Objectives: -To investigate discordance between health literacy of patients with rheumatic and musculoskeletal diseases (RMDs) and assessment by their treating health professional, across the nine domains of the Health Literacy Questionnaire (HLQ).

-To explore whether discordance is associated with the patient's socioeconomic background.

Methods: Patients with rheumatoid arthritis (RA), spondyloarthritis (SpA), or gout from three Dutch outpatient rheumatology clinics completed the HLQ [3]. The treating health professional (rheumatologist, physician assistant, nurse (practitioner) or resident) assessed their patient's level for each HLQ domain, or answered "I don't know". Discordance per domain was calculated as the patient's score subtracted from the professional's score (both on a 0-10 scale). Discordance was defined as a ≥ 2 -point difference in either direction. Adjusted multilevel multinomial regression models (ref. = no discordance) with patients clustered by health professionals were computed to test the role of socioeconomic factors (age, gender, education level, immigration background, living alone and employment status) in negative (i.e. professional scored lower) and positive (i.e. professional scored higher) discordance.

Results: Of 778 patients included, 41% had RA, 34% had SpA, and 25% had gout. We observed considerable discordance across all HLQ domains (Table 1). Professionals answered "I don't know" most often for "Having social support for health" (19.4%, domain 4). Most discordance occurred for "Critically appraising information" (42.1%, domain 5). For all HLQ domains except "Having social support for health" (domain 4), discordance was associated with socioeconomic factors. In patients with a non-Western immigration background, professionals were likely to assign lower scores than patients' HLQ scores in six domains. Education level was an important driver of discordance in seven domains, with the direction of the association being domain-dependent. Other factors associated with discordance in multiple domains were type of rheumatic disease, comorbidities, mastery, how well the professional knew the patient, type of professional, and disease impact.

Table 1. Discordance per HLQ domain (n=778)

HLQ domain	Professional scored lower	No discordance	Professional scored higher	Professional did not know
	n (%)			
1. Healthcare provider support	128 (16)	514 (66)	126 (16)	10 (1)
2. Having sufficient information	100 (13)	528 (68)	143 (18)	7 (1)
3. Actively managing health	95 (12)	461 (59)	208 (27)	14 (2)
4. Having social support for health	55 (7)	397 (51)	175 (22)	151 (19)
5. Critically appraising information	78 (10)	448 (58)	250 (32)	2 (0)
6. Actively engaging with providers	205 (26)	500 (64)	70 (9)	3 (0)
7. Navigating the health system	115 (15)	544 (70)	107 (14)	12 (2)
8. Finding health information	163 (21)	492 (63)	98 (13)	25 (3)
9. Understanding health information	145 (19)	511 (66)	110 (14)	12 (2)

Conclusion: Considerable discordance between patients' health literacy and their treating health professionals' assessment exists across health literacy domains. In eight out of nine domains, discordance was associated with the patient's socioeconomic background, particularly education and immigration background. Understanding and addressing the reasons for discordance between patient-reported and professional-perceived health literacy has potential to improve responsiveness to patients' needs, promote better communication and ultimately improve care outcomes.

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DOES COGNITIVE BEHAVIORAL THERAPY IMPROVE PSYCHOSOCIAL OUTCOME IN RHEUMATOID ARTHRITIS: A SYSTEMATIC LITERATURE REVIEW

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Background: Rheumatoid arthritis (RA) is a chronic inflammatory auto-immune disease impacting both physical and mental wellbeing of patients. Cognitive behavioral therapy (CBT), a psycho-social intervention aiming to revert maladaptive thinking and dysfunctional behavior, could improve psychosocial wellbeing in patients with RA. However, it is unclear which CBT components are most successful in improving wellbeing and if certain subpopulations might be more sensitive to CBT therapy.

Objectives: To summarize in a systematic literature review, the effect of CBT on psychosocial outcomes in RA, focussing on most successful components and which patient subgroups benefit most from CBT.

Methods: A search was conducted with the support of a health sciences librarian at the KU Leuven Biomedical Library from inception until 28.06.2020 in 5 electronic databases: PubMed, EMBASE, Web of Science Core Collection, Cochrane Library and Cumulated Index to Nursing and Allied Health Literature (CINAHL). We included studies in English and Dutch involving patients >18 years old with RA, using cognitive behavioral approaches as intervention, with outcomes related to psychosocial variables. Two reviewers (CV&AVB) independently screened first the titles and abstracts of the studies, and later the full texts for eligibility. A third reviewer (DDC) was consulted if no consensus was found. Quality was assessed by the Critical Appraisals Skills Programme (CASP) RCT checklist.

Results: In total, 18 of 1114 retrieved articles could be included (Table 1). Mean age of the participants ranged between 48-63 years with a mean disease duration between 13-16 years. The most used CBT techniques included relaxation training, attention diversion strategies, problem solving skills, goal setting, communication, and social skills training. CBT resulted in ameliorated psychosocial wellbeing related to more active coping styles, improved self-efficacy and reduced perception of disease stressors. Six/18 studies focused on a RA patient subgroup with an increased psychosocial risk profile, such as high levels of depression. There was limited evidence for an improved treatment effect in these patients because of the elevated levels of psychological distress, but internal motivation seemed key for success.

Table 1. Included studies

First Author	Year	Country	Population	Mean age	Outcomes assessed
O'Leary	1988	USA	N=30	49y	Self-efficacy, Depression, Loneliness, perceived stress
Radojevic	1992	USA	N=59	54y	Depression, Anxiety, Pain coping
Germond	1993	SA	N=24	49y	Coping, Health Control, Stress, Mood, Impact
Parker	1995	USA	N=141	60y	Life stress, Daily stressors, helplessness, depression, anxiety, self-efficacy, impact
Kraaimaat	1995	NL	N=43	57y	Anxiety, Depression, Social Support, Pain Coping
Sharpe	2001	UK	N=55	56y	Anxiety, Depression, Coping
Evers	2002	NL	N=64	54y	Anxiety, Negative mood, Social functioning, Illness cognitions, coping, pain, compliance
Parker	2003	USA	N=54	56y	Depression, Stressors, Stress, Anxiety, Helplessness, Self-efficacy
Van Lankveld	2004	NL	N=58	50y	Depression, Anxiety, Stressors, Coping, Social Support
Zautra	2008	USA	N=142	52y	Affect, Depression, Coping, Pain, Catastrophizing
Hammond	2008	UK	N=167	55y	Self-efficacy, distress, Control, Self-Management
Barsky	2010	USA	N=168	53y	Distress
Hewlett	2011	UK	N=117	60y	Anxiety, Depression, Fatigue
Sharpe	2012	AU	N=104	56y	Anxiety, Depression
Garnefski	2013	NL, BE	N=82	48y	Depression, Anxiety, Self-efficacy
Lumley	2014	USA	N=266	55y	Anxiety, Depression
Vermaak	2015	AU	N=113	54y	Depression, Anxiety, Self-Efficacy, Distress, QoL
Hewlett	2019	UK	N=319	63y	Fatigue, Mood, QoL, Self-Efficacy, Helplessness

Conclusion: Adding CBT to standard care induces modest improvements in psychosocial outcomes for patients with RA. CBT seems more successful if patients are motivated to reflect on their cognitions and behaviours. However, more research with large-scale studies, focusing also on the critical early disease phase, is needed to investigate the long-term benefits of CBT.

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