Conclusion: CBP criteria are more likely to diagnose BD and classify patients with severe manifestations of the disease.

REFERENCES:

Disclosure of Interests: Carmen Álvarez-Reguera: None declared, Alba Herrero-Morant: None declared, Laura Sanchez-Bilbao: None declared, David Martínez-López: None declared, José Luis Martin-Varillas: None declared, Guillermo Suárez Amorín: None declared, Cristina Mata-Arnaiz: None declared, Martínez-López: None declared, José Luis Martín-Varillas: None declared, Disclosure of Interests:

HPR Abstract Session (I)

**OP0153-HPR BRIDGING GAPS ACROSS LEVELS OF CARE IN REHABILITATION OF PATIENTS WITH RHEUMATIC AND MUSCULOSKELETAL DISEASES: RESULTS FROM A STEPPED WEDGE CLUSTER RANDOMISED CONTROLLED TRIAL**

G. Berdal1, A. L. Sand-Svartrud1, M. Azimi2, T. Nygaard Dager4, S. Eppeland3, G. Otildedck Fredheim1, A. Simnes Håglund1, A. Klokkeide1, A. D. Linge1, K. Tennebo10, H. Lindvold Vaals1, A. M. Aasvold11, J. Sexton12, I. Kjeken1, National Advisory Unit on Rehabilitation in Rheumatology, Dept. of Rheumatology, Diakonhjemmet Hospital, Oslo, Norway; 2Diakonhjemmet Hospital, Dept. of Rheumatology, Oslo, Norway; 3Hospital for Rheumatic Diseases, Dept. of Rehabilitation, Lillehammer, Norway; 4National Advisory Unit on Rehabilitation in Rheumatology, Dept. of Rheumatology, Diakonhjemmet Hospital, Oslo, Norway; 5Sørlandet Hospital, Dept. of Rheumatology, Arendal, Norway; 6Vikersund Spa Rehabilitation Centre, Dept. of Rehabilitation, Vikersund, Norway; 7Haugesund Sanitetsforening’s Rheumatism Hospital, Andring, Norway; 8Rehabilitation Centre, Dept. of Rehabilitation, Haugesund, Norway; 9Muntunet Rehabilitation Centre, Dept. of Rehabilitation, Ålesund, Norway; 10Valnesfjord Health Sports Centre, Dept. of Rehabilitation, Valnesfjord, Norway; 11Møraker Spa Rehabilitation Centre, Dept. of Rehabilitation, Møraker, Norway; 12Diakonhjemmet Hospital, Dept. of Rheumatology, Oslo, Norway

Background: Previous research show that patients with rheumatic and musculoskeletal diseases (RMDs) benefit from rehabilitation, but the health effects are small and decline over time. Later reports reveal that the quality of rehabilitation services varies largely, with lack of coordination and continuity across levels of care. This may weaken the effect on patients’ long-lasting health, ability to self-manage their conditions and achieve their goals. We therefore developed a new, evidence-based rehabilitation program to strengthen the quality and bridge the gaps in rehabilitation services for this patient group.

Objectives: To evaluate if a new rehabilitation program (the BRIDGE program) designed to improve the quality and continuity of rehabilitation across levels of care, was more effective than traditional rehabilitation in improving goal achievement, function, self-assessed health and health related quality of life (HR-QoL) in patients with RMDs.

Methods: In a stepped wedge cluster randomised controlled trial 8 rehabilitation centres organised in secondary health care and located across all health regions of Norway recruited a total of 374 patients with rheumatic and musculoskeletal diseases. The patients received either traditional rehabilitation (control) (n=206), or traditional rehabilitation extended with an individually adapted complex intervention consisting of a structured goal setting, plans for self-management, motivational interviewing, self-monitored digital feedback, and tailored follow-up support after discharge according to patients’ needs and available resources in primary healthcare (the BRIDGE program) (n=168). Patient-reported data were collected electronically on admission and discharge from rehabilitation, and after 2, 7, and 12 months. The primary outcome measure was patients’ goal achievement measured by the Patient Specific Functional Scale (PSFS) (0-10, 10=best) seven months after rehabilitation stay. Secondary outcome measures were function measured by the 30-seconds Sit-To-Stand Test (30secSTS), self-assessed health and HR-QoL measured by the Euro-Qol instruments EQ-5D-5L-VAS (0-100, 100=best) and EQ 5D-5L-index (-1 to 1, 1=best). The main comparative analysis was performed on the intention to treat population, using all available data, by linear mixed models adjusted for the baseline scores and for the potentially confounding effects of calendar time and data clustering. Sensitivity analyses were performed on data provided by the per protocol population according to predefined criteria, in addition to centerwise comparisons of the control and intervention groups.

Results: No significant treatment effects of the BRIDGE-program were demonstrated either for patients’ goal achievement (mean difference 0.1 [95% CI: -0.5, 0.8], p=0.70) (Figure 1), function (mean difference 0.9 [95% CI: -1.0, 2.2], p=0.18), self-assessed health (mean difference -0.1 [95% CI: -4.1, 3.9], p=0.98), or HR-QoL (mean difference 0.0 [95% CI: -0.0, 0.0], p=0.99) seven months after rehabilitation. Sensitivity analyses confirmed the findings from the primary analysis. A secondary analysis (replacement of missing data for the primary outcome measure (29% in the control and 41% in the intervention group), caused by errors in the digital data collection system, may impair the reliability of the results.

Conclusion: The BRIDGE program was not shown to be more effective than traditional rehabilitation in terms of improving goal achievement, function, self-assessed health and HR-QoL in patients with RMDs. There is still is a need for more knowledge about factors that can improve the quality, continuity and long-term health effects of rehabilitation for this patient group.

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.3331

**OP0154-HPR FEASIBILITY OF A WEB-BASED, PEER-SUPPORTED EXERCISE PROGRAM FOR PEOPLE WITH HIP OR KNEE OSTEOARTHRITIS**

K. L. Joseph1,2, H. Solveig Dagfinrud1, K. B. Hagen1, K. Røren Nordén1, C. Fongen1, O. M. Wold3, A. T. Tveter1, Diakonhjemmet Hospital, National Advisory Unit on Rehabilitation in Rheumatology, The division of Rheumatology and Research, Oslo, Norway; 2University of Oslo, Faculty of Medicine, Institute of Health and Society, Oslo, Norway; 3Norwegian Institute of Public health, Division of Health Service, Oslo, Norway; 4Norwegian Association for Rheumatic diseases, Norwegian Association for Rheumatic diseases, Oslo, Norway

Background: Long-term physical activity (PA) and exercise is recommended as a cornerstone in the treatment of people with osteoarthritis (OA) (1), yet adherence to exercise is challenging (2). The treatment needs for this large group of patients cannot be fully managed within the health-care system, thus developing innovative and effective follow-up strategies is urgently needed.

Figure 1. Goal achievement with PSFS (0-10, 10 best) indicated by difficulty to exercise at goal time-points: discharge from rehabilitation (baseline for this particular variable) and after 2, 7 and 12 months. Vertical lines indicate estimated mean (center) with 95% confidence interval (shaded area). At 2 months, a significant improvement of missing data for the primary outcome measure (29% in the control and 41% in the intervention group) caused by errors in the digital data collection system, may impair the reliability of the results.

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.987
Objectives: To explore the feasibility and preliminary efficacy of a web-based, peer-supported exercise program for people with hip or knee OA.

Methods: This study was a single-group, pre-post feasibility study. Patients aged 40-80 years with hip or knee OA who were not candidates for surgery were eligible. The 12-week intervention was delivered through a patient-organizations (The Norwegian Association for Rheumatic Diseases) web-based platforms, and included weekly exercise programs, weekly motivational messages, an OA and exercise website and assigned peer-supporters. Feasibility was evaluated by calculating the proportion of eligible patients who were enrolled and retained at follow-up, as well as time resources used on delivery of the intervention. Acceptability was evaluated by calculating proportion of patients who had valid baseline accelerometer data and completed the maximal cardiorespiratory exercise test according to protocol. Primary efficacy measures were change in PA assessed by accelerometers and change in exercise capacity (VO2peak) assessed by indirect maximal cardiorespiratory exercise test. Secondary efficacy measures were change in patient reported outcomes assessed by HOOS and KOOS (www.koos.nu) (a 10-point change in normalized scores was considered a minimally important change). Data was analysed using paired sample t-test, given as mean change (95% confidence interval) and p-values.

Results: We identified 49 eligible patients of which 35 (71%) consented and were enrolled. Among those who consented, 22 (63%) were retained. Time resources used on delivery of the exercise programs and motivational messages were mean (SD) 7.3±1.1 min per week/patient. Compliance with wearing the accelerometer was mean (SD) 6.1±1.0 valid days (mean (SD) 13.8±1.3 hours/day). Twenty (67%) out of 30 patients who attended baseline testing performed the maximal cardiorespiratory exercise test, of which 18 completed according to protocol. Due to Covid-19 restrictions, follow-up testing of primary efficacy measures was change in patient reported outcomes assessed by HOOS and KOOS (www.koos.nu) (a 10-point change in normalized scores was considered a minimally important change). Data was analysed using paired sample t-test, given as mean change (95% confidence interval) and p-values.

Conclusion: Overall, the examined study processes were considered to be feasible and acceptable. Some minor amendments should be applied to improve the recruitment and retention rate before it can be carried out in a larger trial. The efficacy results should be interpreted with caution due to the small sample size. The recruitment and retention rate before it can be carried out in a larger trial. The remote treatment decisions were made by an independent (blinded) health professional, based on the self-assessment questionnaires and information collected in the study: medical history, ongoing therapies for RA, clinical outcomes, adverse events and toxicity. In this analysis, the independent blinded clinician did not have the same information as the routine hospital visit clinician (blood results and joint assessment).

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.1313