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AB0881-HPR

EVALUATION OF NURSING CARE PLANS FOR RHEUMATOID ARTHRITIS PATIENTS: NURSING 2.0 PROJECT

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Background: A better quality of care for chronic patients is only obtainable through multidisciplinary teams. In recent years, rheumatology nurses have been involved in the remote monitoring of aged Rheumatoid Arthritis (RA) patients, as their high levels of multi-morbidity and disability make routine contacts too complex for patients and caregivers. Nursing health care should be evidence-based and organized to optimize the professionals' time.

Objectives: To develop a pilot study of two Nursing Care Plans (NCP) in Rheumatology consultations for Rheumatoid arthritis patients, exploring the satisfaction, disease activity, adherence and quality of life of the patients.

Methods: This is a non-randomised interventional study. All the established RA patients attending our clinics were offered one of the care plans, based on clinic characteristics, functional status, social needs, social support, preferences and health literacy. They are focused on three fundamental axes: adaptation, adherence and safety of the patient. We evaluated the two NCP that were created: (1) Elderly established RA face to face/phone visit, (2) Active young established RA face to face/phone visit. The study included a first baseline visit and a second visit at six months. Outcomes were adherence to treatment: using the Morisky Green questionnaire, disease activity; through the erythrocyte sedimentation rate (ESR), patient satisfaction; using the LOPSS questionnaire and quality of life: using the EUROQOL 5D questionnaire, Visual analog scale of the attention received and Visual analog scale of the care received. Final visit were compared to baseline visit in both groups. The paired Wilcoxon or McNemar test were used.

Results: We included 48 patients, 16 from the NCP 1 and 32 from the NCP 2. All patients except one from the NCP 2 were followed-up and ended the study. The mean age of the participants was 56 years. 77.5% were women. 30.6% had an active smoking habit. 46% had university studies. 53.1 had an active labor situation. Regarding the main outcomes: a) Disease activity, a slight decrease in activity was observed between baseline and 6 months, but without statistically significant differences. b) Quality of life, we detected some improvement in all care plans in the EQ-index and in the Visual analog scale (VAE) but there were no statistically significant variations. c) Therapeutic adherence, we show the results in the Morisky Green questionnaire. We obtained statistical significant decrease in the percentage of patients that forgot to take their prescribed medications after 6 months ($p=0.04$), and we also saw an increase in the percentage of patients taking medications at established times (up to 100% in all groups). d) Patient satisfaction with NCP obtained at the end of study, we used the LOPSS questionnaire. We obtained at six months a punctuation less than 1.5 (ordinal scale that 1 is good 5 is bad). e) Satisfaction of the care received by patients over the phone assessed at the end of study, it was almost 100%, being 75% of the patients scores 9 or over. f) Satisfaction with the care plans assessed at the end of study, the score given by patients was almost 90%, being 75% of the patients scores 8 or over.

Conclusion: After applying the NCP in both groups, we found positive results after 6 months and mainly regarding the therapeutic adherence. The program was well evaluated by the patients in terms of satisfaction of the care provided.

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ANCA-ASSOCIATED VASCULITIS: A CLINICAL PRACTICE ASSESSMENT

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Background: AAV (ANCA-associated vasculitis) is a group of progressive, rare, severe autoimmune diseases^{1,2}. AAV can affect blood vessels in different parts of the body resulting in damage to vital organs such as the lungs, kidneys, nervous system, gastrointestinal system, skin, eyes, and heart.² There are currently no approved therapies for remission-induction in patients with AAV. The current treatment armamentarium for AAV is comprised of various immunosuppressive therapies in combination with steroid treatment. Understanding clinical practice gaps in the management of AAV, can inform development of tools to improve physician practices.

Objectives: This medical education activity aims to assess physicians' knowledge on the various manifestations of antineutrophil cytoplasmic antibody-associated vasculitis (AAV), current guideline-recommended treatment strategies for remission induction in patients with AAV, as well as recent clinical trial data for combination therapies used for remission induction.

Methods: A 24-question survey consisting of multiple-choice knowledge and case-based questions was made available to nephrologists and rheumatologists without monetary compensation or charge. The questions were designed to evaluate knowledge regarding the various manifestations of AAV and the results from clinical trials that have compared the efficacy of combination therapies used for remission induction in patients with AAV. As well as application of guideline-recommended therapies and clinical trial data for remission induction in patients with AAV within clinical practice. The survey launched online on a website dedicated to continuous professional development. (www.medscape.org/viewarticle/920320) on July 15, 2020. Data were collected until October 1, 2020.

Results: 363 nephrologists and 190 rheumatologists completed the survey. Physicians demonstrated gaps in the following areas:

Topic	Incorrect Responses to Knowledge and Clinical Decision-Making Questions (%)	
	Nephrologists	Rheumatologists
Systemic diseases associated with AAV	59%	45%
How to confirm diagnosis of AAV	42%	25%
Therapy selection to induce remission that would be consistent with guidelines recommendations	71%	51%
Guideline-recommended therapy for patients that do not respond to the induction regimen	32%	34%
Definition of refractory disease	95%	94%
Most effective maintenance strategy for a patient once remission is achieved	80%	64%
Where would an emerging therapy such as a C5a receptor inhibitor fit into the therapeutic armamentarium of AAV?	62%	47%
What are the guideline-recommended therapies to reduce remission in patients without organ-threatening disease?	71%	51%
Most effective maintenance strategy for a patient once remission is achieved	80%	64%
Guideline-recommendations on length of time to continue maintenance therapy	31%	35%

Conclusion: This educational research on assessment of physicians' (nephrologists and rheumatologists) clinical practices yielded important insights into clinical gaps related to understanding of the disease pathophysiology and

progression of AAV, guideline recommendations on diagnosing and managing AAV with guideline-directed medical therapies (GDMTs), strategies for the management of relapsing and refractory disease in AAV and positioning of emerging therapies in the treatment paradigm.

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AB0883-HPR CHRONIC RHEUMATIC DISEASE MANAGEMENT AND THE SELF-EFFICACY OF RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a common chronic disabling autoimmune disease, which cannot be cured completely at present, and patients need long-term medication treatment. The overall management of RA disease and patient self-management is important. Therefore, we built up a chronic rheumatic disease management team, formed by rheumatoid clinicians, clinical nurses and case managers, to provide “integrity continuity” disease management for RA by hospital on-site and WeChat APP. To this end, we used the arthritis self-efficacy scale-8 (ASES-8) to investigate the effect of the chronic disease management with RA.

Objectives: To explore the effect of chronic rheumatic disease management and the related factors of self-efficacy of RA patients.

Methods: Consecutive outpatients with RA who had been implemented chronic disease management were recruited from January 2019 to January 2020. A questionnaire survey of ASES-8 and clinical data were collected.

Results: 1. Among the 376 RA patients who have completed the survey, mean follow-up time of chronic disease management was 29 (8, 41) months, 35.4% patients in CDAI remission stage of disease activity, median ASES-8 score was 59(47,70), and 61.2% patients had medium or above medication adherence.

2. Patients with low ASES-8 had higher RA disease activity (including TJC28, SJC28, Pain VAS, PtGA, PrGA, ESR, CRP), more patients with dysfunction and lower medication adherence than those with high ASES-8 (all $P < 0.05$).

3. Patients were divided into CDAI active RA group and in remission group, and those with low ASES-8 in remission group participated in chronic disease management for fewer months than those with high ASES-8 (median 20 vs. 32, $P = 0.033$), and the HAQ-DI score was higher ($P < 0.05$). Active RA patients with low ASES-8 had higher disease activity, higher HAQ-DI (median 0.25 vs. 0), fewer times of participating in patients' exchange meeting (median 0 vs. 1), lower medication adherence (10.8% vs. 25.9%), and more anxiety or depression (57.6% vs. 31.8%) than those with high ASES-8 (all $P < 0.05$, Table 1 below).

Table 1. Comparison of ASES in different RA disease activity

Characteristics	CDAI remission		P	CDAI active		P
	Low ASES (ASES≤59, n=36)	High ASES (ASES>59, n=97)		Low ASES (ASES≤59, n=158)	High ASES (ASES>59, n=85)	
Female, n (%)	32 (88.9)	81 (83.5)	0.440	137 (86.7)	74 (87.1)	0.939
Age, yrs, ± s	47.4±11.7	46.0±12.5	0.574	49.8±12.9	49.7±12.7	0.933
Disease duration, month, median (IQR)	48 (24,94)	60 (35,96)	0.560	75 (36,120)	72 (36,120)	0.625
Duration of chronic disease management, month, median (IQR)	20 (6,39)	32 (13,41)	0.033	29 (6,41)	29 (5,42)	0.766
Attend patients' exchange meeting, times, median (IQR)	6 (4,10)	8 (6,13)	0.673	0 (0,2)	1 (0,4)	0.035
Incapable to work, n (%)	11 (30.6)	15 (15.5)	0.051	46 (29.1)	18 (21.2)	0.180
Morisky medication adherence scale			0.857			0.002
Low adherence, n (%)	12 (33.3)	30 (30.9)		78 (49.4)	26 (30.6)	
Medium adherence, n (%)	15 (41.7)	38 (39.2)		63 (39.9)	37 (43.5)	
High adherence, n (%)	9 (25.0)	29 (29.9)		17 (10.8)	22 (25.9)	
28TJC, median (IQR)	0 (0,0)	0 (0,0)	0.148	3 (1,3)	1 (1,3)	0.003
28SJC, median (IQR)	0 (0,0)	0 (0,0)	0.734	1 (0,3)	1 (0,2)	0.044
PtGA, median (IQR)	0 (0,0)	0 (0,0)	0.302	4 (2,5)	2 (1,3)	<0.001
PrGA, median (IQR)	0 (0,0)	0 (0,0)	0.302	4 (2,5)	2 (1,3)	<0.001
Pain VAS, median (IQR)	0 (0,0)	0 (0,1)	0.800	3 (2,4)	2 (1,2)	<0.001
CRP, (mg/L), median (IQR)	3 (3,3)	3 (3,3)	0.833	3 (3,10)	3 (3,6)	0.422
HAQ-DI, median (P_{50} , P_{95})	0 (0.0, 0.1625)	0 (0.0, 0.0125)	0.016	0.25 (0.1, 0.25)	0 (0.0, 0.837)	<0.001
Anxiety or depression, n (%)	12 (33.3)	24 (24.7)	0.322	91 (57.6)	27 (31.8)	<0.001

Conclusion: The rheumatic chronic disease management team can help RA patients achieve a higher remission rate by continuous chronic disease management through hospital on-site and the Internet, and can help patients with good self-efficacy and medication adherence. In addition to disease control, we should pay attention to functional limitations and problems of back to work with RA patients in remission, while should pay attention to activity participation, medication adherence and emotional problems with active RA in further practice.

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

AB0884-HPR PERSONALISED TREATMENT GOALS IN PATIENTS WITH IMMUNE MEDIATED INFLAMMATORY DISEASE

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Background: Immune mediated inflammatory diseases (IMIDs) often have a chronic character and large impact on daily life of patients. In order to provide patient-centred care, insight in personal goals is a key issue.

Objectives: The aim of this study was to evaluate treatment goals of patients with IMIDs over time.

Methods: Patients with IMIDs were invited to complete a self-designed questionnaire about lifestyle, personal treatment goals and perceived care at their first visit to our centre and one year after referral. Clinical information was collected through the electronic patient record system.

Results: 41 (30%) patients of the 137 invited, completed both questionnaires. Participants had a mean age of 45.6 years (SD 13.4), N=35 (83%) was female, mean disease duration was 12.7 years (SD 12.7). Patients were diagnosed with connective tissue disease (CTD, n=19; 45%), antiphospholipid syndrome (APS, n=10; 24%), inflammatory arthritis (n=7; 17%) and psoriasis (n=7; 17%). We identified six categories of treatment goals: disease related, daily functioning, lifestyle, emotional wellbeing. Figure 1 shows the reported treatment goals at baseline and follow-up. Most frequently mentioned were goals related to disease, lifestyle and daily functioning. At follow-up we observed a vast increase in reported goals related to psychological wellbeing (from 5% to 16%). At baseline patients with APS chose lifestyle-related goals more often than other patients (RR=3.2; $p=0.015$). At follow-up patients with CTDs reported disease related-goals less often than other patients (RR=0.4; $p=0.002$). Patients did not report significant progress in reaching their goals on a Likert scale of 1-10. However, in 90% at first visit and in 83% of patients at follow-up, patients reported that the provided care was addressing issues they personally prioritized.

Conclusion: IMID patients' most frequent treatment goals relate to disease activity, lifestyle and daily functioning. Patients frequently change their treatment goals during the first year of treatment. Better understanding of