integrity and stability is reliant on efficient pharmacy processes necessary to accommodate the use of new formulations for dose banding.

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AB1260

BASILINE CHARACTERISTICS AND PATIENT SATISFACTION DATA FROM COACH@HOME: THE GERMAN SUPPORT PROGRAM FOR PATIENTS WITH RHEUMATIC DISEASES TREATED WITH CERTOLIZUMAB PEGOL

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Background: Certolizumab pegol (CZP)-treated patients (pts) with rheumatoid arthritis (RA), axial spondyloarthritis (axSpA, including ankylosing spondylitis [AS] and non-radiographic [nr]-axSpA), and psoriatic arthritis (PsA) may be recommended the patient-coaching program, coach@home (c@h) in Germany to manage their disease. Eight coaching calls are offered over one year, scheduled around 'critical' milestones along the therapeutic journey. These calls are made by professionally-trained nurses, who offer support and information about both the disease and its treatment with CZP.

Objectives: The purpose of this observational analysis was to assess the baseline characteristics of pts subscribed to c@h, and the level of pt satisfaction with the program.

Methods: c@h was launched in June 2014 and is available to pts who are prescribed CZP according to the local product label. Pts must be CZP-naïve when subscribed to the program, and pt consent is required prior to subscription by the treating physician. There are no additional criteria for enrolment, although the program must be recommended to the pt by the treating physician.

Pt satisfaction was measured either at the end of the program or at discontinuation using the net promoter score (NPS), which has previously been used for this purpose.¹ The NPS is derived by asking pts to state how likely it is that they would recommend c@h to others (on a 0–10 scale). Rankings of 9–10 are considered 'promoters', 7–8 'passives', and 0–6 'detractors'. Subtracting the percentage of detractors from that of promoters yields the NPS (figure 1).

Results: A cumulative total of 655 pts had been registered to the program as of 5 Oct 2017. Of the total number of reported indications (n=683; multiple indications per pt possible), 55.9% were RA, 16.5% AS, 7.6% nr-axSpA, and 19.9% PsA. The mean age at baseline was 55 (RA), 54 (AS), 53 (nr-axSpA), and 52 (PsA), and the proportion of female pts was 80%, 58%, 65%, and 69%, respectively. Prior biologic DMARD exposure was 32.8%.

The most common topics discussed on phone calls were therapy compliance (in 1339 calls), CZP maintenance dose (in 1333 calls) and syringe disposal (in 870 calls). The average length per call was 15.9 min at the end of Week 0 (total: 28 calls), and 14.0 min at the end of Week 52 (total: 1796 calls). A cumulative total of 272 pts had either completed the 1 year coaching period (n=70) or discontinued (n=202) by 28 Sep 2017, of whom 106 rated the program. Of these, 87.5% gave promoter scores, 10.4% passive, and 3.8% detractor, yielding an NPS of 83.7 (figure 1). The program was still ongoing at the time of this data cut.

Abstract AB1260 – Figure 1. Patient ratings and Net Promoter Score for the coach@home program (as of September 2017)

Patients were asked to rate the coach@home program on a scale of 0–10, where 0="I would certainly not recommend this program" and 10="I would most probably recommend this program". Scores of 9–10 were considered 'promoters', 7–8 'passives' and 0–6 'detractors'. Percentages shown are out of the total number of responders by the end of September 2017 (n=106). NPS: Net Promoter Score.

Conclusions: The c@h program offers guidance and support to pts treated with CZP in Germany. Feedback from pts who were willing to provide a rating indicates a high level of satisfaction with the program.

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AB1261

DEVELOPMENT OF A LOCAL NEEDS-BASED GP CURRICULUM FOR SHARED CARE IN RHEUMATOLOGY

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Background: There is a role for shared care between rheumatologist and primary care for Musculoskeletal (MSK) disorders. General practitioners (GPs) are involved in monitoring of clinical status of patients and their management, in addition to psychosocial aspects of chronic pain and disability. We are going to look at the rheumatology knowledge and skills needed by local GPs and based on their needs we plan to develop an initiative to improve the service provided to our patients. Here are the results of the initial survey of local GPs.

Objectives: We aim to identify knowledge and skill gaps in primary care related to MSK disorders and to develop a need-based curriculum to address these gaps. Develop an implementation plan to deliver the curriculum components.

Methods: Initially we identify the needs and gaps in the current practice using survey in a small group of local GPs. There are two rounds of questionnaires to reach a list of important areas to develop the curriculum. The second round will include large number of GPs. Also, there will be meetings with GPs to reach agreement and to adopt method of delivering these training and skills.

Results: In the first survey, 31 out of 36 GPs (86%) returned questionnaires. One GP (3.2%) refer to rheumatology department twice a week, 4 GPs (13%) refer weekly, 23 GPs (74%) refer every month and three GPs (9.7%) rarely refer to rheumatologist. Reasons for referral were diagnosis and long-term management,²¹ diagnosis and discharge back to GP¹⁵ and patient's request.⁴ Thirteen GPs (42%) have interest in rheumatology conditions management. Regarding GPs' concerns with rheumatology service, 22 of them (71%) mentioned the long wait time for rheumatology appointment. Other issues were delayed clinic letter, need for clear instruction, patients not aware of appointment time, whether there is an urgent clinic and which clinic patient should be referred to (outpatient versus procedure clinics). Nineteen GPs (61%) received undergraduate rheumatology training, 16 (52%) during GP training programme and 4 (13%) attended postgraduate courses. Topics of interest by GPs were variable rheumatology conditions in addition to joint injections,³ referral guidance² and update on DMARD. Preferred teaching methods to deliver the syllabus were small group tutorials,¹² face-to-face lectures⁵ and protocols and guidelines.⁵

Conclusions: From this initial survey, we could identify that the major concern of local GPs is the long waiting time for rheumatology clinic. Some of GPs (42%) expressed their interest to have further training in rheumatology. When we reach an agreed curriculum with GPs, we aim to deliver the syllabus through preferred methods by GPs. Shared care between rheumatologists and GPs would improve quality standard of care in community, provide patient care close to home and reduce referral rates.

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AB1262

TAPERING OF BIOLOGICAL ANTIRHEUMATIC DRUGS IN RHEUMATOID ARTHRITIS PATIENTS IS ACHIEVABLE AND COST EFFECTIVE IN DAILY CLINICAL PRACTICE: DATA FROM THE BRUSSELS UCL RA COHORT

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Background: Several studies demonstrate that Rheumatoid Arthritis (RA) patients achieving low disease activity or remission are able to taper biological (b) DMARDs.

Objectives: The aim of this study is to determine the number of patients suffering from RA in whom tapering of bDMARDs is achievable in daily practice and to evaluate the patient characteristics. Another objective is to analyse the budget impact and determine which bDMARDs are more adapted to dose reduction.

Methods: Inclusion criteria were RA patients from our Brussels UCL cohort treated with a bDMARD for at least one year. A dose reduction was proposed by the senior physician when sustained low disease activity or remission was observed. Data from 357 eligible RA patients (247 women and 110 men) were collected. Patient characteristics and baseline features before the current bDMARDs and flares if happened were collected. Annual drug dosage and cost were calculated.

Results: In 131 patients (35.7%), the dose of the bDMARD could be tapered. Patients in the decreased dose group were older (60.6 vs 55.9 years, $p=0.005$) and started bDMARDs earlier in their disease course (6.8 vs 8.4 years, $p=0.025$). As expected, the current DAS28-CRP was lower (2.26 vs 2.55, $p=0.018$) and interestingly, more patients were treated with a combination of Methotrexate (84% vs 73%, $p=0.019$). No differences between groups was observed for gender, disease duration, baseline HAQ, DAS28-CRP, erosion, ACPA, number of previous bDMARDs and use of Glucocorticoids. In our cohort, Anti-TNF agents were the most commonly prescribed medications (see Table). Annual drug cost was largely decreased for Rituximab and anti-TNF agents. Only 11 patients experienced a flare during the follow-up.

Abstract AB1262 – Table 1

bDMARD	Number of Pts	Stable dose (%)	Annual cost/ Pts (€)	Dose decreased (%)	Annual cost/ Pts (€)
ABA	23	12 (52)	12 979	11 (48)	8643,5
ADA	46	21 (46)	12 525	25 (54)	6908,8
CERTO	7	7 (100)	11740,2	0 (0)	Not available
ETN	69	41 (59)	9328,6	27 (39)	6101,6
GOL	24	22 (92)	12703,08	2 (8)	Not available
IFX	99	74 (75)	7290	25 (25)	6067
RTX	37	22 (59)	8784	17 (46)	4691,6
TOC	52	35 (67)	12773,7	17 (33)	9371,9
	357	234		124	

Conclusions: In daily practice, tapering of bDMARDs in RA patients with low disease activity or remission is an achievable goal, thereby reducing annual drug cost, especially for Rituximab, Infliximab, Etanercept and Adalimumab.

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AB1263

FINNISH HEALTHVILLAGE.FI-RHEUMATICDISEASES.FI: A SPECIALISED CARE SERVICE UNIT DEVELOPED TOGETHER WITH PATIENTS TO OFFER ON-LINE INFORMATION AND TREATMENT FOR PATIENTS IN A MODERN WAY

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Background: Finnish on-line Health village environment, so-called HUS-MAP©, was used to develop on-line information for rheumatic patients.

Objectives: To face the challenge of increasing demand for rheumatological care without additional resources a new virtual client-orientated service was developed.

Methods: In Finland, an on-line Health village environment, so-called HUS-MAP©, has been developed to offer virtual digital information to citizens, patients, and healthcare professionals. By using this HUS-MAP© environment, we provide information and support to citizens and patients who need information on different rheumatic diseases and various unspecified aches and musculoskeletal pains. The study group consisted of participants from every university hospital in Finland, from local authorities; rheumatologists, other specialists, general practitioners, nurses, special professionals such as physical therapists, and patients. Information provided was based on updated international and Finnish guidelines on rheumatic diseases. After the information was reviewed and accepted by our study group, it was fed into a special program and published on-line in the Health village environment.

Results: E-service for citizens and patients was opened in March 2017. Detailed description of symptoms, diagnosis and therapy of various rheumatic diseases, such as rheumatoid arthritis, spondyloarthritis, connective tissue diseases and vasculitis are available. Early diagnosis and treatment to remission when possible is emphasised. The service aids to identify, by using symptom navigator and questionnaires for back pain, as well as swollen and painful joints those who may have a rheumatic disease and guide patients to find medical services without delay. Already 60 500 persons have visited our website.

Conclusions: Finnish e-service, rheumaticdiseases.fi, offers an easy way to reach people and increase citizen's awareness on their own health. By guiding people to search for care the service may reduce delays in diagnosis of rheumatic diseases and the onset of therapy

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AB1264

BARRIERS AGAINST TESTING ANTI-TNF DRUG LEVELS AND ANTI-DRUG ANTIBODIES IN ROUTINE CLINICAL PRACTICE

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Background: There is growing interest in using tests to measure anti-TNF drug levels and anti-drug antibodies (ADAb) in routine clinical practice for patients with rheumatic diseases. Testing may provide rheumatologists with additional information when considering a decision to adjust biologic treatment; for example, a decision to increase the interval between injections of an anti-TNF or to change treatment to a biologic that has a different target. However, it is not clear whether rheumatologists consider drug level and ADAb testing to be a useful technology within their routine clinical decision-making. Testing may be implemented imperfectly if rheumatologists perceive barriers against measuring drug levels and ADAb which, in turn, can affect the effectiveness and cost-effectiveness of care.

Objectives: To explore the potential barriers against testing anti-TNF drug levels and ADAb in routine clinical practice.

Methods: Semi-structured telephone interviews were conducted individually with a purposive sample of consultant rheumatologists from different hospitals across England. The telephone interviews were recorded and transcribed verbatim. Pilot interviews were undertaken to develop the interview schedule. The rheumatologists were invited to discuss their perceptions and experiences of anti-TNF drug