but among them only 344 are recruited in the study, showing a progression rate of about 35% instead of 20%, for a total cost of 1,229,280€.

Conclusion: This work demonstrates the interest for biomarker-based OA-progressors cohort enrichment in DMOAD RCTs. It simulates the gains it could represent for the conduct of these RCTs. The cohorts used in this work (for biomarker measurement and predictive modeling) have a high proportion of women with very large BMI, with K&L grade II-III. The results might thus be replicated on other cohorts. In order to achieve yet stronger cohort enrichment and cost reductions, additional markers and/or clinical factors could be considered for the models.

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HPR Interventions (educational, physical, social and psychological)

THU0699-HPR IS A SMARTPHONE APPLICATION USEFUL FOR SELF-MANAGEMENT SUPPORT IN PATIENTS WITH A RHEUMATIC DISEASE?

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Background: For patients with a rheumatic disease (RD), self-management is the effort to find a balance between the demands of the disease and the activities of daily life. Self-management is an important aspect in the care for patients with a RD, in which they are expected to take an active role. Over the past decade, new technologies have been developed to support self-management, including smartphone apps. These apps perfectly fit the idea that patients prefer an active role in self-management. Therefore, a smartphone application (app) was developed.

Objectives: This study 1) investigates whether the use of an app improved patients' self-management, 2) explores patients' experiences with this RD-app, 3) investigates which factors are associated with the use of the RD-app.

Methods: We performed a prospective before-after study among patients with a RD. The primary outcome was patients' self-management behavior measured with the Partners in Health scale (PIH), a generic validated 12 item self-rated scale, which indicates higher scores for better self-management behavior (1). A paired t-test was used to evaluate changes in the PIH-scale score after three months. To measure the user-experience with the app, survey questions addressed whether the RD-app had contributed to get more grip (or not) on the disease and how (why not). Logistic regression analyses served to investigate variables that are important for using the RD-app.

Results: Of the 1511 eligible patients, 397 completed both the baseline and the follow-up surveys. Participants who completed both questionnaires were most frequently diagnosed with RA, 65% was female and the mean age was 52.0 (SD 15.6) years. Hundred-fourteen participants used the RD-app. Self-management behavior did not improve according to the PIH score in the app-users group after 3 months. However, 42% of the app-users perceived that use of the RD-App had contributed to get more grip on the disease. Receiving tips, information on exercises and gaining insight on self-reported disease activity contributed to get more grip on the disease. However, the other app-users whom did not get more grip on the disease indicated the following reasons: information was not useful, no need for information or additional help, technical issues and too little usage of the app itself. Almost all users would recommend the app to others. To investigate who did use the RD-app, univariate analysis revealed a role for female patients, positive expectations of the RD-app, help needed to get more grip on the disease and a higher VAS global as associated factors with actually using the RD-app. In the multivariate

analysis only positive expectations of the RD-app remained significantly associated with actually using the RD-app ($p < 0.001$).

Conclusion: Almost one third used the RD-app. Although the PIH-score did not change, 42 percent of the participants thought the app helped them to get more grip on the disease. Therefore, the RD-app may be useful for additional self-management support in a clinical practice. Participants seemed to be satisfied with the app, almost all participants would recommend this app to others. More research is needed for additions within the app that could improve the app as a self-management tool.

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THU0700 PHYSIOTHERAPISTS COULD REPLACE PHYSICIANS AS PRIMARY ASSESSORS FOR PATIENTS WITH KNEE OSTEOARTHRITIS IN PRIMARY CARE—A RANDOMISED CONTROLLED STUDY

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Background: It has been estimated that consultations to healthcare will increase with 30-50% among patients with osteoarthritis (OA) over the next 20 years [1]. Patients with knee OA (KOA) report among the lowest health-related quality of life (HrQoL) compared with other chronic diseases [2]. Most patients are assessed by a physician which claims unnecessary healthcare resources since physiotherapists also are primary assessors for patients with KOA and provide recommended treatments. However, it is unclear if physiotherapists could be the first option as primary assessor for this patient group. We hypothesise that all patients with suspected KOA in primary care could be assessed by a physiotherapist first and be referred to physician only when it is required, without having a negative impact on HrQoL.

Objectives: The aim of this study was to explore differences in HrQoL, pain and physical function in patients with suspected KOA after being assessed, diagnosed and treated by physiotherapist first compared with being assessed by a physician in primary care first.

Methods: Patients seeking primary care with suspected KOA were randomised to either a physiotherapist or a physician for assessment, diagnose and treatment. Inclusion criteria were knee pain and > 38 years old. Exclusion criteria: knee pain due to traumatic cause, other systemic, somatic, mental or rheumatic diseases, pregnancy, or already been diagnosed or assessed by another healthcare giver due to current knee pain. HrQoL (Euroqol - EQ5D-3L index, EQ5D-3L VAS), pain intensity (visual analogue scale) and physical function (30 seconds chair stand test) were measured before randomisation, and at 3-, 6- and 12 months. Mann-Whitney's U test and Chi2 test for independence were used with a significance level of $p < 0.05$.

Results: 69 patients with suspected KOA were randomised to either a physiotherapist ($n=35$) or a physician ($n=34$). Both groups improved their HrQoL, pain and physical function at all follow ups. Patients rated significantly better HrQoL (EQ5D-3L VAS) one year after physiotherapy assessment (84 (SD 11); vs 74 (SD 15), $p=0.018$). No other significant differences were found between the groups.

Conclusion: Physiotherapy assessment could replace physician assessment without having negative impact on patient reported outcomes after treatment for patients with suspected KOA. This may play a role in managing the expected increase in OA consultation in primary care. However, more research is needed to clarify if this management is more cost effective, and how patients with KOA experience other primary assessors than physicians.

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