5.5/10 pre-education; this rose to a median of 10/10 post-education. The median anxiety score was 3/5 pre-education; this dropped to 2/5 post-education. The presentation was adapted based on questions that arose during the sessions. Multiple patients gave informal, verbal feedback stating that they found the group environment to be beneficial, providing a chance to meet others with similar conditions, share experiences and feel reassured that they are not alone in starting biologic therapy.

**Conclusion:** Patient feedback demonstrated that the group education sessions at UCLH were effective in improving their understanding of the rationale for biologic treatment, increasing their confidence in self-administration, and reducing anxiety. Verbal feedback illustrated that many patients enjoyed the group environment and the opportunity to interact and share experiences with others. At an average rate of 4 patients currently being seen a week, it is estimated that this will save 192 specialist nurse appointments per year (out of an estimated 226 commencing biologic therapy). There is scope for further research into the effects that this has had on waiting times to receive education / start treatment, and on drug compliance.

**References:**


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**AB1350-HPR**

**SOCIOECONOMIC BURDEN OF NON-ATTENDANCE IN RHEUMATOLOGY CONSULTATION**

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**Background:** Outpatient non-attendance refers to the phenomenon of patients who have a medical appointment but do not show up at the specified date, time, and location without giving previous notice. In addition to affecting the efficiency and thereby increasing the healthcare total costs, nonattendance might also delay access to care for users on waiting lists. Nonattendance at health appointments is costly to services, and can risk patient health. There is very little data on the nonattendance prevalence and impact in Portugal. This knowledge might be fundamental to improve effectiveness of outpatient care in Portugal.

**Objectives:** 1) describe patient's non-attendance rate; 2) assess and characterize the sociodemographic and clinical characteristics among non-attending patients; 3) estimate the economic burden of non-attendance.

**Methods:** Retrospective, cross-sectional and analytical study. We reviewed a one-month Rheumatology consultation period regarding performed medical consultations and non-attended consultations without previous notification from patients. Direct economic costs of non-attended appointments were calculated based on the ‘Amending Agreement to the ULSAM, EPE Program Agreement’.

**Results:** 982 consultations within January 2018 were included. Appointments episodes for therapeutic prescription, medical reports or programmed admissions were excluded. Fifty-seven (5.8%) of scheduled outpatient appointments were non-attended. Subsequent consultations represented 85.2% of attended appointments and 80.7% of non-attended appointments. Female gender was the most prevalent in both groups – 620 (670%) among attended consultations and 37 (65.0%) among non-attended consultations. Mean age was 57 ± 15 years in the first group and 54 ± 16 years in the second one. Among attended appointments, mean education level was 8 ± 5 years versus 8 ± 8 years among non-attended appointments. There were no differences between both groups in gender, age, education level, diagnosis duration and activity or appointment type (first or subsequent consultation). A cost of 2,438 euros was estimated regarding non-attended appointments for this period, what could represent a burden of more than 29,000 euros yearly, in direct costs, only.

**Conclusion:** Non-attendance at scheduled appointments in public hospitals seems to be influenced by other factors besides gender, age and education level. The burden of non-attended appointments is undeniable. In addition to the costs estimated in this study, further indirect costs such as poorer patients outcomes, impaired access to medical care and hospital penalties should be taken into account. Implementation of awareness strategies aiming the optimization and improvement of outpatient care in Portugal, and on drug compliance.

**References:**


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Background: Rheumatic diseases are immune-mediated disorders that affect the musculoskeletal system, soft tissues, blood vessels and connective tissue. Patients with rheumatic diseases need regular follow up for disease and drug toxicity monitoring. To cope with the increasing service demand, the Division of Rheumatology in the United Christian Hospital developed and expanded the shared care service. In the conventional practice, patients have been seen by rheumatologist for every visit while the shared care service involved follow up by rheumatologist and rheumatology nurse in alternate sessions.

Objectives: To evaluate the effectiveness and safety of the shared care service

Methods: This is a retrospective study involving the period from 1/1/2019 to 31/12/2019. Patients who attended the rheumatology nurse clinic for shared care were recruited and reviewed. All patients were selected and referred by rheumatologists. Criteria for shared care included regular follow up in rheumatology clinic and stable clinical condition. The length of follow up is adjusted according to patient condition. Services provided by rheumatology nurse (Rhn) included disease education, drug and disease monitoring, drug advice and referral to other professionals and community service as indicated. During each visit, patient’s vital signs, disease activity and laboratory results were assessed according to standard protocol. Rhn will make discharge record to ensure continuity of care.

Results: Totally 489 episodes of attendance to nurse led clinic were recruited. Majority (97.3%) were arthritis patients. Others included lupus, vasculitis, Sjogren’s syndrome and miscellaneous conditions. The length of follow up ranged from 3 weeks to 24 weeks and most of the patients were follow up between 8 to 16 weeks. Shared care patients included those with stable disease for interval monitoring, and patients for drug initiation and titration. The ratio for disease monitoring and drug monitoring are 41.3% and 58.7% respectively. For the 489 episodes of attendance, 10 (2%) episodes needed rheumatologist intervention and 18 (3.6%) episodes of nursing intervention were delivered, majority were medication adjustment or musculoskeletal ultrasound investigation.

Conclusion: The shared care service is smooth and can safely lengthen the follow-up intervals to reduce clinic visit burden in rheumatology clinic. Rhn input also allowed prompt advice for steroid tapering and dose titration for disease specific medication for better disease control. Proper case selection and close collaboration between rheumatologist and rheumatology nurse is the key.

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