Conclusions: Self-reported adherence was high in our cohort with differences between the two groups. "Forgetfulness" regarding medication and keeping track of hospital appointments were the commonest reasons for non-adherence rather than deliberate non-adherence. Therefore novel behavioural or electronic cues for medication, including mobile app use, and appointment alerts could lead to improvement. Further work is required to identify whether a different personalised approach in the lupus and vasculitis patients can improve adherence.

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AB1243

GETTING A HEEADSSS IN PSYCHOSOCIAL SCREENING: USE OF STANDARDISED CLINIC NOTE TEMPLATES FOR PSYCHOSOCIAL SCREENING IN A PAEDIATRIC RHEUMATOLOGY CLINIC

E. Brennan Treemarcki, J. Szymonifka, A. Adams, N. Pan, S. Taber, K. Onel.
Hospital for Special Surgery, New York, USA

Background: Children and adolescents with rheumatic diseases are at risk for psychosocial challenges related to illness, treatment, and normal development and should receive psychosocial screening. Psychosocial assessments have been successfully utilised in other paediatric specialties, including oncology and gastroenterology. A common psychosocial screening tool is the HEEADSSS (home environment, education/employment, eating, activities, drugs, sexuality, suicide/depression, and safety). This tool is easy to remember, quickly administered, and modifiable for younger children.

Objectives: We conducted a quality improvement project aimed to increase psychosocial screening by providers in a single paediatric rheumatology clinic by instituting standardised follow up templates for juvenile idiopathic arthritis (JIA) and systemic lupus erythematosus (SLE) including the HEEADSSS assessment.

Methods: The quality improvement intervention evaluated in this study involved the creation of disease specific follow up note templates inclusive of the HEEADSSS assessment and introduction of the templates to the paediatric rheumatology fellows clinic. Charts of patients with an ICD-10 diagnosis of JIA or SLE were reviewed during a 3 month window prior to (February-April 2017) and after (October-December 2017) the intervention. Charts were reviewed for presence of 2 elements of the HEEADSSS assessment documented within the previous 12 months: smoking exposure (all patients) and sexual activity (ages 11 years and up). The proportion of patients with completed HEEADSSS assessment components pre- and post-intervention were compared using Fisher's exact test.

Results: Chart review included 36 patients pre- and 42 post-intervention (table 1). There was an increase in assessment of both measures in the period immediately following the intervention. Assessment of smoking exposure increased from 0.0% to 21.4% ($p=0.003$) with greater but not significant improvement in SLE versus JIA patients (29.4% versus 16.4%, $p=0.45$). Assessment of sexual activity in

patients 11 years and older increased from 13.0% to 37.5% ($p=0.09$), although this comparison may be underpowered due to decreased sample sizes.

Abstract AB1243 – Table 1. Documentation status pre- and post- implementation of standardised follow up templates for providers.

	Pre-Intervention	Post-Intervention	p-value
Smoking assessed			
Overall	0/36 (0.0%)	9/42 (21.4%)	0.003
JIA	0/20 (0.0%)	4/25 (16.0%)	0.12
SLE	0/16 (0.0%)	5/17 (29.4%)	0.04
Sexual Activity (11+) assessed			
Overall	3/23 (13.0%)	9/24 (37.5%)	0.09
JIA	1/9 (11.1%)	2/8 (25.0%)	1.00
SLE	2/14 (14.3%)	7/16 (43.8%)	0.14

Conclusions: Introduction of standardised note templates with the HEEADSSS assessment has resulted in preliminary improvement in psychosocial screening by providers in a single paediatric rheumatology clinic as demonstrated by improved rates of screening for smoking exposure and a trend towards improved screening rates for sexual activity. Additional studies are needed to confirm these findings, and future studies will assess whether the improvement seen is sustained and whether usage of this template can be expanded to other paediatric patient populations.

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AB1244

QUALITY LIFE IN PATIENTS WITH RHEUMATIC DISEASE, NON-RHEUMATIC DISEASES AND HEALTHY POPULATION

E.M. Cuervo¹, on behalf of Grupo de investigación Espondiloartropatías, Universidad de La Sabana-Hospital Militar Central, A.M. Santos¹, J.C. Rueda¹, I. Angarita¹, E.L. Saldarriaga, R. Giraldo¹, J. Ballesteros¹, I. Pelaez², E. Forero³, J. Ramirez⁴, C. Toro⁴, J. Londono¹. ¹Grupo de investigación Espondiloartropatías, Universidad de La Sabana-Hospital Militar Central, Chía, Colombia; ²Hospital General de México, Ciudad de México, Mexico; ³Universidad del Norte, Barranquilla; ⁴Asociación Colombiana de Reumatología, Bogotá, Colombia

Background: Within public health strategies, the quality of life is a fundamental factor of intervention. The EQ-5D-3L is one of the most used instruments worldwide.

Objectives: To describe the change in quality of life and functional limitation of patients with rheumatic diseases compared to a healthy population and patients with other systemic diseases.

Methods: The EQ-5D-3L survey was used in 6693 people from 6 cities in Colombia. An analytical study was developed.

Results: In general, the healthy population ($n=1104$) reported not to have problems according to the EQ-5D-3L (median: 98,34). Of the non-rheumatic patients ($n=642$), 20% showed a moderate compromise because of pain and discomfort, as well as anxiety and depression. Twenty percent of patients with cardiovascular

Abstract AB1244 – Table 1. Dimensions of EQ-5D-3L in patients with non-rheumatic diseases

		HBP n=201	Venous insufficiency n=190	Migraine n=158	Mental diseases n=137	Obesity n=95	Diabetes n=55	CVD n=53	Cancer n=13	Stroke n=11
MOBILITY	No problems	93,5	95,8	98,1	97,1	93,7	96,4	90,6	100	81,8
	Some problems	6,5	4,2	1,9	2,9	6,3	3,6	9,4	0	18,2
	Confined to bed	0	0	0	0	0	0	0	0	0
SELF-CARE	No	97,5	97,9	98,7	100	98,9	98,2	94,3	100	90,9
	Moderate	2	2,1	0,6	0	1,1	1,8	3,8	0	9,1
	Extreme	0,5	0	0,6	0	0	0	1,9	0	0
USUAL ACTIVITIES	No problems	95,5	97,4	99,4	99,3	97,9	100	92,5	100	90,9
	Some problems	4	2,6	0,6	0,7	2,1	0	7,5	0	9,1
	Unable to	0,5	0	0	0	0	0	0	0	0
PAIN/ DISCOMFORT	No	87,1	89,5	86,1	84,7	88,4	92,7	84,9	92,3	81,8
	Moderate	11,9	9,5	12	14,6	11,6	5,5	13,2	7,7	18,2
	Extreme	1	1,1	1,9	0,7	0	1,8	1,9	0	0
ANXIETY/ DEPRESSION	No	91	93,7	92,4	76,6	94,7	96,4	84,9	92,3	90,9
	Moderate	8,5	6,3	7,6	22,6	5,3	1,8	15,1	7,7	9,1
	Extreme	0,5	0	0	0,7	0	1,8	0	0	0