Abstracts

DO PATIENTS WITH SYSTEMIC LUPUS GET BETTER QUALITY OF CARE IN LUPUS CLINICS THAN IN GENERAL RHEUMATOLOGY CLINICS?

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Background Patients with SLE receive care from several physicians in varied health care settings worldwide. Herein, we compared the quality of care received by SLE patients at two settings within the same academic institution (lupus clinic or general rheumatology clinic) using validated SLE quality indicators (QI).

Methods 100 consenting, consecutive patients fulfilling the American College of Rheumatology (ACR) classification criteria for SLE who were receiving longitudinal care at Rush University Rheumatology outpatient clinic and at subspecialty Lupus clinic were recruited. A validated QI survey was updated, modified for self-report and administered during participants’ routine SLE care visit. Retrospective rheumatology medical chart reviews were done in addition for complete evaluation of performance on each QI. The overall performance rate and performance rates on 20 QIs were calculated for the two groups and compared using non-parametric tests. P-value <0.05 was considered significant.

Results 60 patients from sub-specialty lupus clinic and 40 patients from general rheumatology clinic participated. Patients receiving care at lupus clinic had longer disease duration [10 ± 6.6 vs 6.5 ± 6.9 years, P = 0.01] and met more number of ACR criteria [5.4 ± 1.7 vs 4.7 ± 1.0; P = 0.01] compared to patients from general rheumatology clinics. The overall performance rate was significantly greater among lupus clinic as compared to rheumatology clinic SLE patients [87.5% (IQR: 16%) vs.71.1% (IQR: 19%), P = 0.001]. Differences noted among the two groups were in counselling for use of sunscreen (98% vs 87%, p < 0.036), testing for antiphospholipid antibodies within 6 months of diagnosis (70% vs 30%, p < 0.001), recommendation for pneumococcal vaccine if on immunosuppressive medication/s (86% vs 50%, p < 0.003), bone mineral density test performance if on chronic steroids (95% vs 48%, p < 0.001) and prescribing a steroid sparing agent (100% vs 82%, p < 0.007) (Table 1).

Conclusions SLE patients seen in the dedicated lupus clinic had better overall and specific QI performance relative to general rheumatology clinics. This may suggest greater recognition among lupus clinic physicians of the importance of preventive care and disease monitoring among SLE patients. Of particular importance were the findings regarding vaccination and preventive use of sunscreen, as these may substantially affect morbidity in this patient population.

Abstract CE-29 TABLE 1 Performance on Quality Indicatore (QI)

<table>
<thead>
<tr>
<th>QI No.</th>
<th>Description of QI</th>
<th>Lupus clinic</th>
<th>General Rheumatology clinic</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ANA, CBC, Platelet, Creatinine, UA at diagnosis of lupus</td>
<td>60</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>AntidsDNA, Clq4, APL within 6 months of diagnosis</td>
<td>60</td>
<td>42</td>
<td>70.0</td>
</tr>
<tr>
<td>3</td>
<td>Counselling for use of sunscreen</td>
<td>60</td>
<td>59</td>
<td>98.3</td>
</tr>
<tr>
<td>4</td>
<td>Influenza vaccine in last year if on ISM</td>
<td>37</td>
<td>36</td>
<td>97.3</td>
</tr>
<tr>
<td>5</td>
<td>Pneumococcal vaccine if on ISM</td>
<td>37</td>
<td>32</td>
<td>85.6</td>
</tr>
<tr>
<td>6</td>
<td>DECA if have received ≥ 7.5 mg/day CS for ≥ 3 months</td>
<td>42</td>
<td>40</td>
<td>95.2</td>
</tr>
<tr>
<td>7</td>
<td>Calcium and Vitamin D if have received ≥ 7.5 mg/dl CS for ≥ 3 months or is postmenopausal</td>
<td>45</td>
<td>38</td>
<td>84.4</td>
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<tr>
<td>8</td>
<td>Antiresorptive agent if have received ≥ 7.5 mg/dl CS for ≥ 1 month &amp; central T score ≤ 2.5 or h/o fragility fracture</td>
<td>10</td>
<td>10</td>
<td>100</td>
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<tr>
<td>9</td>
<td>Counselling about drugs at initiation</td>
<td>60</td>
<td>54</td>
<td>90.0</td>
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<tr>
<td>10</td>
<td>Baseline tests at initiation of drugs</td>
<td>59</td>
<td>58</td>
<td>98.3</td>
</tr>
<tr>
<td>11</td>
<td>Tests for drug monitoring</td>
<td>59</td>
<td>53</td>
<td>89.8</td>
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<tr>
<td>12</td>
<td>Steroid sparing agent if have taken ≥ 10 mg/d of CS for ≥ 3 months</td>
<td>38</td>
<td>38</td>
<td>100</td>
</tr>
<tr>
<td>13</td>
<td>Follow up tests (UA, CBC, Creatinine) done within 3 months</td>
<td>17</td>
<td>12</td>
<td>70.6</td>
</tr>
<tr>
<td>14</td>
<td>Treatment with ISM &amp; CS within 1 month of diagnosis of Class 3/4 LN</td>
<td>13</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>15</td>
<td>Antihypertensive if have proteinuria ≥ 300 mg/dl or GFR &lt; 60 ml/min &amp; ≥ 2 BP readings &gt; 130/80</td>
<td>14</td>
<td>13</td>
<td>92.9</td>
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<tr>
<td>16</td>
<td>ACE inhibitor or ARB if have proteinuria ≥ 300 mg/dl</td>
<td>15</td>
<td>14</td>
<td>93.3</td>
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<td>17</td>
<td>Assessment of CVD risk &amp; counselling</td>
<td>60</td>
<td>19</td>
<td>31.7</td>
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<td>18</td>
<td>Tests in pregnancy (AntiSSA/SSB, APL)</td>
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<td>6</td>
<td>66.7</td>
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<td>19</td>
<td>Treatment of APS in future pregnancies</td>
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<td>1</td>
<td>100</td>
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<td>20</td>
<td>Reproductive health counselling</td>
<td>23</td>
<td>20</td>
<td>87.0</td>
</tr>
</tbody>
</table>

Abbreviations: PP – Performance percentage, ANA – Antinuclear antibody, CBC – Complete Blood Count, UA – Urinalysis, APL – Anti- phospholipid antibodies, ISM – Immunosuppressive medications, CS – Corticosteroids, HCQ – Hydroxychloroquine, MTX – Methotrexate, MMF – Mycophenolate mofetil, LN – Lupus Nephritis, ARB – Angiotensin receptor blocker, CVD – Cardiovascular Disease, APS – Antiphospholipid antibody syndrome

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