observed, which is an area of improvement. Effectiveness is good, waiting to compare with the previous year. Nutrition and preventive medicine consultations has not been evaluated because have been recently established. Other indicators are being analyzed at the end of the submission deadline.

The impact of this pioneering management model, with a holistic approach and incorporating patients into its governance, is difficult to measure until its implementation is completed. Uveitis and psychology consultations and patient school starting in 2020 will improve the quality of IMID patient care, as well as their satisfaction and that of their relatives.

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SATURDAY, 06 JUNE 2020

HPR Interdisciplinary research

SAT0608-HPR

EULAR POINTS TO CONSIDER FOR THE DETECTION, ASSESSMENT AND MANAGEMENT OF NON-ADHERENCE IN PEOPLE WITH RHEUMATIC AND MUSCULOSKELETAL DISEASES

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Background: Non-adherence to medication and non-pharmacological interventions precludes reaching an optimal outcome. 30 to 80% of patients with rheumatic and musculoskeletal diseases (RMDs) do not adhere to their recommended treatment regimens.

Objectives: The objective of this EULAR task force was to establish recommendations/points to consider (PtC) for the detection, assessment and management of non-adherence in people with RMDs.

Methods: A EULAR task force (TF) was established, and the EULAR standardised operating procedures for the development of PtCs were followed. The TF included rheumatologists, health professionals in rheumatology (HPRs), and patient-representatives from 12 countries. A systematic literature review of reviews was conducted in advance to support the TF in formulating the PtC. Agreement was obtained by Delphi technique in three rounds (0-10 rating scale).

Results: A definition of adherence, 4 overarching principles and 9 PtC were formulated (table).

Conclusion: The PtCs can help health-care providers to support people with RMDs to adhere to the agreed treatment plan.

Table. Overarching principles and points to consider.

Definition of Adherence		
Adherence is defined as the extent to which a person's behaviour corresponds with the agreed prescription.		
Overarching principles		Agreement
1	Adherence impacts the outcomes of people with RMDs.	99
2	Shared decision making is key, since adherence is a behaviour following an agreed prescription.	96
3	Adherence is influenced by multiple factors.	98
4	Adherence is a dynamic process that requires continuous evaluation.	96
Points to consider		Agreement
1	All HCPs involved in the management of people with RMDs should take responsibility for promoting adherence.	99
2	Effective patient-health professional communication should be applied to enhance adherence.	99
3	Barriers and facilitators of adherence of a specific patient to a specific prescription should be appropriately evaluated.	95
4	Patient education should be provided for people with RMDs as an integral part of standard care.	96
5	Care should be tailored to patient preferences and goals to enhance adherence.	98
6	Adherence should be discussed regularly based on open questions and particularly when disease is not well controlled.	99
7	The HCP should explore which factors might negatively influence adherence, including: opportunity (e.g., availability or cost), capability, (e.g., memory problems), motivation (e.g., concerns).	94
8	Together with the patient, the HCP should tailor the approach to overcome individual barriers to adherence, e.g., - simplifying the regimen, - using reminders, - providing education, - discussing the patient's beliefs on treatments.	98
9	When specific expertise or interventions for adherence are needed, they should be made available to patients.	98

HCP, health-care providers; RMDs, rheumatic and musculoskeletal diseases

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HPR Interventions (educational, physical, social and psychological)

SAT0609-HPR

DELPHI CONSENSUS FOR THE OPTIMAL TREATMENT & MANAGEMENT OF COMPLEX RHEUMATOID ARTHRITIS (RA) PATIENTS

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Background: A significant proportion of patients with rheumatoid arthritis (RA) have additional considerations that must be taken into account for managing their disease.¹ These include; co-morbidities, extra-articular manifestations and poor prognostic factors.²⁻⁵ Tailored management could reduce the burden on patients, the health system and wider society. The 'complex' RA patient group is ill-defined and no specific recommendations exist for their optimal management and treatment. **Objectives:** A group of UK Rheumatology experts aimed to provide a set of recommendations to support consistent and high quality management, grounded in current evidence, expert opinion and best practice. **Methods:** A steering group meeting identified priority topics associated with complex RA.

Table 1. Topics for consensus

Topic	No. of statements
Definition of 'complex' RA from a medical perspective	19
Definition of patient factors that may contribute to 'complex' RA	3
Outcomes for RA patients with co-morbidities and/or extra articular manifestations	5
Prescribing options for 'complex' RA	8
Evidence vs. best practice requirements	4
Burden of 'complex' RA	4
TOTAL NUMBER OF STATEMENTS	43

For each topic, the group defined statements they all agreed with. Delphi methodology was used to ratify these statements with rheumatology peers. High levels of agreement (over 70%) were achieved in the first round, the group proceeded to formulate the recommendations.

Figure 1. Responses received (n=163)

Figure 2. Consensus Plot (total responses n=163)

Conclusion: These recommendations are offered:

1. Healthcare professionals (HCPs) should consider a patient's complexity (including clinical co-morbidities, extra-articular manifestations and poor prognostic factors) prior to making treatment decisions;
2. HCPs should take into account a patient's psychosocial factors and health literacy prior to making treatment decisions;
3. Patient specific outcomes for complex RA should always be proactively agreed with the individual and/or their carers;
4. The local healthcare system should consider the overall costs of complex RA, beyond drug acquisition costs to allow flexibility of prescribing choices, as necessary in this group of patients;
5. Local treatment pathways should reflect that treatments with particular modes of action are more suitable for individual patients with complex RA.

6. Management of complex RA patients should extend beyond guidelines and recognise additional sources of evidence including; clinical studies, Real World Experience (RWE) and post-marketing surveillance.

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

SAT0610-HPR COHERENT REHABILITATION – EXPERIENCES OF PEOPLE WITH INFLAMMATORY ARTHRITIS

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Background: 20-40% of patients with inflammatory arthritis (IA) do not tolerate or do not have sufficient effect of the medication and experience considerable problems in their everyday lives. For these patients multidisciplinary rehabilitation and coherence in healthcare are of utmost importance (1). However, only little is known about coherence in healthcare among patients with inflammatory arthritis **Objectives:** To explore how persons with IA experience coherence in their rehabilitation pathways

Methods: Semi-structured individual interviews with 11 persons with IA who had experience with rehabilitation across primary and secondary health care. Interviews were conducted in the patients' home before admission to an inpatient rehabilitation stay, during the admission and 2-3 weeks and 4-6 months after discharge. In addition, participant observations and informal interviews were performed during admission. The analysis involved case descriptions (2) and interpretation in a thematic analysis (3).

Results: The analysis derived a main theme "a person centered approach", representing the importance for the person to meet professionals who listen and