diagnosis. Furthermore, access to the right specialist, at the right time, in the right place may improve patients' experience of screening and referral practices for chronic back pain. Models of care and targeted patient and medical education strategies aimed at reducing the gap between onset of back pain and diagnosis of axial SpA may have the potential to improve existing screening and referral practices of axial SpA.

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FRI0715-HPR PATIENTS', RELATIVES AND HEALTH PROFESSIONALS VIEWS ON GOALSETTING IN RHEUMATOLOGY REHABILITATION.

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Background: Patient-centered goals are important for successful rehabilitation because they focus on the direction and process of rehabilitation. Scarce knowledge exists about goalsetting in rheumatology rehabilitation.

Objectives: To explore views on the goalsetting process in rehabilitation during admission among health professionals (HPs), patients with rheumatic diseases and their relatives.

Methods: Two focus group interviews, with 11 HPs (physiotherapists, occupational therapists and nursing staff) were conducted as well as eight individual interviews with patients. Relatives participated in two of the patient interviews. The analysis of the transcribed interviews focused on meaning condensation. (Kvale, Brinkmann, 2014)

Results: The analysis resulted in three overarching themes. The first theme focused on *the many aspects of communication before and during the goalsetting process*. The HPs expressed that the patients need to be well-informed. Several of the patients expressed the need for information about what the hospital can provide to ease the goalsetting process for them. The HPs pointed out the need for a uniform approach and to be able to communicate with the patients in a clear and understandable way. Some of the patients' experienced unclear communication, as some were not sure what the long-term goal was until halfway through the actual admission. The second theme was *considerations regarding goals*. The HPs considered patient-centered goals to be important, and patients also expressed that the goals should reflect what they prioritized to work with during admission. Both HPs and patients found that the goals needed to be realistic in order to be beneficial. The HPs considered that goals should be measurable. They saw it as a requirement that they should demonstrate that goals were reached, although this was sometimes difficult to demonstrate. Some of the patients expressed a need to be able to relate to and understand the goal in order to see themselves work towards it during admission. The HPs also pointed out that the patients had to take ownership of the goals. The last theme was *the roles in the goalsetting process*. Both the HPs and the patients expected the HPs to have a guiding role in the goalsetting process. The HPs found that patients needed to participate actively in the goalsetting process to reach a patient-centered goal. Both the HPs, patients and relatives believed that participation of a relative in the goalsetting process was positive since they could complement on what the patients said.

Conclusions: The goal-setting process is complex, and several aspects need to be taken into consideration to achieve successful patient-centered goals. Clear communication and an overall agreement on the content and importance of the goals are important. Each stakeholder has their role to play in the goalsetting process; the patients need to take an active role, relatives complement the patients views and the HPs guide the goalsetting process.

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FRI0716-HPR ASSESSING THE BURDEN OF TREATED AND UNTREATED OSTEOARTHRITIS PAIN IN EUROPE

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Background: Osteoarthritis (OA) is a chronic, progressive musculoskeletal condition, estimated to affect >40 million people across Europe. OA is a major challenge for health care systems worldwide and is a leading contributor to years lived with disability (YLD) globally.¹ Current pharmacological treatment options may provide limited pain relief or may not be appropriate for long-term use in all patients because of adverse events.² There are few studies on the burden of chronic pain due to OA in Europe and whether this burden varies for those being treated with prescription (Rx) treatments compared with those who are not Rx treated.

Objectives: To assess the burden of OA in Europe and to determine whether burden differs by pain severity and treatment status.

Methods: A retrospective, cross-sectional study was conducted using data from the 2016 and 2017 National Health and Wellness Survey (NHWS) from five European Union countries (5EU): France, Germany, Italy, Spain, and United Kingdom. NHWS respondents with a self-reported OA diagnosis who completed the pain module were identified. Neuropathic and phantom limb pains were excluded. OA respondents were categorized into 4 groups by severity of pain and treatment: moderate/severe Rx-treated [M/S-Treated]; moderate/severe Rx-untreated [M/S-Untreated]; Mild Rx-treated; and Mild Rx-untreated (reference group). Outcomes of interest included health-related quality of life (HRQoL) (SF-12v2: mental and physical component summary scores [MCS, PCS]), health status (EQ-5D), productivity loss (Work Productivity and Activity Impairment [WPAI] questionnaire), and healthcare utilization in past 6 months. Multivariable analyses adjusted for baseline differences between groups (e.g., demographic and health characteristics).

Results: 2,417 OA patients reported a mean age of 61.8 (SD=10.8) years and the majority was female (64.5%). Sixty-percent of OA patients had M/S pain (n=1,440). Stratification by pain and treatment groups resulted in the following: M/S-Treated=27.4%, M/S-Untreated=32.2%, Mild-Treated=22.3%, and Mild-Untreated=18.2%. Those with M/S pain severity, both Rx treated and untreated, showed significantly worse HRQoL, health status and work impairment compared with the reference group (table 1). Further, both Rx treated groups had significantly more health care provider visits compared with OA patients without a Rx.

Table 1 Adjusted mean levels per outcome according to disease severity and prescription treatment status^a

Outcome	M/S-Treated (A) (n=663)	M/S-Untreated (B) (n=777)	Mild-Treated (C) (n=538)	Mild-Untreated (Ref) (n=439)	Mild-Untreated (Reference) p-value		
					vs. Group A	vs. Group B	vs. Group C
Mental Component Score (MCS)	41.2	44.3	44.9	45.9	<0.001	0.009	0.135
Physical Component Score (PCS)	38.7	44.8	43.4	50.0	<0.001	<0.001	<0.001
Health Status (EQ-5D)	0.48	0.66	0.65	0.77	<0.001	<0.001	<0.001
Absenteeism ^b	39.9	15.0	22.0	5.1	0.116	0.143	0.102
Presenteeism ^b	49.4	36.2	34.9	15.9	0.001	<0.001	<0.001
Overall Work Impairment ^b	54.4	38.1	37.9	17.3	0.001	<0.001	<0.001
Activity Impairment	45.5	30.6	33.2	20.0	<0.001	<0.001	<0.001
General Practitioner Visits	3.8	2.7	3.6	2.4	0.007	0.085	0.008
Total Traditional Healthcare Provider Visits	9.3	6.8	8.6	6.0	0.004	0.066	0.005

^aAll models controlled for age, sex, marital status, education, income, employment status, smoking status, alcohol use, exercise, body mass index, Charlson Comorbidity index, and country using generalized linear regression models.

^bAmong employed respondents only: M/S-Treated n=163; M/S-Untreated n=234; Mild-Treated n=155; Mild-Untreated n=143.

^cAmong employed respondents only: M/S-Treated n=138; M/S-Untreated n=222; Mild-Treated n=146; Mild-Untreated n=141.

Conclusions: The majority of European patients with OA in this study reported moderate-severe pain irrespective of prescription treatment. Whether treated or untreated, those with moderate to severe OA pain demonstrated a substantial burden on quality of life, health status, and productivity compared with those with mild pain.

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