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POS0607 (2022)

IMPROVING TREAT-TO-TARGET IMPLEMENTATION IN RHEUMATOID ARTHRITIS: A SYSTEMATIC LITERATURE REVIEW OF BARRIERS, FACILITATORS, AND INTERVENTIONS**L. Gossec¹, L. Bessette², R. Xavier³, E. G. Favalli⁴, A. Ostor⁵, M. H. Buch⁶**¹*Sorbonne Université, Pitié-Salpêtrière Hospital, Paris, France*²*Laval University, Rheumatology, Quebec City, Canada*³*Universidade Federal do Rio Grande do Sul, Hospital de Clínicas de Porto Alegre, Porto Alegre, Brazil*⁴*ASST Gaetano Pini-CTO Institute, Division of Clinical Rheumatology, Milan, Italy*⁵*Monash University and Emeritus Research, Cabrini Medical Center, Melbourne, Australia*⁶*University of Manchester, NIHR Manchester Biomedical Research Centre, Manchester, United Kingdom*

Background: Treat-to-target (T2T) is integral to international recommendations for managing patients with rheumatoid arthritis (RA).^{1,2} but its implementation in clinical practice is suboptimal.³ Understanding T2T barriers and facilitators may inform strategies for improving T2T implementation in RA.

Objectives: To review published evidence on barriers to and facilitators of T2T implementation in RA, and interventions designed to improve T2T implementation.

Methods: Two systematic literature searches were conducted to identify barriers to or facilitators of, and interventions designed to improve, T2T implementation in RA (Jan 1, 2015–Mar 1, 2021 and Jan 1, 2010–Jul 1, 2021, respectively). The quality of each study was assessed using the appropriate Critical Appraisal Skills Programme (CASP) checklist.⁴ Barriers/facilitators and interventions were grouped into categories and summarized descriptively.

Results: The barriers/facilitators literature search retrieved 235 articles. Seventy-seven of these, which described primary studies mentioning a total of 331 T2T barriers/facilitators in RA, were included in the analysis. The interventions literature search identified 451 articles, including 70 primary studies reporting a total of 56 unique interventions to improve T2T implementation in RA. The quality of the studies varied; however, most addressed at least half of the information evaluated in the CASP checklists. Barriers/facilitators were categorized into 18 key target areas for patients (n=7), healthcare professionals (HCPs; n=6), or patients and HCPs (n=5). These related to: HCPs' or patients' knowledge or perceptions; patients' clinical or social conditions; patient-HCP communication or alignment; and time or resources (Figure 1). The 56 interventions were grouped into 18 types (Table 1). More than half of the interventions (n=30; 53.6%) were designed to improve or streamline disease activity or patient-reported outcome assessments or increase patient-HCP alignment on disease activity. Interventions designed to improve shared decision-making were also common (n=23; 41.1%); these included patient and HCP education (n=15), decision aids (n=7), and shared decision-making prompts (n=3). Of the 56 interventions, 20 (35.7%) reported improvements in T2T implementation and/or patient outcomes in RA. However, as most interventions were evaluated in single centers, their effectiveness, feasibility, and generalizability across other regions or healthcare settings were unclear.