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Agreement with the French 2019 recommendations on treatment adherence among 357 health professionals

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Sir,

In chronic inflammatory rheumatic diseases, including rheumatoid arthritis, spondyloarthritis, connective tissue diseases and crystal-induced arthritis, long-term adherence to disease-modifying drugs (DMARDs) is only moderate, reported in the range of 30 to 80%.[1-3] Non-adherence may lead to increased disease activity, unnecessary treatment switches and heightened costs [4,5]. In 2017, 105 experts in France developed recommendations to facilitate the evaluation and management of non-adherence to DMARDs in daily practice [1] (**Table 1**). The implementation of recommendations rests on their dissemination and the agreement of health professionals (HPs) with the content and the applicability for usual care.[6] The objective of this study was to evaluate the agreement of French HPs with the recent adherence recommendations, and their perceived feasibility/ease of application in usual care.

In 2018, in 38 face-to-face meetings across France, the recommendations and the key supporting data were presented [1]. Participants then completed a paper form anonymously, with their agreement (from 1 to 5, where 5 is highest) and perceived feasibility (1-5) for each recommendation. Mean agreement and perceived feasibility were calculated for each recommendation, and logistic regression identified the characteristics of the participants who rated feasibility higher than the median.

Overall, 357 participants assessed the recommendations: mean age 46 years [standard deviation, SD 13]; 223 (63%) were female. Among the 247 (69%) rheumatologists, one third were hospital based (N=90, 37%). Other HPs were nurses (N=81, 23%) or pharmacists (N=14, 4%).

Pooled agreement with the overarching principles was very high (mean 4.4 [0.5]): **Table 1**. Agreement with the 10 recommendations was also high: pooled mean 4.3 [0.4]; the recommendation with the lowest agreement (mean 3.9 [0.9]) was recommendation 3 (**Table 1**).

Perceived feasibility was lower (pooled mean 3.4 [0.5]) with lowest perceived feasibility for recommendations 3 and 8 (**Table 1**). The only factor correlated with greater perceived feasibility was being a HP other than a rheumatologist:

odds ratio 2.52 [95% confidence interval 1.23-5.15], while age, gender and type of exercise were not significant (data not shown).

Our results indicate French HPs are in agreement with recently-published recommendations for the evaluation and optimization of adherence to DMARDs [1]. However, feasibility was lower, especially with regard to complex evaluation of non-adherence, and targeted interventions. Adherence may be assessed by simple open-ended questions, or by complex assessments such as questionnaires, health resources use or blood tests.[7] As expected, complex assessments had lower agreement and perceived feasibility. Targeted interventions to improve adherence to medications are often based on patient education, difficult to perform in usual care, which may explain why recommendation 8 rated lower in perceived feasibility [8-10]. Regarding predictive factors, perceived feasibility was higher among non-physician HPs, which may be due to the selection of HPs with a strong interest on patient education.

This initiative has contributed to the dissemination of the recommendations and has allowed a positive assessment of their face validity; however, their implementation will need to be further assessed.

Table 1. Agreement with and perceived feasibility of recommendations regarding drug adherence in inflammatory diseases [1]

	Overarching principles	Agreement	
A	Drug adherence covers 2 complementary notions: compliance, i.e., treatment intake as prescribed, and persistence, i.e., maintenance of intake over time.	4.7 (0.6)	
B	Non-adherence to disease-modifying anti rheumatic drugs is frequent. It can be detrimental, leading to lower drug efficacy and potential cost increases.	4.3 (0.9)	
C	In non-adherence, factors known as "unintentional" (simply forgetting, ...) and "intentional" (linked to the patient's beliefs and fears, ...), are often intertwined.	4.1 (0.8)	
D	Knowledge both of the disease and of the treatment, and patients' perceptions of the benefit/risk of the treatment are key elements in drug adherence.	4.5 (0.7)	
E	In the context of shared decision-making/therapeutic alliance, caregiver-patient communication about treatment is a key factor in drug adherence.	4.6 (0.6)	
	Recommendations	Agreement	Applicability
1	Adherence should be assessed at each patient visit. It must be systematic if the treatment target is not reached and before any therapeutic change.	4.3 (0.8)	3.2 (0.9)
2	Adherence should be evaluated during outpatient visits by at least one open question.	4.4 (0.7)	3.9 (0.9)
3	The assessment of adherence, particularly in the context of multidisciplinary care, can be carried out by more complete methods than an open question alone (self-reported questionnaires, dispensation data, etc.).	3.9 (0.9)	2.8 (0.9)
4	Adherence to hydroxychloroquine can be verified by a blood test and explaining the results to the patient can improve adherence.	4.0 (1.0)	3.3 (1.1)
5	When assessing adherence, risk factors for nonadherence should be examined, in particular those related to the patient (young subject, fear of side effects, mood disorders,...), treatment (polymedication,...) and environment (caregiver-patient relationship, ...).	4.4 (0.7)	3.4 (0.9)
6	In order to optimize drug adherence, the patient should be an actor in his disease and his care within the framework of a shared decision (therapeutic alliance).	4.6 (0.6)	3.6 (0.8)

7	In order to optimize drug adherence, any prescription for antirheumatic treatment must be accompanied by patient information and education.	4.7 (0.6)	3.7 (0.8)
8	The detection of nonadherence to medication must lead to the implementation of a specific intervention (therapeutic education, motivational interview, cognitive behavioural methods, etc.) to improve adherence.	4.2 (0.8)	2.9 (0.9)
9	The patient information and education process, individual or collective, must be carried out repeatedly by one or several health professionals (doctors, pharmacists, specialized nurses...) alone or in a team.	4.3 (0.7)	3.1 (0.9)
10	The patient information and education process can be supplemented by tools such as brochures and multimedia to improve therapeutic adherence.	4.3 (0.8)	3.8 (0.9)

Agreement and applicability were assessed on 1-5 Likert scales where 1= not at all in agreement and 5= fully in agreement. Results are presented as mean (standard deviation).

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