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OP0178-HPR **YOU FIRST: A COST-EFFECTIVE NURSE-LED PATIENT SUPPORT PROGRAMME – RETROSPECTIVE ANALYSIS FROM A LARGE MULTI-ETHNIC SETTING**

Keywords: Real-world evidence, Spondyloarthritis, Psoriatic arthritis

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Background: The global impact of COVID-19 on elective rheumatology services is unprecedented, [1,2] and the number of people on waiting lists for consultant-led elective care in the UK has almost doubled. [3] Implementation of patient support programmes that provide an individualised nurse-led service, such as You First, may help to reduce the strain on healthcare resources. You First is aimed at people who have been prescribed secukinumab, an injectable anti-interleukin 17A monoclonal antibody, for approved indications including psoriatic arthritis (PsA), ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis.

Objectives: This retrospective analysis aimed to evaluate the benefits of the You First patient support programme on the Rheumatology service at a large university teaching hospital with a catchment population of 350,000, of whom 40% are from ethnic minorities.

Methods: The analysis included adult participants who were eligible for treatment with secukinumab according to National Institute for Health and Care Excellence criteria and were enrolled in the You First programme. All You First nurses were registered with the Nursing, and Midwifery Council and underwent specific training, competency assessment and validation to ensure they met all regulatory clinical standards of National Health Service (NHS) practice. Each participant was assigned to a dedicated nurse who visited the participant's home to provide routine clinical assessments, routine follow-up visits, phlebotomy service, psychological support visits, injection training and routine secukinumab administration, as required. Participants could also schedule regular nurse telephone calls to discuss any disease or drug related concerns such as secukinumab dosing/adherence check and side effect management. All data gathered during the home visits and telephone calls were reported to the treating physicians. Calculation of cost savings was based on the number of visits carried out as part of You First and the cost that the NHS would have incurred if the visit occurred at the hospital (£2.02 for phlebotomy service, £24 for telephone contact, and £99 for each assessment, routine follow-up visits and psychological support visit). Here we present annualised data from 28 February 2019 to 14 July 2022.

Results: In total, 126 participants with PsA (n=81) and AS (n=45) were observed for 17.2 months on average. At baseline, the mean age was 52.7 years and 39.2% of participants were male. During the timeframe of this analysis, You First nurses had 1160 contact points with the clinical team (793 visits; 367 telephone calls). The median (interquartile range) number of visits and telephone calls carried out as part of the programme per participant per year was 6.4 (4.6–11.3); phlebotomy service 0.4 (0.0–1.6), clinical assessments 1.4 (0.0–2.0), routine follow-up visit 1.6 (0.7–3.1), psychological support visit 0.0 (0.0–0.0) and telephone contact 2.0 (1.0–4.7). This translated to an annual cost saving of £64,156.49 (phlebotomy service £335.90, clinical assessments £15,159.13, routine follow-up visits £36,434.58, psychological support visit £368.90, telephone contact £11,857.99).

Conclusion: Implementation of You First at this large university teaching hospital yielded substantial cost savings for the NHS, with outsourced visits providing the most cost savings. You First allowed people with PsA or AS to be managed at home, freeing NHS capacity for appointments with new and complex patients in the clinic.

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OP0179-HPR **CHANGES IN WORK ABILITY FOLLOWING REHABILITATION**

Keywords: Rehabilitation, Work-related issues, Patient reported outcomes

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Background: Improved work participation is an important goal in rehabilitation, and has important socio-economic benefits. Despite this, there is limited knowledge about how rehabilitation impacts work ability across different diagnostic groups.

Objectives: To examine whether personal and disease-related factors predict changes in self-perceived work ability one year after rehabilitation.

Methods: In a longitudinal multicenter rehabilitation cohort (RehabNytte) 17 rehabilitation centers across Norway recruited more than 3700 patients with rheumatic and musculoskeletal diseases (RMD) as the largest diagnostic group [1]. Participants completed questionnaires at admission and discharge, and after 3, 6 and 12 months. Work ability was self-reported with a single item from the Work Ability Index (WAI) (2), referred to as the Work Ability Scale (WAS), where patients compared their current work ability to their lifetime best on a 0-10 scale (10= best work ability). For the logistic regression analysis WAS was categorized as either low/moderate (≤ 7) or good/excellent (≥ 8) [3]. Variables of interest were age, gender, diagnosis (cancer, rheumatic and musculoskeletal diseases, other), comorbidities, health region, education level (low, medium, high), body mass index (BMI), smoking, pain intensity (NRS-scale 0-10) and self-reported health (EuroQol VAS, scale 0-100). Retired patients were removed from analysis. A logistic regression model was fitted with variables individually predicting WAS at 12 months follow up, adjusted for sociodemographic and lifestyle variables and baseline WAS.

Results: Mean age at baseline was 53.3 (13.6) years. Seventy percent were female, 42 % had RMD, 24 % cancers and 33 % other diseases. Mean WAS at baseline (n= 3096) was 3.3 (SD 3.0), which significantly increased to 4.4 (3.2) at 12-months follow-up (n= 2397) ($p < 0.001$, Figure 1). Good WAS-score ≥ 8 at 12 months (adjusted for baseline work ability score and BMI) was predicted by high education level, higher age and high self-reported health at baseline, whereas low WAS-score ≤ 7 was predicted by RMD or cancer diseases, number of comorbidities and higher pain intensity (Table 1, OR in bold indicates $p < 0.05$).

Conclusion: In addition to disease- and demographic factors like high age, high education, comorbidities and presence of RMD, changes in work ability scores were related to pain and self-reported health, factors that are modifiable through rehabilitation.

Table 1. Logistic regression model of work ability 12 months after rehabilitation.

Independent variable	Work ability	
	Univariable	Multivariable*
Age	OR (95 % CI) 1.0 (0.99, 1.00)	OR (95 % CI) 1.01 (1.00, 1.02)
Education level		
10 years or less	1 (Ref)	1 (Ref)
High school	1.56 (1.08, 2.26)	1.25 (0.78, 2.01)
University	1.96 (1.37, 2.80)	1.70 (1.07, 2.69)
Diagnosis		
Other disease	1 (Ref)	1 (Ref)
RMDs	0.80 (0.64, 0.99)	0.60 (1.11, 3.31)
Cancer	0.64 (0.49, 0.83)	0.42 (0.26, 0.68)
Comorbidities	0.84 (0.79, 0.90)	0.79 (0.71, 0.87)
Pain intensity	0.86 (0.80, 0.92)	0.90 (0.83, 0.98)
EuroQol VAS	1.04 (1.03, 1.04)	1.02 (1.02, 1.03)

*Final model also adjusted for gender, BMI, health region, and work ability at baseline.

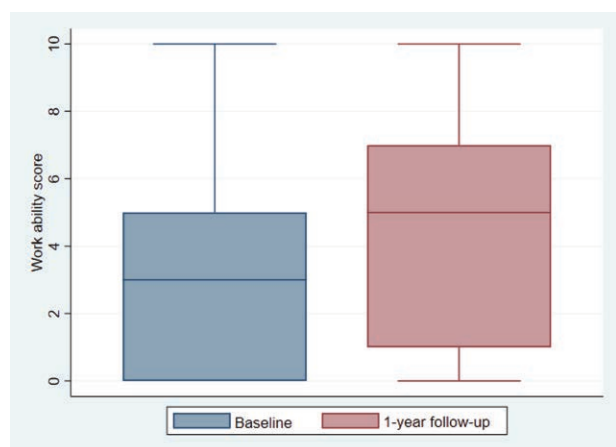


Figure 1. Work ability score (WAS) at baseline n = 3096, and at 1-year follow up n = 2397.

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OP0180-HPR **DOES FOLLOW-UP REALLY MATTER? A MIXED METHODS STUDY EXPLORING PATIENTS' PERSPECTIVES ON FOLLOW-UP SUPPORT IN REHABILITATION ACROSS LEVELS OF CARE**

Keywords: Quality of care, Rehabilitation, Patient reported outcomes

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Background: Lack of continuity in rehabilitation across levels of care is a known weakness of existing services. The BRIDGE-intervention was developed to improve the quality and continuity of rehabilitation for patients with rheumatic and musculoskeletal diseases (RMDs) by means of goal directed, coordinated, individually tailored follow-up after rehabilitation discharge. The intervention was evaluated in a multi-center randomised controlled trial (the BRIDGE trial) in Norway.

Objectives: The objective of this study was to explore what patients with RMDs need and receive of follow-up support in their municipality of residence after rehabilitation in secondary healthcare, and whether such follow-up impacts on clinical outcomes 1 year after rehabilitation. Further, to compare these findings with patients' experiences with follow-up support to develop a better understanding of how such follow-up works across levels of care.

Methods: The study had a concurrent mixed methods design in which quantitative and qualitative data were collected in parallel, analyzed separately, before

integrated into an overall result. All participants in the intervention group (n=168) of the BRIDGE-trial were included. Quantitative data were patient-reported in an electronic portal. Demographic and disease-specific data were collected on admission to rehabilitation. Data on goal attainment (Patient Specific Functional Scale), physical function (30 seconds Sit-To-Stand test), health related quality of life (EQ5D-5L-index), and health status (EQ-VAS) were reported at discharge, 2, 7 and 12 months after rehabilitation. Needs for follow-up were reported at rehabilitation discharge by ticking off a list of 12 predefined options. The patients were categorized into 4 groups based on their needs for follow-up on discharge (yes/no) and the degree of follow-up received according to stated needs the first year after rehabilitation (none/partial/complete). Quantitative data were analyzed using descriptive statistics, ANCOVAs, and linear regression. Qualitative data about patients' experiences with follow-up were collected in semi-structured interviews with 21 patients and analyzed using reflexive thematic analysis. The results were integrated in the overall interpretation and discussion.

Results: The patients most often reported needs for follow-up from General Practitioner, physiotherapist, and social security services, and did mostly receive (> 85%) these services within 1 year after rehabilitation. There were no significant differences between the 4 groups with regard to characteristics at discharge, or clinical outcomes 1 year after rehabilitation. Received individually tailored follow-up was not shown to significantly influence clinical outcomes, and was, surprisingly, associated with reduced patient reported health 1 year after rehabilitation: EQ-VAS β 0.28 [95% CI -0.48, -0.09], $p=0.004$. The qualitative analysis resulted in three themes: "Contact between service levels" (established through various actors, processes, documents), "Follow-up keeps the rehabilitation process going" (by increasing motivation and focus on goals and self-effort after discharge), and "Loss of momentum" (linked to personal and structural factors).

Conclusion: Patients with RMDs report needs for follow-up from one or more healthcare services after rehabilitation in secondary care. Clinical outcomes 1 year after rehabilitation appeared to be influenced by several other factors than the actual received follow-up support. Health personnel's competence and structural factors across health service levels, such as waiting lists and limited access to care, seemed to be decisive for the progress of the rehabilitation process over time, together with factors related to the individual patient and his/her life situation. The findings can contribute to increased insight into what promotes continuity in rehabilitation processes, effective follow-up, and better health for this patient group.

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OP0181-HPR **SOCIO-ECONOMIC, DISEASE-RELATED, AND PERSONAL FACTORS ASSOCIATED WITH PARTICIPATION IN REMOTE FOLLOW-UP IN RHEUMATOID ARTHRITIS – A CROSS-SECTIONAL STUDY**

Keywords: Patient reported outcomes, Telemedicine, Rheumatoid arthritis

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Background: Remote follow-up by collecting patient-reported outcome (PRO) measures allows for new opportunities such as real-time monitoring of symptoms and flexible scheduling of hospital visits based on patient needs[1]. In Denmark, a remote PRO-based follow-up intervention has been implemented among outpatients with rheumatoid arthritis (RA), and today, 35% of the outpatient population attends remote care. However, no study has explored factors associated with participation in remote care.

Objectives: To identify socio-economic, disease-related, and personal factors associated with participation in remote follow-up in RA patients.

Methods: We conducted a cross-sectional study among 775 prevalent RA patients from Aarhus University Hospital. In January 2019, eligible RA patients received an electronic questionnaire, covering health literacy and patient experience regarding involvement and confidence with remote care. In addition, we collected data from nationwide registers regarding socio-economic status, labor market affiliation, and co-morbidity. Associations between register and questionnaire-based factors and remote follow-up were analyzed using multiple logistic regression.

Results: A total of 775 patients were included in the register-based analyses. Since 129 patients did not have a digital mailbox, 646 patients received the electronic questionnaire which was completed by 394 (61%) patients. No labor market attachment and low household income was associated with lower odds for remote follow-up participation (OR 0.53 (95% CI 0.34 – 0.83)) and (OR 0.69