increased the odds of a normalization of SBP (2.13[1.30; 3.50], 0.0027). In high risk patients, higher education (1.94[1.05; 3.57], 0.0338) and higher income (2.07 [1.00; 4.28], 0.0508) increased the odds of a normalization of SBP although not significant, we include this effect based on the confidence interval not including any values indicating a decreased odds

Table 1 Changes in CV risk profile from first to subsequent screening consultation for high and low risk patients

Risk factor	Patients with high risk (SCORE $\geq$ 5%)	Low to moderate risk (SCORE<5%)
	Number with changes out of number affected (%)	Number with changes out of number affected (%)
Changes in exercise habits from < 5 times a week to $\geq$ 5 times a week	73/153 (48%)	27/136 (20%)
Smokers changed to non-smokers	12/60 (20%)	10/66 (15%)
Elevated blood sugar (fasting Blood sugar or HbA1C): changes to normal level	69/72 (96%)	94/95 (99%)
LDL-cholesterol: changes from elevated level to normal level (<3 mMol/Mol)	4/18 (22%)	0/0 (0%)
Systolic blood pressure $\geq$ 145: changes from elevated level to normal level ($\leq$ 140 mmHg)	73/153 (48%)	0/0 (0%)
BMI $\geq$ 30: reduction with at least 1	21/68 (31%)	36/90 (40%)

Conclusions: Clinically relevant reductions in CV risk factors were seen after SC for CV risk in both high and low risk patients. Surprisingly female patients improved their exercise habits less often than male patients did. Older age increased the odds to reach a normal SBP. In high-risk patients, education and income positively influenced the odds to reduce SBP to normal

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HPR Interventions (educational, physical, social and psychological)

FRI0739-HPR EXPERT RECOMMENDATIONS ON PSYCHOLOGICAL NEEDS OF PATIENTS WITH RHEUMATOID ARTHRITIS

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Objectives: To generate recommendations in order to: 1) Optimize the management of psychological needs of RA patients, their family and caregivers; 2) Promote and improve communication and decision making with patients; 3) Establish referral criteria to mental health professionals.

Methods: A nominal group meeting of RA experts, rheumatologists and psychologists was held, in which the most important psychological and emotional needs and related aspects in RA were addressed. With an extensive review of the literature, a set of preliminary recommendations was generated that the experts discussed and modified. The definitive recommendations were voted in a Delphi which was extended to 20 more professionals. Participants voted from 1 (strongly disagree) to 10 (totally agree). Agreement was considered if at least 70% voted $\geq$ 7 (GA). Each recommendation was assigned a level of evidence (LE) and a grade of recommendation (GR) according to the Center for Evidence Based Medicine of Oxford.

Results: A total of 13 recommendations were generated (see table 1).

#	RECOMMENDATIONS	LE*	GR*	GA†
1	One of the objectives of the treatment of RA should be the psychological well-being of the patient	5	D	80%
2	The panel recommends to perform, along with the usual clinical actions, a psychological approach of patients with RA at the diagnosis and during the course of the disease	5	D	80%
3	It is recommended to analyze the impact that the information on the diagnosis of RA may cause in the patient	4	D	93%
4	It is recommended to adapt the information we give, to patient knowledge of their own illness, their concerns and characteristics, and to offer it sequentially, using all the available resources	5	D	100%
5	Information about RA should avoid medical technicalities as much as possible, as well as words and expressions that may negatively impact on the patient	5	D	87%
6	The panel recommends to use a constructive messages when we inform the patient about RA	5	D	100%
7	It is recommended to encourage and motivate the patient regarding to the treatment plan of the RA	2a	B	100%
8	During the course of the disease special attention must be paid to the psychological needs of the patient and their family and caregivers	4	D	100%
9	It is recommended to generate an atmosphere of trust, to share treatment decisions, and to avoid paternalistic attitudes or reprimands	5	D	87%
10	It is recommended to use open questions, an active listening, and to let the patients express themselves freely, as well as time for reflection	5	D	93%
11	Empathy should be practice in daily consultation, allowing discussion to seek consensus, and avoiding confrontation	5	D	100%
12	In patients with negative attitudes, it is recommended to promote self-efficacy, to promote the solution of problems and to offer other therapeutic options	5	D	87%
13	In patients with emotional lability, the panel recommends to use the HADS screening questions in order to detect depression	5	D	73%

Conclusions: These recommendations will help health professionals address psychological needs of the patient in daily practice, in order to manage them and improve patient's quality of life.

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HPR Patients' perspectives, functioning and health (descriptive: qualitative or quantitative)

FRI0740-HPR RESPONDING RESILIENTLY TO CHRONIC DISEASE: RHEUMATOID ARTHRITIS PATIENTS' DISCOURSE ON COPING STRATEGIES AND CHALLENGES

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Background: Little is known about how rheumatoid arthritis (RA) patients build and maintain resilience, or their ability to recover from, and adapt successfully to, stressful situations.¹ As symptoms and limitations caused by RA are often beyond patients' control, it is important to understand how patients develop and maintain resilience throughout fluctuations in their condition.

Objectives: We qualitatively explored patient narratives of coping with RA to examine their strategies for building/maintaining resilience in the context of RA.

Methods: Semi-structured interviews were conducted with adult RA patients in the United States. Interviewees were asked to discuss their experiences with diagnosis, living with RA, coping with challenges, treatment, and healthcare providers. The interviews were audio-recorded and transcribed verbatim. Transcripts were analyzed to identify patients' strategies for building/maintaining resilience (including examples, patterns in how and when strategies were used, and changes in use as patients gained experience with RA). Patients were categorized as 'high resilience' and 'low resilience' based on how confidently they coped with symptoms, physical limitations, the prospect of future life with RA, taking treatments, and communicating with healthcare providers. The characteristics of the high-resilience and low-resilience groups were qualitatively described.

Results: Eighteen patients were interviewed, with ages of 27–80 years and RA durations of 4–40 years. Patients used 10 strategies to build/maintain resilience