

Self-mutual help group was the most appreciated free service, in which participants shared personal stories and perspectives thoughtfully and courageously. The training initiatives organized in collaboration with physicians helped them to learn tips for a better lifestyle management, diet and exercise, and psychosocial techniques but above all helped to overcome concerns and frustration regarding the lack of understanding in the medical community. The network succeeds to increased awareness and understanding of FMS across the public opinion and GPs.

References:

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.1782

OP0321-HPR HIGHER QUALITY OF CARE AND LESS SURGERY AFTER IMPLEMENTING OSTEOARTHRITIS GUIDELINES IN PRIMARY CARE- LONG-TERM RESULTS FROM A CLUSTER RANDOMIZED CONTROLLED TRIAL

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Background: To improve quality of care for patients with hip and knee osteoarthritis (OA), a structured model for integrated OA care was developed and implemented among general practitioners (GPs) and physiotherapists (PTs) in primary care. The model was developed based on international treatment recommendations. After 6 months, patient-reported quality of care and satisfaction with care were greater, more patients were referred to physiotherapy and fewer to orthopaedic surgeon, and more patients fulfilled physical activity criteria among OA patients receiving the new model of care compared to the usual care control group¹.

Objectives: To assess the long-term effects 12 months after implementing the model in primary care.

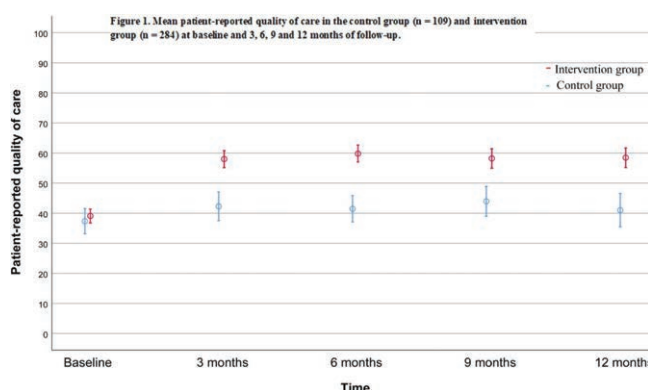
Methods: A cluster-randomised controlled trial with a stepped-wedge design was conducted in six Norwegian municipalities (clusters). The intervention included implementation of the model, facilitated by interactive workshops for GPs and PTs. The main components of the model were a PT led, 3 hour patient education programme followed by 8-12 weeks of individually tailored, supervised exercise. Patient participants were ≥45 years with symptomatic hip or knee OA. Primary outcome was patient-reported quality of care (OsteoArthritis Quality Indicator questionnaire; 0-100, 100 = optimal quality). Secondary outcomes included satisfaction with care, referrals to physiotherapy, orthopaedic surgeon and magnetic resonance imaging (MRI), joint replacement surgery, fulfilment of physical activity recommendations, and proportion with overweight (body mass index ≥25 kg/m²). Data was analysed using multilevel mixed models adjusted for age, sex and secular time.

Results: In all, 40 of 80 GPs and 37 of 64 PTs attended the workshops. A total of 393 patients with hip and knee OA were included, with 284 in the intervention and 109 in the usual care control group. In the intervention group, 92% attended the OA education programme and 64% completed ≥8 weeks of exercise. At 12 months the intervention group reported significantly higher quality of care (score 58 vs. 41, mean difference: 17.6; 95% CI 11.1, 24.0) compared to the control group. The intervention group reported significantly higher satisfaction with care (Odds ratio (OR) 7.8; 95% CI 3.55, 17.27) and a significantly larger proportion (OR: 4.0; 95% CI 1.27, 12.63) met the recommendations for physical activity compared to the control group. A smaller proportion was referred to orthopaedic surgeon (OR 0.5; 95% CI 0.29, 1.00) and a smaller proportion received joint replacement surgery in the intervention (4%) compared to the control group (11%) (OR 0.3; 95% CI 0.14, 0.74). The proportion of patients referred to physiotherapy or MRI and the proportion with overweight were similar between the groups.

Conclusion: Implementation of a structured model for OA care led to improved quality of care, higher satisfaction with care and higher physical activity levels after 12 months. These results are comparable to the 6 months results, which indicate a long-term persistence in the beneficial effects of the intervention. The lower surgical rate in the intervention compared to the control group suggests that higher uptake of OA recommendations in primary care may reduce or postpone the need for surgery in people with hip or knee OA.

References:

- [1] Østerås N, Moseng T, Bodegom-Vos LV, et al. Implementing a structured model for osteoarthritis care in primary healthcare: A stepped-wedge cluster-randomised trial. *PLOS Medicine*. 2019;16(10):e1002949.



Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.3575

How to communicate effectively with the patients_____

OP0322-PARE HOW TO COMMUNICATE DIAGNOSTIC INFORMATION AND CUTTING EDGE SCIENCE TO PATIENTS WITH RHEUMATIC DISEASES

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Background: According to the 2017 Swedish Rheumatology Association (SRA) member strategy a recurring member survey as well as a member withdrawal survey was stipulated. The strategy was developed to evaluate to what extent SRA fulfills the requirements and expectations of its members. According to the 2019 survey, the most important output from a SRA membership, the members rank information about their diagnosis (#1) and supporting the research of these diagnoses (#2) most valuable.

Objectives: To transfer the medical and scientific expertise of the rheumatic diagnoses into lay information in order to meet the member's needs; to take part of the results of the cutting edge science and research progress, funded by SRA, that are relevant and important to individuals living with rheumatic conditions.

Methods: A targeted scientific communication strategy was made consisting of lectures, interviews and scientific writing created for multi-channel distribution.

Results: Actions taken upon the survey result

- Brief summaries of every research project funded by SRA in 2019 was written and distributed via social media.
- A research day for lay people was arranged in collaboration with a regional SRA branch and invited speakers. The filmed lectures are also available online.
- A research report with in-depth interviews with researchers and brief summaries about the research funded by SRA was produced. The report was printed and distributed in 70,000 copies to the SRA members, donors and at SRA meetings and conferences.
- Diagnosis sheets aimed to newly diagnosed patients with the most essential information has been developed in collaboration with a patient research partner and an expert researcher within the field. The sheet is printable and can be distributed by any healthcare practitioner or by patients/public.
- Online patient school prototype - gout. In collaboration with the SRA funded gout network we are gathering high quality information about the diagnosis, treatment, self-care and support in the meeting with the healthcare provider for patients to easily navigate and to find robust answers to their inquiries about their disease.

Conclusion: As a member of SRA, regardless of rheumatic disease, the main interest is knowing more about their diagnosis and about the ongoing research in the field. Through collaborations and communicating rheumatic conditions and