Methods: We studied a one and a half-year period, from June 2018 to December 2019. During this time, 57 applications were submitted to participate in the courses. All participants who arrived were tested before starting the course. Test included 40 general questions about MSUS. Test results as well as commitment to training were analyzed in two groups: rheumatologists and radiologists. Non-parametric statistics were used for data processing.

Results: Among 57 applications submitted for the courses, 26 were from rheumatologists and 31 from radiologists, but the courses were attended by 13 rheumatologists and 26 radiologists (68%). Thus, commitment was reliably higher in radiologists (84%) than in rheumatologists (50%). Fisher's methods show high statistically significance ($\chi^2 = 7.51$, $p = 0.006$). Although the test focused on ultrasound, it was surprise for us that the median percentage of correct answers was higher in rheumatologists - 64 (54; 80)%, than radiologists ("ultrasonography specialists") 48 (40; 62)%. Difference also were significantly ($p = 0.04$).

Conclusion: Thus, despite better preparedness of rheumatologist, motivation to study MSUS prevails among radiologists. It is necessary to actively introduce MSUS into general rheumatologic educational programs in order to motivate rheumatologists to study MSUS. Changes in professional standard will also encourage wide use of MSUS by rheumatologists.

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THU0646-HPR EXPLORING THE ROLE OF NURSE IN RHEUMATIC CARE AND FEASIBILITY OF ENHANCING TREAT TO TARGET STRATEGIES IN JAPAN.

M. Fusama^{1,2}, M. Uda³, H. Matsumura⁴, Y. Van Eijk-Hustings⁵, S. Oliver⁶, H. Nakahara². ¹Yukioka Hospital, Osaka, Japan; ²Osaka Yukioka College of Health Science, Osaka, Japan; ³Kyoto College of Nursing, Kyoto, Japan; ⁴Higami Internal Medicine Rheumatism and Diabetes, Nara, Japan; ⁵Department of Patient & Care/Clinical Epidemiology and Medical Technology Assessment (KEMTA), Maastricht, Netherlands; ⁶Susan Oliver Associates, London, United Kingdom

Background: The role of rheumatology nurses is considered important for the implementation of T2T [1]. For nurses' contribution to implementation of the T2T strategy, it is necessary to explore the nurses' opinion on their roles in real clinical practice.

Objectives: The aim of this study is to evaluate what is required for nurses to implement T2T in real clinical practice in Japan.

Methods: Registered nurses engaged in rheumatic care in clinical practice in Japan were enrolled. Focus group interviews were conducted exploring 'What is necessary for RA nurses to implement T2T' using semi-structured interviews. Data analysis was used with Krippendorff's content analysis method.

Results: 24 nurses (all females) from 10 hospitals were enrolled in this study. The results of the qualitative analysis were categorized in 10 main categories, derived from 37 subcategories based on 64 different codes: (1) provide basic knowledge of RA, (2) provide knowledge of RA drugs, (3) provide knowledge and skills of self-monitoring, (4) enhance self-efficacy and support self-management, (5) support decision-making, (6) psychological and social support, (7) understand the diversity and feelings of patients and their families, (8) support based on individual needs, (9) ensure continuing educational opportunities for nurses to enable the provision of high quality care, (10) collaborate with multi-disciplinary teams.

These categories are mostly covered in the contents of the 2018 updated EULAR recommendations for the role of nurses except "evidence-based rheumatic care", "telehealth" and "comprehensive participation in disease management".

Conclusion: These findings indicate the areas of exploration including further educational and training needs, attitudes and the professional scope for nurses to extend their roles to provide greater value to patient care.

In Japan, evidence-based RA nursing and telehealth systems have not yet been established. In addition, therapeutic intervention by nurses and nurse-led clinic are not permitted. Our results might reflect this situation and possibly elucidates the gap between EULAR's evidence-based recommendations and opinions of Japanese nurses working in daily clinical practice. As evidence-based nursing is considered to be crucial from both cost-effectiveness and improvement of patients QOL, this result also might shed light on what we need for future better rheumatic nursing in Japan.

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THU0647-HPR SHARED DECISION MAKING AMONGST RHEUMATOLOGISTS IN TRAINING IN THE NETHERLANDS: WHERE DO WE STAND?

L. Kranenburg¹, M. Dankbaar², N. Basoski³, W. Van den Broek², J. Hazes¹.

¹Erasmus MC, Rheumatology, Rotterdam, Netherlands; ²Erasmus MC, Institute for Medical Education Research Rotterdam, Rotterdam, Netherlands;

³Maasstad hospital, Rheumatology, Rotterdam, Netherlands

Background: The training curriculum for rheumatologists in training in the Netherlands describes competences and entrusted professional activities (EPA) to monitor the progress in learning. However, this training program does not discuss training of Shared Decision Making. As the basis for shared care and patient participation is made during these years, the question arises how rheumatologist in training think about Shared Decision Making and how they use this in daily practice.

Objectives: Inventory of vision, experience and self-evaluation of skills related to Shared Decision Making amongst rheumatologists in training in the Netherlands in order to identify barriers in the implementation of Shared Decision Making in daily practice.

Methods: Qualitative data was collected from an online survey amongst rheumatologists in training who were registered in January 2018 by the Dutch Society of Rheumatology.

Results: Forty-two rheumatologists in training from various years of training responded (60%). Respondents think that Shared Decision Making is important. A third applies Shared Decision Making on a regular basis in daily practice. Self rating of skills for Shared Decision Making varies from sufficient to good. However, respondents are uncertain about their performance due to a lack of feedback and unclearness of the concept. They indicate that Shared Decision Making is not possible for all patients and find it difficult to assess whether the patient has a clear understanding of the options. Patient's preferences are discussed only by 33% of the doctors on a regular basis when starting new treatment.

Conclusion: Rheumatologists in training agree on the importance of Shared Decision Making, but are uncertain about their performance. Unclearness of the concept is described as a known barrier in literature^{1,2} and is frequently mentioned by respondents. Rheumatologist in training indicate that not all patients are fit for Shared Decision Making. Regarding the limited training on the subject this could also be a misjudgment of patients preferences and lack of experience how to deal with different patient types. There is a clear plea for more training and feedback on the subject. Training should be integrated in the curriculum focusing on how to assess patients preferences and how to apply Shared Decision Making also for patients who indicate to leave decisions up to their doctor.

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THU0648-HPR STUDY OF PAIN ATTITUDES & BELIEFS BETWEEN RHEUMATOLOGISTS, PHYSICAL THERAPISTS AND PATIENTS FOR FIBROMYALGIA- A CROSS-SECTIONAL SURVEY

S. K. Paramasivam^{1,2}, C. S. Kumar² on behalf of Chronic Pain Research Group of Academy of Orthopaedic Manual Physical Therapists (AOMPT). ¹Academy of Orthopaedic Manual Physical Therapists (AOMPT), Bethel Medical Mission, Physiotherapy, Bengaluru, India; ²Bethel Medical Mission, Physiotherapy, Bengaluru, India