informed of their patients' needs and actions taken to address them. We assessed prevalence of SDoH needs, used multivariable logistic regression to examine factors associated with ≥1 SDoH need (vs. 0), and used multilevel, multivariable logistic regression to examine the association between census tract social vulnerability index (SVI) quartile and presence of needs, adjusting for demographics. We categorized actions taken by the rCRS.

Results From 6/23/22–4/18/23, 7,146 adults (≥18 years) completed the SDoH questionnaire. 6,309 (88%) were associated with rheumatology visits, 837 (12%) with primary care and re-reviewed in rheumatology. There were 2,015 SDoH needs among 1,143 (16%) patients; 120 others requested resources without specifying needs. SDoH needs varied by demographic factors and insurance status (**table 1**). 417 (36% of patients with needs) indicated food insecurity, 340 (30%) had difficulty paying utility bills, 297 (26%) had difficulty paying for medications (figure 1). We observed significantly higher odds of ≥1 SDoH need vs. no needs among Black (vs. White) and Hispanic (vs. non-Hispanic) individuals, Medicaid, and Medicare beneficiaries (vs. Commercially insured) and Spanish speakers (vs. English) (**table 1**). We did not observe statistically significant differences in burden of needs by rheumatic condition. While SDoH needs were present among individuals in all neighborhoods, living in the most vulnerable SVI quartile (vs. the least) was associated with 4.92 times higher odds (95% CI 1.43–16.92) of SDoH needs. The rCRS connected patients to varied resources to address needs (**table 3**).

Conclusions Screening and addressing SDoH in rheumatology clinics is feasible and has revealed a significant burden of needs not being met elsewhere. While needs were concentrated among individuals living in more vulnerable neighborhoods and among historically marginalized populations, they were not limited to these groups suggesting the importance of inclusive screening and connections to resources to improve care for all patients.

103 A NOVEL, COMMUNITY-ENGAGED APPROACH TO ENCOURAGE DIVERSE PATIENT PARTICIPATION IN LUPUS CLINICAL TRIALS

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10.1136/lupus-2023-lupus21century.3

Background Efforts to encourage and increase diverse patient participation in lupus clinical trials (LCTs) require novel approaches to address complex patient and provider level barriers. To address these unmet needs, the American College of Rheumatology (ACR) developed the Training to Increase Minority Enrollment in Lupus Clinical Trials with CommunitY Engagement (TIMELY) program. TIMELY seeks to engage and improve how healthcare providers (providers) and community health workers (CHWs) discuss LCTs with diverse patients living with lupus. The TIMELY program uses a two-stage approach to engage providers and CHWs.

Providers and CHWs received access to tailored online education, followed by interactive roundtable discussions that include the principal investigators of the project and their research teams. In addition to discussing diverse patient participation in LCTs, the roundtables seek to connect interdisciplinary providers with each other and CHWs with providers. Engaged, connected providers and CHWs can then bridge the gap between traditional clinical care and community-based health resources to overcome patient and provider level barriers to diverse patient participation in LCTs.

Methods The TIMELY program was implemented with providers and CHWs in congruent geographic areas, New York and North Carolina, to address both provider and patient level barriers to LCT participation. Provider and CHW participants, in tandem, completed an online education (providers – The ACR's Materials to Increase Minority Involvement in Clinical Trials (MIMICT) continuing medical education (CME) course; CHWs – the CHW Lupus Clinical Trials Training (LuCTT) program) and participated in roundtable discussions. We analyzed site- level roundtable reports and providers' and CHWs' post-roundtable open-ended responses to assess the extent to which the TIMELY roundtable approach engages and connects providers and CHWs.

Conclusion Overall, providers and CHWs demonstrated high engagement and connection during the roundtables. The provider roundtables included dermatologists, nephrologists, rheumatologists, and primary care providers. The CHW roundtables included CHWs from both New York and North Carolina. The small group and more informal nature of the roundtables created a setting in which providers and CHWs were able to meet, engage in discussion with, and connect with each other. Indeed, one provider noted, 'I like the variety of interdisciplinary teams that were involved and being able to place faces with names. Now that I have met other specialists, I'm more prone to reach out when I have questions.' Similarly, a CHW shared, 'It was informative and [I] also like that it was participants from other states involved and that health care professionals were involved.' TIMELY-trained providers and CHWs are currently utilizing knowledge and connections made to address barriers to LCT participation among diverse patients in their communities.

104 DEMOGRAPHIC AND CLINICAL FACTORS THAT CONTRIBUTE TO CLINICAL STUDY ENROLLMENT IN SYSTEMIC LUPUS ERYTHEMATOSUS

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10.1136/lupus-2023-lupus21century.4

Lay Summary Participation in clinical trials is part of treatment for many patients with chronic diseases. However, patients with systemic lupus erythematosus (SLE), especially those of African American and Hispanic descent, have been reluctant to participate in clinical trials. Here, we describe patients' decisions to participate in a study that plans to enroll 200 patients in an engagement program modeled after the Lupus Research Alliance Patient Advocates for Lupus Studies (PALS) program. These data suggest that lupus patients' intention to participate in clinical research is influenced by severity of disease, patient factors, and the study design. It is difficult to tell