

and motivation. Participants were enthusiastic about accessing several intervention techniques via an app, but warned that smartphones and technology can exacerbate mental fatigue and eye dryness. The invisible nature of symptoms, and highly visible nature of management techniques (e.g. applying eye drops), presented further self-management challenges relating to their interactions with other people.

Conclusion: Promising components to include in an SS app were identified but should be tested in an optimisation trial. The in-app delivery of component modules should be designed to support diverse self-management approaches, choice and autonomy, yet provide module recommendations and guidance when needed, and be simple to use to reduce mental fatigue and dry eye symptoms. A self-management app should also be designed to enable users to share information about SS with other people.

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SATURDAY, 06 JUNE 2020

HPR Patients' perspectives, functioning and health (descriptive: qualitative or quantitative)

SAT0615-HPR FACTORS ASSOCIATED WITH PATIENT ACTIVATION IN PEOPLE WITH RHEUMATIC CONDITIONS

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Background: Patient activation describes the skills, abilities and confidence someone uses to actively manage their health. Patient activation abilities in rheumatology are unclear, and there is little knowledge about factors that explain variation in patient activation. Therefore, understanding these factors can contribute to the development of appropriate, rheumatology-specific interventions targeting activation. The Patient Activation Measure (PAM) captures patient activation and provides people with both a score and a level to describe how able they are to actively manage their health.

Objectives: To explore longitudinal changes to patient activation (measured using the PAM) (Hibbard *et al.*, 2005), and the PAM's associations with related constructs (including self-efficacy, health literacy and health beliefs) in a sample of participants with inflammatory arthritis.

Methods: A postal survey was administered at two time points that were nine months apart. This survey captured the PAM and a range of clinical, demographic and psychosocial variables in a sample of rheumatology patients from 6 NHS sites in England. The measures included in the survey had been selected based on both theory and prior qualitative research and the survey pack was designed in collaboration with a patient partner. Following data collection, candidate variables for a multiple regression analysis were initially identified using univariable analysis. These variables were included in a forced entry multiple regression at each time point, and the variables that were statistically significant contributors at a 0.1 level were included in the final models. Changes to PAM scores over time were investigated using a Wilcoxon matched-pair signed rank test.

Results: 251 participants completed the first survey and 154 participants completed both full surveys. Self-efficacy, illness beliefs, health literacy and health locus of control were consistently associated with variance in PAM scores. The first three factors were also predictive of variance in PAM levels. With the 154 participants who fully completed both surveys, there was a statistically significant difference in participants' PAM scores between the two surveys.

Conclusion: The findings suggest factors that may be targets for interventions that aim to increase patient activation. The changes to PAM scores across the data collection period also suggest that when using the PAM as a clinical tool, healthcare professionals would benefit from incorporating regular reviews and preparations for any increases or reductions in patient activation.

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SAT0616-HPR IMPLICATED FACTORS IN THERAPEUTIC ADHERENCE OF PATIENTS WITH RHEUMATOID ARTHRITIS: THE PATIENT'S PERSPECTIVE

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Background: Therapeutic adherence has become a topic of growing interest for medical research. Studies have reported non-adherence rates of 20-50% in rheumatoid arthritis (RA) patients (1). Poor adherence has a negative impact on disease outcomes and implies an economic burden for the health system (2). Identifying the potential risk factors for non-adherence is essential to develop intervention strategies to solve this problem

Objectives: To establish the contribution of illness and medication beliefs to therapeutic adherence in RA. To explore the association of treatment adherence with other patient and disease factors.

Methods: RA patients \geq 18 years old from a military hospital diagnosed with RA based on ACR/EULAR 2010 criteria were included in a cross-sectional study. Compliance Questionnaire Rheumatology (CQR) was used to assess treatment adherence. Unsatisfactory compliance was defined as taking correct dosing $<$ 80%. Illness and medication beliefs were evaluated using the "Brief Illness Perception Questionnaire" (IPQ-b) and the "Beliefs about medicine questionnaire" (BMQ). Demographic data and clinical characteristics were collected by standardized clinical interview and revision of medical records.

Results: 144 patients were included the study, 106 (73.6%) women, with a mean age of 62 years (SD 12) and median disease duration of 5 years (interquartile range 25-75: 2-11). 113 (78.4%) patients showed good treatment adherence. No differences were observed regarding demographics and clinical characteristics. Strong beliefs about drugs potential damage was associated with poor compliance (13 \pm 5 vs. 11 \pm 3, $p=0.013$), meanwhile increased belief in medication necessity was associated with good compliance (21 \pm 3 vs. 20 \pm 3, $p=0.015$). From the illness perception measures, adherent patients had increased feeling of treatment control (8.8 \pm 1.5 vs 7.7 \pm 2.1, $p=0.008$) and greater emotional response (6.2 \pm 3.1 vs 4.8 \pm 3.4, $p=0.042$). In a multivariate analysis was found that for each unit of increase in the score of BMQ's damage domain, adherence was reduced by 20% (CI 95% 0.7-0.9, $p=0.001$); for each unit of increase in the treatment control item of the IPQ-b, adherence increased 1.42 times (CI 95% 1.1-1.8, $p=0.006$); and for each unit of increase in the emotional response item of the IPQ-b, adherence increased 1.2 times (CI 95% 1.08-1.46, $p=0.002$).

Conclusion: Illness and medication beliefs could influence compliance to treatment in patients with RA.

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SAT0617-HPR QUALITATIVE STUDY EXPLORING THE BARRIERS AND FACILITATORS TO HOME-BASED EXERCISE PROGRAMS ADHERENCE WITH KNEE OSTEOARTHRITIS: THE PERSPECTIVES PHYSIOTHERAPISTS AND PATIENTS.

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Background: Home exercise programs are widely used in the treatment of knee osteoarthritis (OA). However, adherence to these exercises decreases in the long term due to different factors. In recent years, new approaches are being developed to increase exercise adherence (EA) for patients with OA. Although it is known that EA is low in Turkish patients, there is no study that examines the

barriers of adherence to home exercise programs in patients with OA by qualitative research methods.

Objectives: Aim of our study was to investigate the barriers and facilitators for adherence of home-based exercises for knee osteoarthritis management from the perspective of physiotherapists and patients.

Methods: A Qualitative study by using focus groups discussions and semi-structured interviews were designed to investigate the barriers and facilitators to home-based exercise program adherence for OA. Two researchers facilitated focus group interview. Participants of focus group members were eight physiotherapists (PT) working with OA with different experience levels. Third researcher conduct the interviews which lasted 30-60 minutes with patients (patients with knee OA, n=5 ages>50). Data were audio recorded, transcribed verbatim and thematically analyzed with NVIVO 12 software. Three researchers conducted the thematic analysis to ensure the validity.

Results: In total, 25 main themes from the focus group discussions and interviews were determined. Major barrier themes from focus group were (a) beliefs to exercise benefits (b) patient education and (c) fear avoidance beliefs on exercise; from the interviews were (a) negligence of self-management (b) fatigue and (c) patient education. Patients and therapists all agreed for patient education is one of the most important factors for home EA. Patients wanted to get education on arthritis management. A patient said: "Actually, the clinicians should give information more deeply. I don't know which is correct for me after therapy, resting or moving?" Major facilitator themes from the focus group were (a) motivation from PT (b) client-centred exercise (c) digital technology; from interviews were (a) motivational approaches of therapists (WhatsApp messages) (b) having pain and (c) patient education for disease management. Therapists agreed on that personalized exercise is the most important facilitator. A therapist commented, "If the personalized exercise given the patient with correct intensity and repetitions, I don't think that patients would not do their home exercises."

Conclusion: This is the first qualitative study about exercise adherence in knee osteoarthritis in Turkey. It has been determined that the lack of education and motivation are the most important barriers. More studies are needed to examine the factors affecting EA for patients with OA. In future studies, implementations to increase home EA on Turkish patients with OA should be investigated by qualitative research methods.

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SAT0618-HPR

PATIENTS WITH INFLAMMATORY MYOPATHIES WHO DO NOT REACH HEALTH ENHANCING LEVELS OF PHYSICAL ACTIVITY REPORT HIGHER LEVELS OF ANXIETY AND DEPRESSION - A CROSS-SECTIONAL STUDY OF SELF-REPORTED DATA

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Background: The adult idiopathic inflammatory myopathies (IIM) comprise dermatomyositis (DM), polymyositis (PM), immune-mediated necrotizing myopathy (IMNM), antisynthetase syndrome (ASS), overlap myositis and inclusion body myositis (IBM). Impaired physical capacity, self-reported fatigue and pain are common features in IIM. Quality of life is reduced compared to population-based reference values. To our knowledge self-reported levels of physical activity has not been studied in patients with IIM. Further, anxiety and depression are common in other rheumatic diseases, such as SLE, but is less studied in IIM, and not previously in relation to levels of physical activity. There is evidence for symptom reducing effects of exercise for patients suffering from depression (1).

Objectives: The objective of this study is to assess the levels of self-reported physical activity, depression and anxiety amongst adult patients with IIM. A further aim is to evaluate differences in anxiety/depression based on levels of physical activity as well as to analyze relationships between physical activity and anxiety/depression.

Methods: All patients with IIM visiting the Rheumatology clinic at Karolinska University Hospital in Solna between February 2019 and January 2020 where asked to fill in questionnaires about their levels of physical activity for the last seven days using the International Physical Activities Questionnaire – short

form (IPAQ), and anxiety and depression using Hospital Anxiety and Depression Scale (HADS). The myositis team nurse distributed the questionnaires. Spearman's rho was used for correlation analysis. Kruskal-Wallis test and post-hoc adjustment with Bonferroni correction was used to analyze group differences. HADS is scored in two separate scales, one for depression (HADS-D) and one for anxiety (HADS-A). The cut-off value for probable depression or anxiety is ≥ 8 of a maximum of 21 per scale (2). IPAQ-results was scored as 1 (low, < 150 min/w), 2 (moderate, ≥ 150 min/w – health-enhancing levels of physical activity, HEPA, according to WHO) and 3 (high, ≥ 300 min/w).

Results: A total of 61 patients answered the questionnaires. 52 (85 %) of the patients reported to reach HEPA and 24 of these patients reported to be active on a high level. 22 patients (36 %) scored probable anxiety or depression, with six scoring ≥ 8 for both depression and anxiety. Patients with low levels of physical activity (IPAQ-1) scored significantly higher anxiety and depression compared to those reaching HEPA (IPAQ-2 and IPAQ-3) $p < 0.0001 - 0.020$. The correlation between physical activity and depression (Fig. 1) was $r = -0.48$ (-0.66; -0.26) and between physical activity and anxiety (Fig. 2), $r = -0.27$ (-0.49; -0.02).

Conclusion: Self-reported data indicates that most patients with IIM in this sample reached HEPA level or higher. Patients who do not reach HEPA score significantly higher anxiety and depression compared to those reaching HEPA. However, levels of physical activity correlates moderately to depression and weakly to anxiety. The number of patients who reached HEPA is high compared to studies in rheumatoid arthritis or the general population. This could be explained by frequent visits to physical therapists early in the disease and yearly check-ups with a focus on exercise and physical activity. Further the inter-professional myositis team also has a focus on exercise and the importance of everyday physical activity. This is cross-sectional, self-reported data and longitudinal studies are needed also including objective measures. This is preliminary data with data collection ongoing throughout 2020.

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SAT0619-HPR AN AUDIT OF GLUCOCORTICOID PRESCRIPTION IN PATIENTS WITH GIANT CELL ARTERITIS

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Background: Giant cell arteritis (GCA) is treated with high dose glucocorticoids

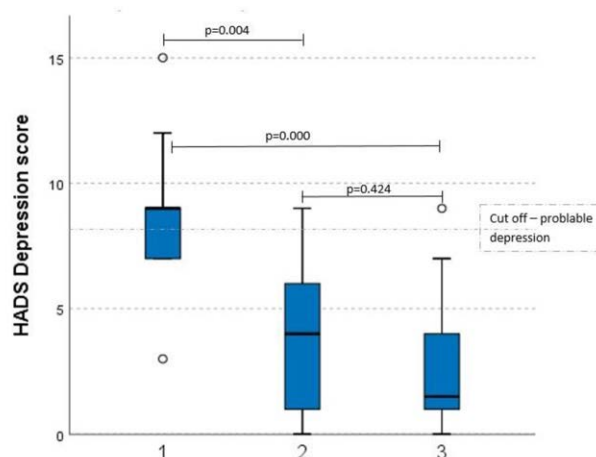


Figure 1. IPAQ level

1-low physical activity, not reaching health-enhancing levels of physical activity (HEPA), 2-moderate physical activity, reaching HEPA, 3-high physical activity, surpasses HEPA

and progressively reduced over months to years.

Objectives: We undertook an audit to evaluate self-reported adherence to the original recommended glucocorticoid course and explored reasons for any variation.

Methods: We recruited patients attending a single rheumatology department over 18 months. Respondents were given two self-administered questionnaires