, Minden, Germany*; [7]*University Medical Center Heidelberg, Division of Rheumatology, Department of Medicine V, Heidelberg, Germany*; [8]*University of Bielefeld, Klinikum Bielefeld Rosenhöhe, Bielefeld, Germany*; [9]*Deutsche Rheuma-Liga, Bundesverband e.V., Bonn, Germany*; [10]*Heinrich-Heine-University Duesseldorf, Medical Faculty, Clinic for Rheumatology and Hiller Research Centre for Rheumatology, Duesseldorf, Germany*; [11]*Rheumatology Practice, Munich, Munich, Germany*; [12]*Evang. Kliniken Essen-Mitte, Klinik für Rheumatologie & Klinische Immunologie, Essen, Germany*; [13]*Ruhr-Universität Bochum, Rheumazentrum Ruhrgebiet Herne, Herne, Germany*

Background: Despite the establishment of national and international recommendations for the management of patients with rheumatoid arthritis (RA), remediable deficits in the quality of care (QoC) still exist. On behalf of the German Society for Rheumatology, with participation of the patient organization Deutsche Rheuma-Liga, eight Quality standards (QS) have been developed to improve the QoC in Germany. The QS can be used to determine and quantitative gaps in QoC in respect to time to diagnosis, use of glucocorticoids, rates of remission and impairments in physical function [1].

Objectives: To quantify gaps in QoC based on five QS in patients with RA for whom data from the National Database of the German Collaborative Arthritis Centres (NDB) exists.

Methods: In 2020, 4863 patients with RA from 12 Rheumatology centres were followed in the NDB. Five QS were reviewed: (QS1) How often was RA diagnosed within 8 weeks of symptom onset? (QS2) How many patients are in remission? (QS3) How many patients are in glucocorticoid-free remission? (QS4) How many patients who were not in remission had their medication adjusted? (QS5) How many patients with impairments in physical function received physiotherapy, functional training, and/or rehabilitation? Remission was investigated both by DAS28 and by CDAI cut-offs. Impairments in physical function were assessed with the FFbH (≤70% of full function). Switches, additions, or dose increases of disease-modifying antirheumatic drug (DMARD) were considered adjustment of medication. Individual components of the DAS28 are reported to determine reasons for not achieving remission.

Results: Fulfillment of QS (Figure 1) was investigated in 4863 patients (Table 1). In 2020, 76 patients had their first contact to rheumatologist and 30 were seen by a rheumatologist within 8 weeks (39%). Of 61 patients with available diagnosis date, 25 (41%) were diagnosed within 8 weeks. 1523 of 3410 patients with available DAS28 were in DAS28 remission (45%) and 933 of 4023 patients with available CDAI were in CDAI remission (23%). 1155 of 1520 patients in DAS28 remission and 789 of 930 RA patients in CDAI remission were glucocorticoid-free (76%/85%). 373 of 1676 patients who were not in DAS28 remission had adjustment of medication (22%). Patients without therapy adjustment had fewer clinical signs of inflammatory activity (SJC 1.3 vs. 2.6, TJC 2.6 vs. 3.7, ESR 25.7 vs. 27.4, Physician global 1.8 vs. 2.8, Patient disease activity 4.1 vs. 4.8) compared to patients with adjustment of medication. 68 of 149 patients with high disease activity (DAS28>5.1) had adjustment of medication (46%). 377 of 772 patients with impairments in physical function and information on physiotherapy received physiotherapy (49%), 32 of 767 patients with data on functional training received functional training (4%) and 117 of 1175 patients with data on rehabilitation received rehabilitation (10%).

Table 1. Patient characteristics, n=4863

Female sex (%)	74
Age, mean in years	63
Disease duration, mean, years	14
ACPA or RF positive (%)	72
DAS28, mean (n=3,410)	2.9
CDAI, mean (n=4,023)	7.7
TJC, mean	1.6
SJC, mean	1.0
ESR, mean in mm/h	19.1
Patient global disease activity, mean	3.5
Physician global disease activity, mean	1.5
Functional assessment (FFbH 0-100), mean (n=4526)	75.4
cs/bDMARDs (%)	70/ 29
Glucocorticoids (%)	35
First Rheumatology visit in 2020, n	76
Duration of symptoms, mean/median, months	20.2/4.0
Rheumatologist contact within 8 weeks, n (%)	30 (39%)
Diagnosis within 8 weeks, n (%) (n=61 with available diagnosis date)	25 (41%)

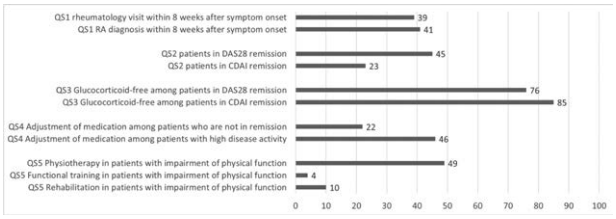

Figure 1. Fulfillment of quality standards (%)

Conclusion: With the new QS, QoC of patients with RA can be measured in a standardized form. While some results reflect high quality of care, other QSs point to opportunities for improvement. The implementation of the QS enables both a comparative evaluation at facility level and a general rheumatology health care outcome. This will help to optimize the QoC for patients with RA in Germany.

REFERENCE:

[1] PMID 34652486

Acknowledgements: We thank all participating rheumatologists and patients for their valuable contributions. The NDB is supported by the Association of Regional Cooperative Rheumatology Centres, the German Society for Rheumatology and joint contributions to the Rheumatological Training Academy and the DRFZ by the following members of the Working Group of Corporate Members of the German Society for Rheumatology: AbbVie, AstraZeneca, BMS, GALAPAGOS, GSK, Lilly, Medac, MSD, Pfizer, Sanofi-Aventis and UCB.

Disclosure of Interests: Katinka Albrecht: None declared, Katja Thiele: None declared, Martin Aringer: None declared, Johanna Callhoff Speakers bureau: Janssen-Cilag GmbH, Kirsten Karberg: None declared, Klaus Krueger: None declared, Jürgen Lakomek: None declared, Hanns-Martin Lorenz: None declared, Martin Rudwaleit Speakers bureau: Abbvie, Boehringer, Galapagos, Janssen, Lilly, Novartis, Pfizer, UCB, Rotraud Schmale-Grede: None declared, Matthias Schneider: None declared, Susanna Spaethling-Mestekemper: None declared, Christof Specker: None declared, Silke Zinke: None declared, Jürgen Braun: None declared, Uta Kiltz: None declared.

DOI: 10.1136/annrheumdis-2023-eular.453

POS1091

INFLAMMATION IS MORE PROMINENT THAN JOINT DAMAGE AT INITIAL VISITS OF PATIENTS WITH INFLAMMATORY ARTHRITIDES, BUT ORGAN DAMAGE AND PATIENT DISTRESS ARE AS PROMINENT IN OVERALL RHEUMATOLOGY CARE: DATA FROM A FEASIBLE PHYSICIAN RHEUMATIC CHECKLIST

Keywords: Inflammatory arthritides, Treat to target, Comorbidities

T. Pincus[1,1,1,1], T. LI[2], J. Schmukler[1]. [1]*RUSH University Medical Center, Medicine/Rheumatology, Chicago, United States of America*; [2]*Georgetown University, Biostatistics, Bioinformatics & Biomathematics, Washington, United States of America*

Background: Patients consult rheumatologists for symptoms which may result from inflammatory activity (INF), joint or other organ damage (DAM) and/or distress (STR), e.g., fibromyalgia, depression. However, quantitative assessment in routine rheumatology care is directed primarily (often exclusively) to INF, e.g., DAS28, CDAI, SLEDAI, ASDAS, and DAPSA. DAM and STR are recognized in many patients, but generally recorded only as narrative descriptions, rather than as quantitative data. INF indices function effectively in clinical trials, but measures and indices designed to assess INF may be elevated in many unselected routine care patients by comorbid DAM and/or STR, often despite little or no INF. A RheuMetric checklist includes 4 0-10 visual numeric scales (VNS) for physician global assessment (DOCGL), DOCINF, DOCDAM, and DOCSTR, and estimates of the % of DOCGL attributed to INF, DAM, and STR.

Objectives: To analyze RheuMetric scores in unselected routine care patients with all diagnoses at initial or return visits to an academic rheumatology setting.

Methods: A retrospective cross-sectional study was performed of RheuMetric checklist 0-10 VNS estimates for DOCGL and estimates of %INF, %DAM, and %STR (total=100%) completed in routine care by the treating rheumatologist. Mean levels of these estimates were analyzed according to primary diagnosis, classified as INF (RA, SLE, SpA, vasculitis and gout), osteoarthritis (OA), primary fibromyalgia (FM), and "other," at initial or return visits, using descriptive and chi-square statistics.

Results: Highest DOCINF was in inflammatory diseases, DOCDAM in OA, and DOCSTR in primary FM (Table 1). The % of DOCGL attributed to INF, DAM, and STR was highest in INF diseases, OA, and primary FM, respectively

Table 1. Cross sectional analyses of mean (standard deviation) for 0-10 physician global estimate (DOCGL) and % of DOCGL attributed to inflammation (%INF), damage (%DAM), and patient distress (%STR) (Total=100%) at 244 first visits compared to 319 return visits

	Initial visits					Return visits				
Primary rheumatic physician ICD-10 diagnosis	N (%)	DOC GL	Mean (SD) % of DOCGL attributed to…			N(%)	DOC GL	Mean (SD) % of DOCGL attributed to…		
		DOC GL	% INF	% DAM	% STR		DOC GL	% INF	% DAM	% STR
Inflammatory diseases (RA, SLE, SpA, Vasc, Gout)	67 (27%)	4.3 (2.5)	62%Δ (33%)	24% (24%)	14% (24%)	127 (40%)	3.7 (2.6)	33%Δ (31%)	49% (35%)	18%* (27%)
Osteoarthritis	45 (18%)	4.4 (2.0)	14% (19%)	72%Δ (28%)	14% (18%)	69 (22%)	5.0 (2.2)	7% (14%)	69%Δ (30%)	24% (28%)
Fibromyalgia	32 (13%)	4.9 (2.6)	14% (22%)	12% (16%)	74%Δ (28%)	36 (11%)	5.0 (2.0)	12% (21%)	20% (21%)	68%Δ (26%)
Other diagnosis	100 (41%)	3.0 (2.1)	37% (33%)	35% (31%)	29% (33%)	87 (27%)	3.5 (2.4)	26% (29%)	52% (35%)	22% (30%)
TOTAL	244 (100%)	3.9 (2.4)	36% (35%)	36% (33%)	28% (34%)	319 (100%)	4.1 (2.5)	22% (28%)	51% (35%)	28%◊ (32%)

Δ32%)35%))nosisseases (RA, SLE, SpA, Vasc, Gout) at 244 first visits compared to 319 return visits

(p<0.001) (Table 1). At initial visits of patients with INF, mean DOCGL was 4.3, attributed 62% to INF, 24% to DAM and 14% to STR, respectively; at return visits, DOCGL was 3.7, attributed 33% to INF, 49% to DAM and 18% to STR (Table 1). In patients with all diagnoses, 36%, 36%, and 28% of DOCGL were attributed to INF, DAM, and STR, respectively, at first visits, vs 22%, 51%, and 28% at return visits (Table 1). RheuMetric estimates required 15-20 seconds to complete.

Conclusion: RheuMetric physician estimates for INF, DAM, and STR are feasibly assessed in routine care, with face validity documented by significantly higher INF in inflammatory diseases, DAM in OA, and STR in FM. DOCINF was higher at first vs return visits, reflecting highly effective anti-inflammatory treatments at this time, while %DOCDAM rose. At return visits, INF accounted for 22% of DOCGL vs 50% for DAM and 28% for STR, indicating that control of inflammation is not the primary activity in overall rheumatology care after the first visit.

REFERENCES: NIL.

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

DOI: 10.1136/annrheumdis-2023-eular.2734

Rehabilitation

POS1092

PHYSICAL ACTIVITY AND SEDENTARY BEHAVIOR IN PATIENT WITH CHRONIC INFLAMMATORY RHEUMATIC DISEASES: A CASE CONTROL STUDY

Keywords: Lifestyles, Rehabilitation, Inflammatory arthritides

A. Adnine[1], F. Z. Taik[1], N. Takhrifa[1], N. Soba[2], F. Z. Aharrane[1], M. Fourtassi[2], F. E. Abourazzak[1]. [1]*Abdelmalek Essaidi University, Faculty of Medecine of Tangier-Tetouan- Al Hoceima, University Hospital Center Tangier-Tetouan-Al Hoceima, Rheumatology, Tangier, Morocco*; [2]*Abdelmalek Essaidi University, Faculty of Medecine of Tangier-Tetouan- Al Hoceima, University Hospital Center Tangier-Tetouan-Al Hoceima, Physical Medicine and Rehabilitation, Tangier, Morocco*

Background: Engaging in regular physical activity (PA) is important in maintaining health and increasing the overall quality of life of patient living with chronic inflammatory rheumatic diseases (CIRD). Its is assumed that patients with CIRD reports low levels of physical activity. In the era of evidence-based medicine few studies compare PA levels and its predictors between patient with CIRD and healthy control.

Objectives: we aim to investigate PA levels of patients with CIRD, to examine predictors of PA and furthermore compare findings to healthy control.

Methods: A cross-sectional study was performed among patients with CIRD Aged between 18 and 65 years old who visited the outpatient clinic between April 2022 and October 2022. The diagnosis of spondyloarthritis was based on ASAS criteria and the diagnosis of rheumatoid arthritis was based on ACR/EULAR 2010 criteria. Healthy controls were recruited in a specialized consultation. Socio-demographic findings were collected. Patients were assessed for pain and disease activity using visual analogic scale (VAS), DAS28 CRP and ASDAS CRP. Physical activity levels were assessed using the international physical activity questionnaire (IPAQ-SF). Furthermore, all participants underwent screening for anxiety and depressive disorders using Patient health questionnaire (PHQ-9) and General anxiety disorder (GAD-7) respectively.

Results: The final study simple was made up of 172 patients (92 RA, 65 SpA and 15 Undifferentiated CIRD) and 159 healthy controls.

Table 1. socio-demographic informations, clinical findings and physical activity levels of patients with CIRD and healthy controls.

	Patients with CRID N= 172	Healthy controls N= 159	p Value
Age (Mean ±SD)	45,97 ± 12,063	45,53 ± 12,244	P= 0.787
Sexe (female pourcentage)	72,7%	70,3%	P= 0.654
BMI (Median percentiles)	25 [20.93, 28.08]	26.39 [23.63, 29.75]	P=0.033
Socioeconomic status:	Low: 50.6 %(n=87) Medium: 28.5 %(n=49) High: 1.7 % (n=3) Don't Know: 19,2 %(n=33)	Low: 28.9 % (n=46) Medium: 40.3 % (n=64) High: 11.3 % (n=18) Don't Know: 19,5 % (n=31)	P=0.007
IPAQ-SF: Met/min/week (Median percentiles)	936 [231, 4282]	1546 [864, 3612]	P= 0.001
IPAQ-SF: category	Low PA: 38.4% (n=63) Moderate PA: 32.9%(n=54) High PA: 28.7% (n=47)	Low PA: 17% (n=27) Moderate PA: 31.4% (n=50) High PA:51.6% (n=82)	P=0.000
Sedentary behavior: Min/day (IPAQ-SF)	120 [60, 240]	120 [60, 180]	P= 0.015
Depression PHQ-9 scale	8 [5, 14]	4 [1, 9]	P=0.000
Anxiety GAD-7 scale	8 [4.75, 12]	6 [3, 10]	P=0.001
Disease duration year	8 [3, 17]	N/A	N/A
Disease activity	Remission: 39 %(n=67) Low disease activity: 11.6% (n=20) Moderate disease activity: 24.4%(n=42) High disease activity: 25%(n=43)	N/A	N/A

In patients with CIRD uni and multivariate analysis showed no association between PA levels and disease related variables: Disease activity(OR (95%CI) = -0.032 (-0.160, 0.095); p=0.61), disease duration(OR (95%CI) = -0.013 (-0.028, 0.003); p=0.111) and comorbidities(OR (95%CI) = -0.013 (-0.109, 0.083); p=0.794) on the contrary PA levels were negatively associated with depression (OR (95%CI) = -0.011(-0.021,- 0.002); p=021)In healthy controls uni and multivariate analysis showed that PA levels were negatively associated with age (OR (95%CI) =-0.013 (-0.004, -0.023; p=0.007)), BMI (OR (95%CI) = -0.029 (-0.051, - 0.006; p=0.013)) and depression (OR (95%CI) =-0.029 (-0.049, - 0.009; p=0.004)).

Conclusion: Our study shows that patients with CIRD reports significantly low levels of PA and high level of SB compare to healthy controls. The unexpected finding in our study is that low levels of PA in patients with CRDI were not associated with disease activity nor disease duration. Depressive disorders are an important predictor of physical inactivity and sedentary behavior regardless of the presence of CRID. Depressive disorders are common among patients with CRID. Screening for depression and treating in time is essential to help overcome sedentary behavior in our patient and community.

REFERENCES: NIL.

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

DOI: 10.1136/annrheumdis-2023-eular.1873

POS1093

WHO ARE THE PATIENTS WITH INFLAMMATORY RHEUMATIC DISEASE IN NEED TO SPECIALISED MULTIDISCIPLINARY REHABILITATION?

Keywords: Rehabilitation, Non-pharmacological interventions

E. Besada[1,2,3]. [1]*Fysikalskmedisinsk avdeling, UNN Tromsø, Tromsø, Norway*; [2]*Medisinsk avdeling Kirkenes, Finnmarkssykehuset, Kirkenes, Norway*; [3]*Institutt for klinisk medisin, UiT Norges arktiske universitet, Tromsø, Norway*