Abstract THU0647 – Table 1. Odds Ratios (95% CI) for Effect of Poverty Status between 2003 and 2009 on Prevalent and Incident Persistent Depression. CESD Score ≥ 24 in 3 or More Years), between 2009 and 2015, with and without Adjustment

Outcome	Poor Every Year	Exited Poverty	Never Poor
Prevalent Persistent Depression (n=535)			
Unadjusted	3.9 (2.1, 7.2) *	1.0 (0.4, 2.2)	Ref.
Adjusted†	2.9 (1.4, 6.1) *	0.8 (0.3, 1.8)	Ref.
Incident Persistent Depression (n=312)‡			
Unadjusted	4.5 (1.3, 15.4) *	0.9 (0.2, 3.9)	Ref.
Adjusted†	4.1 (0.9, 19.1)	0.7 (0.1, 3.7)	Ref.

* $p < .01$

† Adjusted for gender, age, marital status, race/ethnicity, education, disease duration, extent of accumulated damage in 2009, smoking status, and BMI

‡ Excludes persons with high levels of depressive symptoms 2006–2009

Conclusions: Public policy to help persons with SLE stay out of poverty or to exit poverty may lower their rates of prevalent and incident persistent depression. Attention to the economic status of persons with SLE should be part of an overall treatment strategy including treatment for depression since such attention may help reduce accumulation of damage as well as reduce the prevalence and incidence of persistent depression.

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THU0648

“AS A PRACTITIONER I FEEL ENRICHED”: RHEUMATOLOGY TUTORS' EXPERIENCES OF DELIVERING A MANUALISED GROUP COGNITIVE-BEHAVIOURAL FATIGUE PROGRAMME TO PATIENTS WITH RHEUMATOID ARTHRITIS (RA)

E. Dures¹, A. Hammond², S. Hewlett¹, on behalf of The RAFT Group. ¹School of Health Sciences, University of the West of England, Bristol, Bristol; ²School of Health Sciences, University of Salford, Salford, UK

Background: Reducing Arthritis Fatigue by clinical Teams using cognitive-behavioural approaches (RAFT) is a 7-centre RCT of a manualised group cognitive-behavioural (CB) programme to reduce fatigue impact.¹ After four days training plus a delivery observed by clinical supervisors, tutor pairs (rheumatology nurses and occupational therapists (OTs)) delivered the programme four times to patients with RA. Quality assurance observations confirmed tutors used CB approaches and RAFT results show the programme reduced patients' fatigue impact at 26 weeks.²

Objectives: The aim of the current study was to understand tutors' experiences of RAFT training and delivery to inform future programme roll out.

Methods: 14 RAFT tutors (9 nurses; 5 OTs) participated in one-to-one interviews, which were audio-recorded and transcribed. Data were analysed by ED, SH, and AH using inductive thematic analysis.

Results: Four main themes were identified.

Theme 1: “It's quite daunting” - Delivering a complex programme that was “quite different to what any of us had done before” required time and effort (“I couldn't really make sense of it without actually doing a lot of work around it”). Initially, training with clinical supervisors (“experts”) who are “so good at what they do” challenged tutors' confidence (“the anxiety is are we going to deliver it the way they did?”).

Theme 2: “Most useful was actually getting to practice the sessions” - Tutors valued watching clinical supervisors demonstrate programme sessions during training (“professionals who have shown us how to do it”) plus the opportunity to practice themselves (“role playing the sessions was really helpful”).

Theme 3: “Putting it in a way that was still true to the message” - The RAFT manual was “very valuable” and “it had to be adhered to”; however, tutors wrote individual crib notes (“our own manual in our own words”) to consolidate information, deepen understanding, and gain confidence. The process was supported by “positive and constructive criticism” in the observed delivery (“the supervisor kept putting us back on track”).

Theme 4: “As a practitioner I feel enriched” - CB skills acquired during RAFT impacted tutors' wider work (“making a massive difference to my clinical practice”), and enhanced the self-management support they offered patients, including

“the particular ability to draw things out from people” and “learning when to listen and stand back and try and get the patients to find the answers”.

Conclusions: Initially, RAFT training and delivery were a challenge for tutors because the CB approach was a new way of working. Individually adapting RAFT manual wording plus feedback from supervisors increased tutors' confidence. Tutors believed the CB skills acquired during RAFT enhanced their wider clinical practice and the self-management support they offered patients. Future training should include RAFT session demonstrations and skills practice for tutors, with feedback from clinical supervisors.

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THU0649

UNDERSTANDING ETHNIC DIFFERENCES IN THE UTILISATION OF EXERCISE FOR OSTEOARTHRITIS

E.R. Vina¹, D. Ran², M.J. Hannon³, C.K. Kwoh¹. ¹Division Rheumatology, Medicine; ²Arthritis Center, University of Arizona, Tucson; ³Medicine, University of Pittsburgh, Pittsburgh, USA

Background: According to a US survey, the prevalence of arthritis-attributable activity limitation, work limitation and severe pain are all significantly higher among Hispanics than among non-Hispanics (NHs). Ethnic differences in osteoarthritis (OA) patients' experience of pain may be related to marked disparities in the use of OA treatments. According to EULAR OA guidelines, exercise should be an integral part of the management of knee and hip OA. Whether or not exercise is underutilised and why it may be underutilised by Hispanics to treat OA is unclear.

Objectives: The objective of this study was to determine if there are ethnic differences in the history and current use of exercise as therapy for patients with knee or hip OA. The secondary objective was to compare Hispanic and NH patients with lower extremity OA with respect to their familiarity and perceptions of the efficacy and risk of exercise as treatment for OA.

Methods: Research participants ≥ 50 years of age with chronic and frequent pain due to knee or hip OA were recruited from a university medical centre. Structured interviews were conducted to determine patient sociodemographic characteristics, clinical information, self-reported actual use/prescription receipt of exercise for OA treatment (currently, last 5 years), and familiarity with exercise (3 items, yes/no response). Perceptions of the benefits (4 items) and risks (3 items) of exercise, and willingness to exercise to treat OA were also evaluated; each question in these measures has a five-category ordinal response scale. Fisher's exact or Wilcoxon-Mann-Whitney tests were conducted to determine if knowledge and perceptions about exercise were associated with ethnicity (Hispanic vs NH).

Results: In our cohort of patients with knee or hip OA, Hispanics (n=119), in comparison to NHs (n=201), were younger (mean age 61.5 vs. 65.3) and less likely to have an annual income of $\geq \$50,000$ (13.5% vs. 39.1%). A lower proportion of Hispanics than NHs reported using exercise to treat OA at present (51% vs. 66%, $p=0.0165$) and in the last five years (68% vs. 84%, $p=0.0010$) or receiving a prescription for exercise in the last five years (45% vs. 67%, $p<0.0001$) (figure 1). Hispanics, compared to NHs, were also less likely to report ever hearing about exercise to treat OA (71.43% vs. 91.83%, $p<0.0001$), having family/friends that received it for treatment (33.33% vs. 51.20%, $p=0.0023$), or having a good understanding of it as a treatment for OA (66.96% vs. 79.33%, $p=0.0161$). A lower proportion of Hispanics than NHs believe that exercise is beneficial (or very beneficial) for arthritis (49.12% vs. 69.09%, $p<0.0001$) and that exercise is helpful (or very helpful) for them (60.52% vs. 75.61%, $p=0.0056$). No ethnic differences in the perceptions of risk of exercise were observed. Hispanics were also less willing to exercise to treat OA than NHs (67.83% vs. 82.61%, $p=0.0018$).

Abstract THU0649 – Figure 1 Proportion, who reported use of or prescription receipt for exercise to treat OA by ethnicity **Conclusions:** Among patients with knee or hip OA, Hispanics were less likely than NHs to utilise exercise as treatment for arthritis.

They were also less familiar with its use for OA treatment, less likely to believe in its efficacy, and less willing to use it as treatment for OA. Improving patient knowledge and attitudes about exercise may increase utilisation of this OA treatment and help reduce ethnic differences in OA outcomes.

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THU0650 EARLY HELP SEEKING OR SELF-MANAGEMENT: A QUANTITATIVE ASSESSMENT IN THE CONTEXT OF RHEUMATOID ARTHRITIS

G. Simons¹, J. Belcher¹, K. Kumar¹, M. Falahee¹, C.D. Mallen², R.J. Stack^{1,3}, K. Raza¹, ¹University of Birmingham, Birmingham; ²Keele University, Keele; ³Nottingham Trent University, Nottingham, UK

Background: Rheumatoid arthritis (RA) should be treated with DMARDs in its earliest stages to reduce the likelihood of permanent joint damage and disability¹. This therapeutic window is often missed. One important cause is delayed help seeking by patients themselves². Qualitative work with members of the public has previously identified a number of potential causes for this delay³.

Objectives: To quantify and extend the findings of existing qualitative research investigating factors which impact on speedy help seeking for symptoms of RA.

Methods: A survey of members of the public without a diagnosis of inflammatory arthritis assessed the speed with which they would seek medical attention if they were to experience symptoms of RA (stiffness, pain and joint swelling). It explored factors which might impact on the speed with which help would be sought, including: self-management of symptoms; barriers to and drivers of help seeking and information seeking.

Results: 1088 people (788 females; 9 undisclosed) aged between 18 and 96 years completed the survey. 48% indicated that they would seek help quickly for RA symptoms, however 63% would delay seeing their GP in order to try to self-manage the symptoms. Most intended to self-manage with over the counter medication (e.g. ibuprofen), massaging the joint or exercising. Barriers endorsed included difficulty getting a GP appointment (39%); fear of wasting the GP's time (34%) and being busy with family/work (37%). Drivers (>90%) included worsening of symptoms, inability to work, struggling to do usual activities, symptoms spreading to other parts of the body or inability to self-manage symptoms. Most participants would seek out information prior to seeking medical attention for the symptoms. Sources of information frequently endorsed were: Internet (74%); relatives/friends (49%); someone with a joint problem (41%) and pharmacists (37%).

Conclusions: Less than half of the current sample would seek help quickly for the symptoms of RA. Several barriers and drivers identified in qualitative research³ were endorsed by the survey sample making them valid targets for interventions. Most participants would further seek out information about the symptoms prior to seeking medical attention and their preferred sources of information such as the internet or the pharmacist should be used in these targeted interventions.

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THU0651

THE INFLUENCE OF AGE, GENDER, EMPLOYMENT STATUS, OR EDUCATION ON THE CHOICE OF BIO-SIMILAR VS. BIO-ORIGINAL VARIANT OF THE SAME bDMARD IN PATIENTS WITH RA OR AS STARTING BIOLOGICAL THERAPY – REAL LIFE DATA FROM THE CZECH BIOLOGICS REGISTRY ATTR

J. Zavada¹, L. Nekvindova², K. Pavelka¹, J. Vencovsky¹, on behalf of collaborators of the ATTR registry. ¹INSTITUTE OF RHEUMATOLOGY, Prague; ²Institute of Biostatistics and Analyses spin-off, Faculty of Medicine, Masaryk University, Brno, Czech Republic

Background: Perceptions on bio-originator (bo) and bio-similar (bs) biologics among HCPs and pts, as well administrative regulations or economic incentives may influence their utilisation in clinical practice. The ATTR registry captures more than 95% of pts with RA and AS treated with biologics in the Czech Republic (CZ). Access to biological therapy in CZ is limited to about 30 authorised centres. Bs infliximab (INF) has been prescribed in CZ since 11/2013, and bs etanercept (ETA) since 1/2016 concurrently with bo INF and ETA. There has been no administrative regulation concerning the use of bs or bo in CZ.

Objectives: To explore whether age, gender, employment status, or level of education influence the choice of bs vs. bo variant of the same bDMARD in pts with RA or AS starting bDMARD in CZ.

Methods: Data from the ATTR registry on pts with RA or AS starting their first bDMARD between 11/2013 and 10/2017 were used. The start of bo vs. bs ETA, or bo vs. bs INF as the first bDMARD was the main outcome of interest. Multivariate logistic regression analysis was used to explore the impact of education, employment status, age and gender on the start of a first bDMARD after adjustment for disease characteristics, and the bDMARD molecule.

Results: 560 pts started ETA (22.6% bo, 14.2% bs) or INF (9.7% bo, 53.5% bs) in the study time frame. In the multivariate model (table 1) pts starting ETA (ref. INF) had lower odds to receive a bs (OR 0.11, CI95% 0.07–0.17), and pts with primary education (vs. secondary or tertiary) had higher odds to receive any bs (OR 1.84, CI95% 1.08–3.13). When we performed separate analyses for pts treated in academic/public hospitals (n=314), the adjusted OR for pts with primary education was 0.78 (CI95% 0.37–1.64), while in private centres (n=246) the OR was 5.32 (CI 95% 2.32–12.16). When we introduced an interaction term for type of practice x level of education, the adjusted OR for pts with primary education in private centres was 2.26 (CI95%, 1.14–4.46, p=0.019).

Abstract THU0651 – Table 1.

Parameters	OR (95% CI)	p-value
HDA vs. REM+LDA+ MDA (acc to DAS28/ASDAS)	0.94 (0.50; 1.77)	0.859
CRP [mg/l]	1.00 (0.99; 1.01)	0.770
HAQ	1.16 (0.75; 1.78)	0.513
AS (vs. RA)	1.40 (0.81; 2.40)	0.229
ETA (vs. INF)	0.11 (0.07; 0.17)	<0.001
Age at start of 1st bDMARD	1.01 (0.99; 1.04)	0.271
Disease duration	1.01 (0.98; 1.04)	0.693
Female	0.78 (0.48; 1.26)	0.316
Primary education (vs. Secondary or Tertiary)	1.84 (1.08; 3.13)	0.024
Sick leave (vs. employed)	1.61 (0.68; 3.82)	0.283
Disability pension (vs. employed)	0.74 (0.36; 1.54)	0.421
Old age pension (vs. employed)	0.61 (0.28; 1.31)	0.205
Unemployed (vs. employed)	1.08 (0.48; 2.42)	0.845
Maternity leave/student (vs. employed)	1.48 (0.43; 5.08)	0.529

Conclusions: We found that in private centres providing biological therapy in CZ, pts with primary education had higher adjusted odds to obtain bs as the first bDMARD. We cannot exclude that different pt characteristics and residual confounding may have been involved. The interpretation is complex and related not only to perception of bs by HCPs and pts, but also to unmeasured economic incentives and other factors.

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