OP0257-PARE

USING PATIENT HEALTH LITERACY PROFILES TO IDENTIFY SOLUTIONS TO CHALLENGES FACED IN RHEUMATOLOGY CARE

M. Bakker¹, P. Putrik¹, J. Rademakers², M. Van de Laar³, H. Vonkeman³, M. R. Kok⁴, H. Voorneveld⁴, S. Ramiro⁵, M. De Wit⁶, R. Osborne⁷, R. Batterham⁷, R. Buchbinder⁸, A. Boonen¹. ¹MUMC+, Maastricht, Netherlands; ²Nivel, Utrecht, Netherlands; ³MST, Enschede, Netherlands; ⁴Maasstad Hospital, Rotterdam, Netherlands; ⁵LUMC, Leiden, Netherlands; ⁶AUMC, Amsterdam, Netherlands; ⁷Swinburne University, Melbourne, Australia; ⁸Monash University, Melbourne, Australia

Background: The prevalence of limited health literacy (i.e. cognitive and social resources of individuals to access, understand and apply health information to promote and maintain good health) in the Netherlands is estimated to be over 36% [1]. Access to and outcomes of rheumatological care may be compromised by limited patient health literacy, yet little is known about how to address this, thus action is required. As influencing individual patients' health literacy in the rheumatology context is often unrealistic, it is paramount for the health system to be tailored to the health literacy needs of its patients. The Optimising Health Literacy and Access (Ophelia) process offers a method to inform system change [2].

Objectives: Following the Ophelia approach:

- Identify health literacy profiles reflecting strengths and weaknesses of outpatients with RA, SpA and gout.
- Use the health literacy profiles to facilitate discussions on challenges for patients and professionals in rheumatological care and identify possible solutions the health system could offer to address these challenges.

Methods: Patients with RA, SpA and gout attending outpatient clinics in three centres in the Netherlands completed the Health Literacy Questionnaire (HLQ) and questions on socio-demographic and health-related characteristics. Hierarchical cluster analysis using Ward's method identified clusters based on the nine HLQ domains. Three researchers jointly examined 24 cluster solutions for meaningfulness by interpreting HLQ domain scores and patient characteristics. Meaningful clusters were translated into health literacy profiles using HLQ patterns and demographic data. A patient research partner confirmed the identified profiles. Patient vignettes were designed by combining cluster analyses results with qualitative patient interviews. The vignettes were used in two two-hour co-design workshops with rheumatologists and nurses to discuss their perspective on health literacy-related challenges for patients and professionals, and generate ideas on how to address these challenges.

Results: In total, 895 patients participated: 49% female, mean age 61 years (± 13.0), 25% lived alone, 18% had a migrant background, 6.6% did not speak Dutch at home and 51% had low levels of education. Figure 1 shows a heat map of identified health literacy profiles, displaying the score distribution per profile across nine health literacy domains. Figure 2 shows an excerpt of a patient vignette, describing challenges for a patient with profile number 9. The workshops were attended by 7 and 14 nurses and rheumatologists. Proposed solutions included health literacy communication training for professionals, developing and improving (visual) patient information materials, peer support for patients through patient associations or group consultations, a clear referral system for patients who need additional guidance by a nurse, social worker, lifestyle coach, pharmacist or family doctor, and more time with rheumatology nurses for target populations. Moreover, several system adaptations to the clinic, such as a central desk for all patient appointments, were proposed.

Figure 1. Heat map of identified health literacy profiles, with patterns of scores across nine health literacy domains. Range for domains 1-5 is [1-4]; Range for domains 6-9 is [1-5]. Orange and red scores represent low to very low levels, yellow and green scores represent moderate to good levels. * indicates the profile displayed in figure 2.

Figure 2. Excerpt of a health literacy vignette corresponding to a hypothetical patient with profile number 9. Range for domains 1-5 is [1-4], range for domains 6-9 is [1-5]. Orange and red scores represent low to very low levels, yellow to green scores represent moderate to good levels.

Conclusion: This study identified several distinct health literacy profiles of patients with rheumatic conditions. Engaging with health professionals in co-design workshops led to numerous bottom-up ideas to improve care. Next steps include co-design workshops with patients, followed by prioritising and testing proposed interventions.

References:

- Heijmans M. et al. Health Literacy in the Netherlands. Utrecht: Nivel 2018
- Batterham R. et al. BMC Public Health 2014, 14:694

Disclosure of interests: Mark Bakker: None declared, Polina Putrik: None declared, Jany Rademakers Speakers bureau: In March 2017, Prof. Dr. Rademakers was invited to speak about health literacy at the "Heuvellanddagen" Conference, hosted by Janssen-Cilag., Mart van de Laar Consultant of: Sanofi Genzyme, Speakers bureau: Sanofi Genzyme, Harald Vonkeman: None declared, Marc R Kok Grant/research support from: BMS and Novartis, Consultant of: Novartis and Galapagos, Hanneke Voorneveld: None declared, Sofia Ramiro Grant/research support from: MSD, Consultant of: Abbvie, Lilly, Novartis, Sanofi Genzyme, Speakers bureau: Lilly, MSD, Novartis, Maarten de Wit Grant/research support from: Dr. de Wit reports personal fees from Ely Lilly, 2019, personal fees from Celgene, 2019, personal fees from Pfizer, 2019, personal fees from Janssen-Cilag, 2017, outside the submitted work., Consultant of: Dr. de Wit reports personal fees from Ely Lilly, 2019, personal fees from Celgene, 2019, personal fees from Janssen-Cilag, 2017, outside the submitted work., Speakers bureau: Dr. de Wit reports personal fees from Ely Lilly, 2019, personal fees from Celgene, 2019, personal fees from Pfizer, 2019, personal fees from Janssen-Cilag, 2017, outside the submitted work., Richard Osborne Consultant of: Prof. Osborne is a paid consultant for pharma in the field of influenza and related infectious diseases., Roy Batterham: None declared, Rachelle Buchbinder: None declared, Annelies Boonen Grant/research support from: AbbVie, Consultant of: Galapagos, Lilly (all paid to the department)

DOI: 10.1136/annrheumdis-2020-eular.877

OP0258-PARE

ESTABLISHMENT AND DEPLOYMENT OF PATIENT EXPERT PROGRAM

A. Phoka Charalambous¹. ¹Cyprus League Against Rheumatism, Nicosia, Cyprus

Background: Patient Expert on RMD's is a Patient Instructor who can train on the clinical examination technique of hand, hip, or knee for Rheumatoid Arthritis or Osteoarthritis. This Patient can explain the differences between RA and OS, can give information about symptoms for RMDs, and can share personal experience. Having a Patient Expert Program in a patient organisation helps on Raising awareness with future Health Professionals, gives strength and makes a stronger voice. After a very successful development of the Patient Expert Program, with the help of Euler Pare Knowledge Transfer Program, the time for installation of the program in universities has come.

Objectives: The aim was Medical Schools and Health Professional Universities to accept the program, in order for it to be a part of their education or training program. Having the program as part of their education or training program would benefit the next generation of Physicians or Health Professionals in the following ways. Better understanding for RMD's and the patient perspective, increasing awareness and early diagnosis, to build a rapport with the patient. The challenge was in having the program accepted by the schools and universities, as is the only program on this kind in the country.

Methods: We created a task force to achieve our goal. The task force developed a strategic plan using the Swot analysis, to be able to achieve our goal. From that analysis the following plan was made: First we needed to prepare a presentation for the program. Second, we needed to demonstrate it. Third, we had to have all our evaluation forms ready. And lastly, we had to make contacts with Medical schools by writing and by calling them. The stronger weakness and threat that came up was the possible refusal of the Universities, to accept the program.

Results: We started our communications with the Medical Schools when all of the steps were ready. The Medical School that had undergraduate students accepted to have a meeting with us. During our meeting, we made the oral presentation of our program and the Professors' response was positive and they proposed it to the Academic Board. The Academic Board asked for a demonstration