between patients with RA and SLE, being much lower in patients with SLE (p value < 0.0001). Regarding gender differences, in men, there were 33 (12.7%) SLE and 89 (19.6%) RA face-to-face consultations, while in women there were 227 (87.3%) SLE and 364 (80.4%) RA in a face-to-face consultation. Regarding patients who were attended through telemedicine, 45 (11.7%) SLE and 966 (18.3%) RA were men, while 341 (88.3%) SLE and 4326 (81.7%) RA were women; that means, in the RA cohort, a greater number of men prefer the face-to-face consultation than in the SLE cohort (p value < 0.0185). 10 RA patients were diagnosed with the Covid-19 in teleconsultation; in all cases, close contact with infected relatives was verified as the probable cause.

Table 1. Differences by gender in the level of teleconsultation acceptance and face-to-face assistance in patients with SLE and RA

RA Patients					
Gender		Teleconsulting (%) ^a		Face-to-face consultation (%) ^a	
Male	1055	966	91,57%	89	8,43%
Female	4690	4326	92,23%	364	7,77%
SLE Patients					
Gender		Teleconsulting (%) ^a		Face-to-face consultation (%) ^a	
Male	78	45	57,69%	33	42,31%
Female	568	341	60,03%	227	39,97%

^a Total percentage of patients by gender. RA: Rheumatoid arthritis; SLE: Systemic lupus erythematosus.

Conclusion: Telemedicine may provide a viable option for the follow-up of patients with rheumatological diseases even beyond the pandemic. But unexpectedly, data showed an important difference in the acceptance of teleconsultation between patients with RA and SLE, being much higher in older and/or male patients with RA compared to patients with SLE; however, further studies are needed to support this conclusion.

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AB0908-HPR

SIGNED, SEALED, DELIVERED: PHARMACISTS ACHIEVING BETTER CARE CLOSER TO HOME IN RHEUMATOLOGY HIGH COST DRUG MANAGEMENT DURING THE COVID-19 PANDEMIC

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Background: The Pharmacy High Cost Drug (HCD) and Homecare (HC) team, based at a large acute teaching hospital consists of a range of skilled pharmacists, technicians and administrative staff. The team act as a HCD liaison between the hospital and commissioners, working closely with an expanding variety of specialist clinical teams to manage prescription processing for the following patient groups; HC: 2238; Hospital FP10: 1060; Outsourced Subsidiary Pharmacy Model: 41. HCD management, particularly immunosuppressive biologic therapies for complex rheumatology conditions such as rheumatoid arthritis, has been challenging during the Covid-19 pandemic. The inelasticity in demand for better care closer to home and a functional Integrated Care Records system has intensified, as many patients are now shielding/self-isolating at home.¹ Frugal innovations have been key during this time – achieving value and simplicity in service re-design to deliver better patient care.

Objectives: This review explores the support provided by the Pharmacy HCD and HC team to the rheumatology service since March 2020 to aid in service improvements during the pandemic.

Methods: The Pharmacy HCD and HC team reviewed existing practice to better respond to the service changes required during the pandemic in regard to the following areas; identifying patients for Covid-19 shielding; responding to changes in HC service provision; communication with commissioners; remote staff working; reviewing HCD formulations and administration routes; changes in commissioning arrangements.

Results: i) Rapid development of patient datasets following identification of 1,623 immunosuppressive drug entries in line with BSR Covid-19 guidance (first published in March 2020), thus enabling social distancing/shielding guidance to be issued to patients via letters/virtual platforms.² ii) Swift re-routing of urgent new biologic HC registrants to a new hospital pharmacy home delivery provision when certain HC providers temporarily imposed restrictions on intake of new registrants. This hospital initiative was further enhanced to a hub and spoke model enabling patients to have easy access to their medications from their nominated local community pharmacy branch. iii) Providing assurance to commissioners that clinical follow up reviews could continue virtually, blood samples could be taken at an external hub and blueteq documentation would be completed

covering NICE technology appraisal (TA) criteria. iv) A successful pilot utilising the lean PDSA (Plan, Do, Study, Act) quality improvement methodology, to enable remote working pharmacists and technicians to process HC prescriptions remotely in the absence of an electronic prescribing and medicines administration system. v) Reviewing potential plans to switch certain hospital day-case intravenous biosimilar infusions such as infliximab to subcutaneous administration via HC. vi) Business contingency development plans to protect fragile medication supply chains. vii) Clarifying implications for changes in contracting and payment arrangements announced by NHS England and NHS Improvement due to the pandemic.³

Conclusion: In summary, the role of the HCD Pharmacists during the pandemic in supporting rheumatology patients and the multidisciplinary team has been fundamental; ensuring signed prescriptions are securely processed to safely deliver medication to those in need.

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AB0909-HPR

COVID 19 CRISIS: RAPID DEVELOPMENT OF REMOTE RHEUMATOLOGY MEDICATION CLINICS

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Background: We used to initiate DMARD(s) and Biologic therapies via nurse-led shared medical appointments (Group clinics) and could see up to 30 patients per week, with a maximum of 6 patients per group. We did this to start patients on their medications efficiently and safely and to manage the increase in workload.

However, with the onset of the COVID 19 pandemic, we had to stop these clinics immediately, but, we did not have capacity to start everyone on their medications in a timely manner by telephone. Telephoning each individual took > 9 hours per week, whereas previously it took 3-4 hours.

Objectives: We wanted to start patients on their all rheumatology medications safely and efficiently (within 10 days).

Methods: By April 2020, we had organised the filming of 10 short healthcare videos to give patients all the information they required to start a range of DMARDs and biologics.

We developed a new protocol (fig 1); patients are asked to view the relevant video, contact our department to confirm they understand the safety monitoring, risks, potential side effects, dose increases etc. As soon as they confirm by email they are happy to start treatment, a prescription is generated and emailed to the hospital outpatient pharmacy, where it is dispensed and delivered to the patient's home. We send a follow up reminder letter about blood test monitoring etc (copy to GP) and a 'shared care agreement' to GP. They are given the option to have a telephone clinic appointment with a specialist nurse if required.

Figure 1.

Results: Of those requiring DMARDs, 62% reviewed the video, completed the checklist and confirmed by email they were happy to start treatment, within 24-hours. 88% had completed within 7 days.

Over half the patients (56%) were starting DMARDs for the first time, of those 8% requested a telephone consultation to discuss treatment further with the Rheumatology nurses. Of the 44% of patients already taking a DMARD and due to start a second medication 24% required a telephone clinic appointment. As this is a new service, we asked for feedback, receiving replies from 34%, all scoring between 9/10 and 10/10.

We have released > 7 hours of specialist nurse time for telephone/helpline clinics.

Conclusion: The development of digital / remote medication clinics has been a success and we will continue with this approach. We have limited face-to-face appointments, started patients on rheumatology medications more quickly and efficiently than previously (but maintained safety), allowed the nursing staff time to spend more time working in our telephone clinics and have had excellent patient feedback. Although, we are aware, this is at a cost of no peer-to-peer interaction, which has been of value in the past.

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HPR Professional education, training and competencies

AB0910-HPR

LEVELS OF DEPRESSION AND ANXIETY DURING COVID-19 PANDEMIC: AT WHAT DEGREE ARE HEALTH CARE WORKERS AFFECTED IN TUNISIA?

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Background: Since December 2019, a novel pneumonia caused by coronavirus-19 (COVID-19) has been spreading internationally. Facing this critical pandemic, health care workers who are involved in treating these patients are at risk of developing psychological distress.

Objectives: To evaluate mental health outcomes among health care workers treating patients exposed to COVID-19.

Methods: This cross-sectional study collected demographic data and mental health measurements from health workers in different hospitals using an online questionnaire. Participants were divided in two groups: G1 included participants working in a COVID-19 unit and G2 included those who worked in a normal ward. Participants were asked to complete the 9-item Patient Health Questionnaire (PHQ-9) and the 7-item Generalized Anxiety Disorder scale (GAD-7). The total scores of these measurement tools were interpreted as follows: PHQ-9 normal (0-4), mild (5-9), moderate (10-14) and severe (15-21) depression; GAD-7 normal (0-4), mild (5-9), moderate (10-14) and severe (15-21) anxiety. We compared the two groups in terms of psychological distress using a Chi-square test.

Results: A total of 155 individuals with a mean age of 31.3 ± 25 years [26-45] and a sex-ratio of 0.3 completed the online questionnaire. Seventy-two participants (46%) worked in a COVID-unit. The mean number of nightshifts per month in the COVID-unit was 9.5 in G1 and 1.3 in G2 respectively. The mean number of work hours per day in the COVID unit was 5 hours in G1, and 0 in G2. G2 participants worked in COVID-units during nightshifts only. An increase in workload compared to the pre-epidemic was noted only in G1. Depression and anxiety scores were higher among participants of G1 compared to G2 (Table 1).

Table 1. Comparison of the participants according to the PHQ-9 and GAD-7 scores:

Score	G1	G2	p
Mild depression	33%	12%	0.001
Moderate depression	14%	9%	0.000
Severe depression	7%	0.9%	0.002
Mild anxiety	29%	17%	0.005
Moderate anxiety	18%	7.3%	0.002
Severe anxiety	8.4%	2.1%	0.001

G: Group

The need for psychological support was more frequent in G1 compared to G2 (38% vs 9%; p=0.005). Participants of G1 were diagnosed with depression (9 cases), anxiety (9 cases) and burn-out (3 cases). In G2, 4 participants were diagnosed with anxiety. The prescribed treatments were: antidepressants (5 cases), anxiolytic (10 cases), and psychotherapy (12 cases).

Conclusion: Individuals experience varying levels of distress during pandemics. In our study, health care workers in the frontline of COVID-units experienced high levels of anxiety and depression. Thus, necessary measures should be attached to psychological support strategies for health care workers.

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AB0911-HPR

ROLE OF MOBILE APPLICATIONS IN RHEUMATOLOGY CARE: A MULTICENTRIC SURVEY

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Background: Although mobile health applications (apps) are becoming increasingly popular across several medical specialties, no data are available in rheumatology. The aim of this study is to investigate whether apps are routinely used by rheumatologists.

Objectives: In our study we aim assess real-life use of mobile applications in rheumatology clinical activity and to evaluate mobile apps role in rheumatology training, in particular for residents, and clinical activity.

Methods: We invited a non-selected sample of rheumatologists (consultants, residents and medical students committed to begin rheumatology residency) to participate in an anonymous web-based survey. This survey investigated mobile application use in rheumatology care and issues and concerns about mobile device use in rheumatology.

Results: Sixty participants completed the survey (40% consultants, 48.3% residents, 11.7% students). 52/60 (86.7%) declared to use mobile apps during their work. More than 50% used apps at least once a day. Apps were mostly used for calculating clinical disease activity scores for chronic inflammatory arthritides. Most rheumatology residents stated that these apps could be a useful tool in medical training. However, using a smartphone during a clinical examination was deemed to be inappropriate by 26/60 (43.3%).

Conclusion: Mobile apps as clinical tools are widespread among rheumatologists.

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