

Objectives: To assess the efficiency and utilisation of virtual and telephone clinics in a general rheumatology department.

Methods: Data was collected from electronic (Cerner) patient records on 240 patients who had a virtual appointment in May 2018. The data was analysed using Excel 2010.

Results: 240 patients had virtual appointments in one month. 121 (50.4%) were via telephone and 119 (49.6%) via patient letter. 34 (14.1%) patients had multiple virtual/telephone appointments. 129 (54%) were carried out by consultants, 78 (32%) by nurses and 33 (14%) by registrars. 37% had rheumatoid arthritis. 32 (13%) appointments lead to a prescription. Virtual appointments produced 44 referrals, including 18 to another specialty, 16 to physiotherapy, and the rest to hand therapy or podiatry. Most patients had a F2F appointment before and after their virtual appointment in May 2018, 1 patient had died before having a second face to face appointment and 13 (5%) were discharged from their virtual appointment.

	Mean Number of Days between appointments
From 1 st Face to Face to Virtual Appointment	44
From Virtual Appointment to 2 nd Face to Face	53
From 1 st Face to Face to 2 nd Face to Face	94

Abstract AB1421HPR Table 1. The mean number of days between each type of appointment.

Conclusion: Consultants undertook the bulk of virtual clinics, and these appointments resulted in the majority of referrals and prescriptions. Virtual appointments reduce the waiting times for contact with a healthcare professional between appointments. Many patients had several virtual appointments between face to face appointments and this cohort may benefit from more scrutiny. Current technology already improves communication and leads to significant changes in patient care without requiring F2F appointments. Internet based and app based interaction should face the same scrutiny.

Disclosure of Interests: None declared

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AB1422-HPR MODERATE AND HIGH ADHERENCE TO A DISEASE MANAGEMENT MODEL IN PATIENTS WITH RHEUMATOID ARTHRITIS IMPROVES CLINICAL RESULTS IN A BIG UNICENTRIC COHORT

Laura Villarreal¹, Fernando Rodriguez², Michael Cabrera³, Pedro Santos-Moreno⁴.

¹Biomab – Center for rheumatoid arthritis, Psychology, Bogot, Colombia; ²Biomab

– Center for rheumatoid arthritis, Patient program coordinator, Bogot, Colombia;

³Biomab – Center for rheumatoid arthritis, EHR administration, Bogot, Colombia;

⁴Biomab, Rheumatology, Bogot, Colombia

Background: Rheumatoid arthritis (RA) is an inflammatory, chronic disease of unknown etiology. Usually it leads to deformity and destruction of joints through the erosion of cartilage and bone. Over 90% of patients with RA report to suffer symptoms in hands and joints, swelling, loss of motion, muscle weakness among others. These symptoms affect all aspects in a patients life. Therefore, management of a patient with RA should not only include evaluate outcomes related to the rheumatology specialty, on the contrary, aspects such as physical disability, nutrition, mental health, among others should be taken into account. Centers of excellence in rheumatoid arthritis have proposed a multidisciplinary model of care with an initial diagnosis, treatment prescription and follow-up with a rheumatologist, periodic consultations with a physiatrist, psychologist, physiotherapist, occupational therapy nutrition, and, a patient focused program. With a multidisciplinary model of care the patient is seen as a whole, and the expectation is to achieve the best results in the management of RA.

Objectives: The aim of this research was to define adherence/attendance to a multidisciplinary model of care for patients with RA that attend to a RA specialized center in Colombia.

Methods: We implemented the center of excellence model program proposed by REAL-PANLAR group in 2015 (3). In order to define adherence to the multiapproach model the authors performed an informal expert consensus to propose a method to measure adherence to the model. The authors proposed three levels of adherence. We proposed three levels of adherence as follows: **High adherence:** For rheumatology patients had to attend between 6 and 12 consultations in one year. For physical therapy, physiatry, psychology, occupational therapy and

nutrition patients had to attend to 3 or more consultations during one year per each specialty. **Moderate adherence:** For rheumatology patients had to attend between 3 and 5 consultations in one year. For physical therapy, physiatry, psychology, occupational therapy and nutrition patients had to attend between 2 or 4 consultations during one year per each specialty. **Low adherence:** For rheumatology patients had to attend between 1 and 2 consultations. For physical therapy, physiatry, psychology, occupational therapy and nutrition patients achieved only 1 consultation or less during one year per each specialty. We performed a descriptive analysis and compared the level of adherence and disease activity.

Results: During 2018 we reviewed the medical charts of 6851 patients diagnosed with rheumatoid arthritis; 82% were female and 18% were male. Mean age was 59 years 13 years old. Regarding disease activity mean DAS28 was 2.69 0.84. Most of patients that were considered as Moderate or High adherent achieve remission or LDA.

See table 1. Levels of Adherence in Patients with RA

DAS	LOW ADH		MODER ADH		HIGH ADH	
	n	%	n	%	n	%
REMISION	245	4%	2090	31%	1495	22%
LDA	121	2%	874	13%	589	9%
MDA	193	3%	699	10%	465	7%
SDA	27	0.4%	31	0.5%	22	0%

Conclusion: This is an initial approach in order to evaluate patients adherence and attendance to a new implemented multidisciplinary disease management model of attention for patients with RA in Colombia. Our descriptive study demonstrated that patients with moderate or high adherence can achieve better clinical outcomes compared to those who are not adherent to the model.

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AB1423-HPR ELICITING THE AGENDA OF PATIENTS WITH MUSCULOSKELETAL DISORDERS; THE PHYSIOTHERAPIST-PATIENT INTERACTION

Sercan Yilli¹, Serkan Kalmaz¹, Faruk Altay², Elif Turgut². ¹Hacettepe University, Ankara, Turkey; ²Hacettepe University, Department of Physiotherapy and Rehabilitation, Ankara, Turkey

Background: Eliciting main concerns via interviewing is important for patient-centered care and for planning individualized rehabilitation program (1, 2). Recently, it has been shown that clinicians often fail to elicit the patients agenda and, when they do, they interrupt the patients discourse (3). However, the prevalence of agenda setting in physiotherapist as a health care provider and the physiotherapist-patient interaction remains relatively unexplored.

Objectives: The aim of this study was to describe agenda elicitation in rehabilitation, to determine the frequency of encounters in which physiotherapists elicited the patients with musculoskeletal disorders agenda, the proportion and timing of interrupted answers.

Methods: An audio-recording analysis of 52 clinical encounters recorded during first physiotherapist-patient interaction were performed. The elicitation of the patient agenda characteristics as the time to interruption or to complete statement were analyzed.

Results: Physiotherapists elicited the patients agenda in all (96.1%) clinical encounters. Interestingly, in those encounters in which physiotherapists elicited patient concerns, the clinician interrupted the patient after a median of 15 seconds (interquartile range 6 to 22 seconds). In the uninterrupted encounters in which physiotherapists elicited patient concerns, the patients with musculoskeletal disorders was state their agenda in 2414.5 seconds.

Conclusion: Physiotherapist emphasize to elicit the patients agenda, however, they interrupt expression very sooner. Eventually, the failure to elicit the patients agenda inhibits the physiotherapists-patient communication and this would lead to failure to plan rehabilitation program based on the needs of each patient.

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Arthritis research

AB1424-PARE EFFECTING A CHANGE AS A PATIENT INSIGHT PARTNER

Stephanie Skeffington¹, Emma Dorris². ¹University College Dublin, Patient Voice in Arthritis Research, Dublin, Ireland; ²University College Dublin, Centre for Arthritis Research, Dublin, Ireland

Background: In my patient advocacy work I had experience in every aspect except research. Through UCDs (University College Dublin) Centre of Arthritis Research (CAR) patient-research co-produced newsletter *News Rheum* I became aware of the Patient Voice initiative they had set up which is where I discovered the vasculitis research project I became involved with.

Objectives: My objectives to effect change were to be achieved by

- Sharing my knowledge
- Showing the value of patient involvement/engagement
- Learning how the research process works by being directly involved in the process

Methods: A personal perspective

Results: My formal involvement in this project started with my being invited to be a member of the interview panel choosing the postdoctoral researcher for the project. My remit was to ask the candidates about the impact of the project beyond just the science aspect, to try to figure out who just wanted a job, and who was interested and passionate about this project. I was not only choosing someone for the position but someone I was committing to work with for three years.

One of my first tasks was to act as a mentor in plain English to help the chosen researcher prepare a lay summary of the project. This helped both of us get to grips with the project and its objectives, as well as working out our working dynamic.

I work most closely with the project researcher, who has worked in rare disease but not in rheumatology. She has been very receptive and not only took an interest in learning more about the disease area but me as well.

I was introduced me to her first as a mentor, and second as a patient advocate. This helped us get to know each other and opened discussions including how PPI could aid her work and how invaluable it is from the patient perspective. This has given our relationship a great start and in a relatively short period we have built the great foundations for an excellent working relationship on a project we are both share a passion for.

For the researchers, to improve the process of PPI I would like some honest feedback on my performance as a patient insight partner. It may not be every patients ideal, but PPI is a knowledge exchange and we are all equal parties, I believe providing more robust feedback and sharing avenues for my improvement in a constructive way would be beneficial for my advocacy and future PPI work.

To prepare patient insight partners (PIPs) with no or limited experience of PPI there should be an opportunity to talk to another or former PIP about their experience or perhaps a leaflet detailing such experience which can be given to new PIPs. This is something not currently done within UCD, but, in response to my suggestion, Im working with UCD CAR to produce.

We are building the profile of our collaboration and showcasing the research by creating a blog together. The unique aspect of this blog is that it will represent both of our perspectives as researcher and patient advisor on specific topics. This is also an opportunity to inspire others involved in research projects to view other ways in which they can build on such collaboration, educate people about all aspects of the process

and learn from each other even more along the way. The reciprocal learning nature of this blog is the number one reason for its creation.

Conclusion: Anyone thinking about being a PIP should be aware of how important it is to share their expert knowledge in such as setting and shouldnt let their fear or perceived lack of knowledge hold them back. They should be willing to be an equal and expect to be treated as such and be willing to contribute fully to the knowledge exchange process including giving honest constructive feedback

Despite this relationship still being quite new we have plans to grow and build my PPI within UCD CAR.

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Patient information and education

AB1425-PARE FAMILY PLANNING IN CHRONIC RHEUMATIC DISEASES: UNMET NEEDS OF WOMEN AND MEN IN SWEDEN

Li Alemo Munters^{1,2}, Nathalie Holmen³, Suzanna Jansson¹. ¹Swedish Rheumatism Association, Stockholm, Sweden; ²Karolinska University Hospital, Stockholm, Sweden; ³UCB Pharma, Stockholm, Sweden

Background: Family planning (FP) in the context of chronic rheumatic disease (CRD) can be challenging for both women and men, with additional requirements for information and support.¹ However, it is unclear whether the needs of this population are being met by current clinical practice in Sweden.

Objectives: To gain insight into the perspectives of women and men with different CRDs on FP, and to assess whether they feel adequately supported to make informed decisions.

Methods: A 10-minute survey focusing on participants experiences and current needs around FP was designed. The survey was distributed (24 Aug 5 Sept 2018) via a web-based system to members of the Swedish Rheumatism Association; men and women aged 18-77 years were included. Data are reported for participants with arthritic or systemic CRDs (rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, juvenile idiopathic arthritis, systemic sclerosis, systemic lupus erythematosus, polymyositis, dermatomyositis). Participants with fibromyalgia, Ehlers-Danlos syndrome, other or no CRD were excluded.

Results: Of 944 participants, 542 (57%) women and 60 (6%) men with arthritic or systemic CRDs responded. Over a quarter of women (28%) who had/were expecting children felt their CRD had affected their ability to have children and more than half either believed that their CRD had influenced the number of children they had or were undecided (**Figure A**). Men were less affected by their CRD with respect to FP, with >60% reporting no impact on their ability to have children and/or how many. Of participants who did not want children/more children in the future, around a third attributed this to their CRD (women: 37% [n=86/232]; men: 30% [n=9/30]). Their biggest concerns were not being able to physically handle and/or cope with taking care of a child, and passing on their disease (**Figure B**). Womens concerns regarding disease activity after pregnancy were not unfounded, with 66% reporting disease worsening postpartum. The most common treatments reported by women with CRD while trying to conceive were DMARDs (20%), NSAIDs (18%), corticosteroids (14%) and anti-TNFs (13%). Of women on anti-TNF therapy (n=71), 68% discontinued treatment during pregnancy. Only around a third of women felt they had received adequate support and information about FP from their healthcare provider (HCP; 33%) and that this information was consistent between HCPs (28%). Men with CRD were even less satisfied with both the level of support (13%) and the consistency of information received around FP (13%).

Conclusion: The results of this survey suggest that in Sweden, CRD has a marked impact on FP for women, and to a lesser extent for men. Furthermore, the level of support and information on FP provided by HCPs to people with CRD, as well as the consistency of information received from different HCPs, were deemed inadequate. Providing better information on FP by HCPs, to both women and men with CRD, would help to support them on their journey to parenthood and overcome perceived obstacles to having children and continuing therapy.