

THU0579

“EVOLVING THE MANAGEMENT OF RA” PROGRAMME: EDUCATIONAL TOOLS TO SUPPORT DAILY PRACTICE

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Background: The eRA (evolving the management of RA) programme was initiated in Europe to provide practical educational tools that address unmet needs in the management of rheumatoid arthritis (RA). Several eRA tools – covering early access to care, management of comorbidities, treat-to-target strategies, and patient empowerment – are available to the rheumatology community. Through ongoing activities, the eRA Steering Committee (SC) identified a need for tools on non-pharmacological management of RA.

Objectives: To improve accessibility to eRA tools for rheumatology professionals; to review the evidence base of non-pharmacological interventions to create new eRA resources that may support management decisions.

Methods: A web platform providing information on eRA programme and tools was developed in 2019. The platform collects survey-based metrics to quantify perception of eRA and use of eRA tools in clinical practice. Platform and tools are translated to further support access and use across Europe.

To address unmet needs in non-pharmacological patient management, the eRA SC reviewed the core literature on agreed priority interventions, including physical activity, diet, patient education and self-management, psychosocial interventions, occupational therapy and orthotics, hand exercises, and hydrotherapy/balneotherapy. Available evidence for each intervention was assessed and graded according to the Oxford Centre for Evidence-based Medicine Levels of Evidence.

Results: The eRA web platform is now live in 3 countries (www.evolvingthemanagementofRA.com), hosting translated copies of the eRA tools, with additional countries launching throughout 2020.

From a review of core literature on non-pharmacological interventions, the eRA SC determined that strong evidence exists to support use of physical activity, patient education and self-management, psychosocial interventions, and occupational therapy and orthotics. Evidence was lacking or conflicting for diet and nutrition, hand exercises, and balneotherapy/hydrotherapy. A set of educational slides was produced by the eRA SC to summarise the evidence (Fig. 1) and provide top-line guidance on use of interventions in practice that should engage relevant members of the multi-disciplinary team. These slides are available through eRA dissemination activities.

Conclusion: The eRA programme content is now freely available to health care professionals in several countries on a web platform, supported by translations of the eRA tools. An additional slide set on non-pharmacological management serves to further increase the practical guidance of this programme's educational offering.

| Intervention | Strength* | Evidence summary |
|---|----------------------------|--|
| Physical activity | Strong evidence | Resistance and/or aerobic exercise has positive effects on several outcomes (e.g. strength, function). Some types of physical activity present with inconsistent evidence (e.g. Tai Chi, yoga) regarding their effects on outcomes. |
| Occupational therapy interventions and orthotics | Strong evidence | Occupational therapy interventions have positive effects on function. Podiatry interventions have positive effects on pain, but evidence is inconsistent regarding effects on function. Wrist splints may have positive effects on pain, but there is insufficient evidence regarding their effects on function. |
| Patient education and self-management interventions | Strong evidence | Patient education has positive effects on coping ability (e.g. with pain) and adherence (e.g. to supportive interventions). For education, there is inconsistent evidence regarding the long-term benefits and effects on self-efficacy. For self-management programmes, there is inconsistent evidence regarding effects on function. |
| Psychosocial interventions | Strong evidence | Psychosocial interventions have positive effects on many outcomes when used as an adjunct to pharmacological management, but evidence is inconsistent regarding long-term effects. Cognitive-behaviour therapy has positive effects on depression and fatigue. |
| Hand exercises | Additional evidence needed | Additional high-quality evidence is required before findings can translate into daily practice in RA management. |
| Diet and nutrition | Additional evidence needed | Additional high-quality evidence is required before findings can translate into daily practice in RA management. |
| Balneotherapy / hydrotherapy | Additional evidence needed | Additional high-quality evidence is required before findings can translate into daily practice in RA management. |

Fig. 1. Summary of evidence for non-pharmacological interventions

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EULAR TASK FORCE ON GENDER EQUITY IN ACADEMIC RHEUMATOLOGY: PRELIMINARY SURVEY FINDINGS

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Background: Women represent an increasing proportion of the overall rheumatology workforce, but are underrepresented in academic rheumatology, especially in leadership roles [1].

Objectives: The EULAR Task Force on Gender Equity in Academic Rheumatology has been convened to establish the extent of the unmet need for support of female rheumatologists, health professionals and non-clinical scientists in academic rheumatology and develop a framework to address this through EULAR and EMEUNET.

Methods: To investigate gender equity in academic rheumatology, an anonymous web-based survey was targeted at the membership of EULAR and Emerging EULAR Network (EMEUNET) and their wider networks. The survey was developed based on a narrative literature review [1], best practice from The Association of Women in Rheumatology, a survey of task force members and face-to-face task force discussions. Personal experiences were explored and 24 potential interventions to aid career advancement were ranked. Statistics were descriptive with significance testing for male/female responses compared using chi-squared/t-tests. The level of significance was set at $p < 0.001$.

Results: A total of 301 respondents from 24 countries fully completed the survey. By profession, 290 (86.4%) were rheumatologists, 19 (6.3%) health professionals, and 22 (7.3%) non-clinical scientists. By gender, 217 (72.1%) were women, 83 (27.6%) men, and 1 (0.3%) third gender. By age, 203 (67.5%) were 40 or under. By ethnicity, 30 (10.0%) identified themselves as ethnic minority. A high proportion of respondents reported having experienced gender discrimination (47.2% total: 58.1% for women and 18.1% for men) and sexual harassment (26.2%: 31.8% and 10.8% respectively) (Figure 1). Chi-squared tests on the numbers on which these proportions were based showed