Objectives: The aim of this study was to describe patients' experiences of nurse-led care tight control.

Methods: Qualitative design was used in order to receive deeper understanding of the phenomenon. Interviews were conducted with 12 informants (with strategic sample) that participated in the intervention group of a randomized controlled trial exploring the effect of patient centered care, the Got-Net study. The interviews were analyzed using phenomenography approach.

Results: The informants' experiences of nurse-led care tight control emerged in three categories. The three categories describe the process, the relationship between the concepts. The first step describes the *Meeting of competence*, the next step that the informant experienced was *Relationship building* and the last step to have *Made a personal journey*.

Conclusions: Patients with RA who got the opportunity of nurse-led care and tight control became strengthen, got extended knowledge about their illness. Patients have been treated on their own level, knowledge and needs, by using a person-centered approach.

Disclosure of Interest: None declared

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SATURDAY, 17 JUNE 2017

HPR interventions (educational, physical, social and psychological)

SAT0725-HPR GOTHBURG NURSE LED TIGHT CONTROL STUDY - GOTNET. A STUDY COMPARING "CARE AS USUAL" WITH NURSE LED CLINIC, TIGHT CONTROL AND PERSON CENTRED CARE IN PATIENTS WITH RHEUMATOID ARTHRITIS (RA) AND WITH MODERATE/HIGH DISEASE ACTIVITY

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Background: The treatment guidelines of EULAR recommend treatment according to "tight control" (TC), clear treatment goals (Treat-to-Target, T2T) and patient involvement. Despite this, the care for patients with RA needs to be improved as demonstrated by the fact that as many as that 45% of patients with RA in Sweden (according to the Swedish Rheumatology Quality Register in 2015) do not reach the level of low disease activity. One way to overcome this could be nurse led clinics of RA patients, which for patients in remission have shown positive effects on patient's pain, knowledge and self-efficacy. We hypothesized that a nurse-led clinic based on the above principles of TC, T2T and Person-centered care would result in better outcome compared to care as usual.

Objectives: The aim of the study was to compare the effect of such nurse-led clinic with frequent visits and person-centered care with regular care of patients with established RA and a moderate to high disease activity.

Methods: This was a randomized, controlled, blinded assessor study that aimed to compare the effect of nurse-led clinic with regular care of patients with the established RA. Inclusion criteria were; duration of RA >2 yrs., DAS28>3.8, age <85 yrs. and not having experience with all available csDMARDs and bDMARDs. Patient with any severe current comorbidity were excluded. Intervention Group (IG): intervention included two elements; 1) disease activity control every 6th week, with clear treatment goals (DAS28 <2.6) and escalation of pharmacological therapy according to existing Swedish guidelines, 2) a written person-centered care health plan with shared goal setting and decision making between patient and nurse. Control Group (CG): Patients in the control group were followed by a physician once every 3 to 6 month. Evaluation was done at w 26 both per protocol (shown) and according to intention to treat (ITT) with LOCF. Primary outcome was change in DAS28 at week 26 and secondary outcome the proportions of good/moderate EULAR response. Pre study power calculations estimated group sizes to 60 patients in each group. Due to difficulties in the recruiting process the study was stopped preterm.

Results: The study included 70 patients of which (IG: 36 and CG: 34) with similar baseline characteristics as a result of the randomization. Sixty-two patients completed the study at w 26 (IG: 29 and CG: 33). Both groups improved significantly in DAS 28 (Table 1). The change in DAS 28 was not significantly different between groups, although the numerical improvement was larger in the IG compared to CG (Table 1). Furthermore, significantly more patients in the IG improved according to EULAR Good or Moderate response (Table 1). Results were similar when analyzing according to ITT with LOCF.

Table 1. Primary outcome (delta DAS 28) and secondary outcome (good/moderate EULAR response)

	IG	CG	Difference (95% CI)
ΔDAS 28 (95% CI)	1.5 (-2.0,-1.0)	1.1 (-1.6,-0.6)	- 0.43 (-1.13,0.27)
EULAR Good/Moderate (%)	22/29 (76%)	16/33 (48%)	27% (3-51%)

Conclusions: This controlled trial suggest that a nurse-led clinic for RA patients

with moderate/high disease activity may be effective. Although not shown, it likely to be cost-effective and possible to implement in clinical care.

Disclosure of Interest: None declared

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

SAT0726-HPR FUNCTIONAL IMPAIRMENT IN PATIENTS WITH RA IN AN EIGHT YEAR PERSPECTIVE

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Background: In people with Rheumatoid arthritis (RA) impaired physical functioning is an acute as well as long term effect of the disease. Observational performance tests reflecting range of motion in upper as well as in lower extremities should be easy to perform in the clinic as well as in research as a complement to self-reported measures of physical functioning. The Signal Of Functional Impairment (SOFI)¹ is a performance test which so far has been applied only in Sweden but commonly used in the clinic and in long term follow-up clinical studies.

Objectives: The aim was to study performance-based function assessed with SOFI over 8 years and, secondly, to study which items included in SOFI that were associated with change in functioning over time.

Methods: An inception cohort of 1 052 patients with early RA, from the BARFOT-study, recruited 1992–2006 was investigated, mean (SD) age was 54 years (14), 70% were women. The patients were followed by a structured protocol at baseline, 3 and 6 months and at 1, 2, 5, and 8 years. SOFI consists of 3 parts measuring hand, arm (upper), and leg (lower) function (1). Hand function is tested by 4 movements; cylinder grip (H1), pen grip (H2), pincer grip (H3) and opposition of the thumb (H4). Arm function is assessed by 3 movements; hand behind the head and the ability to touch the cervical spine processes with fingers (A1), elbow supination (A2) and elbow extension (A3). Leg function is tested by 4 movements; the ability to touch the opposite knee with the heel while sitting (L1), knee extension in supine position (L2), dorsiflexion of the foot standing on a balance board (L3), and the ability to stand on tip toes without shoes (L4). An assessor scores the patient's ability to perform the different tests on an ordinal scale (0=normal, 1= partly impaired and 2= unable to perform). The range of SOFI scores is 0–44 (best to worst).

Results: At baseline the mean (SD) SOFI was 7.2 (5.8), and at 1 year follow-up the improvement was 2.75 (5.65), $p<0.001$. From 1 year to 8 year follow-up the deterioration was 1.5 (4.6), $p<0.001$. When studying hand, upper and lower function separately, the pen grip and the ability to stand on tip toes improves most during the first year. From 1 to 8 year the pincer grip and the ability to stand on tip toes are the items that deteriorate most (Figure). Assessment of the pen grip, the pincer grip and the ability to stand on tip toes explain 58% to 70% of the SOFI score over time, with the highest rate at 5 (65%) and 8 years follow-up (70%).

Conclusions: Functioning as assessed by SOFI improved during the first year in patients with early RA and then deteriorated slowly. Over a longer period, pincer grip and the ability to stand on tip toes seemed to be the two most important items to measure when assessing functional impairment over time.

References:

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