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.

REFERENCES:

- [1] www.medscape.org/viewarticle/920320.
- [2] Hutton HL, et al. *Semin Nephrol* 2017;37(5):418–35.
- [3] Al-Hussain T, et al. *Adv Anat Pathol* 2017;24(4):226–34.

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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		<i>P</i>	CDAI active		<i>P</i>
	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