

interviews lasted approx. 60–90 mins. Participants shared experiences of using the wearable, and its impact on their communication with the PT. Analysis was guided by a relational ethics conceptual lens (including key concepts such as choice, interdependence, trust, uncertainty) and a phenomenographic approach to gain insight into the qualitatively different ways in which participants experienced benefits and downsides of the intervention in the context of their OA self-care.

Results: Interviews of 20 participants (11 female; 9 male) aged 40–82 years were analyzed. Our analysis identified three early categories of description: 1) *Negotiating with my wearable*: Participants often viewed their Fitbit as having human-like qualities (e.g., stubbornness, or nagging, or providing encouragement “just like a friend”). Tensions were experienced by some participants when their wearable’s prompts to be active were at odds with other priorities they were juggling in their everyday lives. Others experienced their wearable as a trusted support and source of motivation to reach shared physical activity goals; 2) *Having a new self-awareness*: Participants expressed interest in learning about themselves by using a Fitbit to monitor their physical activity and sleep, and some viewed their new awareness as a step in taking back control over their OA. Some felt uncertain about how to act on the new information; 3) *Feeling accountable to others*: Many participants described situations in which they used their wearable data to prove or justify their physical activity levels to others who they felt a responsibility to (e.g., the PT, research staff, family members).

Conclusions: Findings describe different ways in which persons with knee OA can experience their use of a wearable as a source of tension at odds with their other priorities, or as a beneficial support for their capacity to take control in their everyday self-care with a health professional. Drawing on a relational ethics lens, our study sheds some light on how persons with knee OA experience relational aspects (i.e. choice, interdependence, trust, uncertainty) that can facilitate or limit their capacity for autonomy when using a wearable-enabled physical activity counselling intervention. It raises questions, based on the experiences of persons with knee OA, about what it means to respect a person’s capacity for autonomy when incorporating the use of a wearable-enabled intervention into everyday self-care of knee OA.

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WILLINGNESS FOR SURGERY AND HEALTH-RELATED QUALITY OF LIFE AFTER SIX MONTHS IN A DIGITAL OSTEOARTHRITIS SELF-MANAGEMENT PROGRAM

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Purpose: To investigate the change in willingness to undergo surgery and in health-related quality of life in those participating in a digital first-line osteoarthritis self-management program during six months.

Methods: Data on people with hip- or knee osteoarthritis, having participated in a digital self-management program for 6 months and reporting whether they experienced symptoms so severe they wanted to undergo joint surgery (dichotomous reply, yes/no), was extracted from the Joint Academy® patient registry. Reported willingness and the change over time was analyzed together with EQ5D-5L data. Individuals were separated into two groups, those willing to undergo surgery at baseline and then changing their mind (YES-NO), and those willing at baseline and still willing to undergo surgery at 6 months (YES-YES). Demographic data and frequency of response for each level of dimension from the EQ5D-5L per group was calculated. The Mann-Whitney U test was performed to investigate whether the distributions of levels in each dimension of EQ5D-5L were the same between groups, at baseline and at 6 months. Ethical approval was received from the regional ethics committee of Lund University and the Swedish Ethical Review Authority (Dnr: 2018/650 and 2019-02232).

Results: A total of 1073 individuals answered the question on willingness for surgery at baseline and at 6 months. Of these, 200 individuals reported willingness for surgery at baseline. At 6 months, 94 individuals (47%) reported they did no longer have a need for surgery, whilst 106 (53%) individuals were still willing to undergo surgery (Table 1). Of those unwilling at baseline, 8% reported willingness for surgery after 6 months. The Mann Whitney U-test indicated that at baseline the distribution of frequencies was similar for the two groups (YES-YES and YES-no) for the EQ5D-5L dimensions Pain/Discomfort, Usual Activities and Anxiety/Depression, whilst showing statistically significant worse responses for Mobility ($p=0.04$) and Self Care ($p=0.03$) for those still willing to have surgery after 6 months (YES-YES). At 6 months, there were differences in all dimensions between the two groups, and the distribution of frequencies indicated greater health-related quality of life in the YES-NO group. For the

YES-YES group, there was a statistically significant difference in Self Care at baseline and at 6 months, and Pain / Discomfort at 6 months, between participants with knee- and hip OA. For the YES-NO group, there was a statistically significant difference in Self Care at baseline only, between knee- and hip OA participants.

Conclusions: Previous research has shown that the percentage of patients with hip- and knee osteoarthritis willing to undergo surgery decreased by 31% after 6 weeks of participation in a digital osteoarthritis self-management program. In this unique study, where individuals with knee or hip osteoarthritis have adhered to a digital treatment program for 6 months, results suggest that with increased treatment adherence time the proportion of ‘no longer willing’ increases. Thus, the potential to avoid or delay total joint replacement may increase with increased participation time, and patient selection for total joint replacement may be facilitated. In addition, change in willingness from yes to no was associated with improvement in health-related quality of life during participation in the digital self-management program.

Table 1. Demographic data in means, frequency or percentage, per willingness-group.

Characteristic	YES-NO (n=94)	YES-YES (n=106)
Age (SD)	62.4 (9.5)	62.2 (7.3)
Female, n (%)	70 (75)	82 (77)
Knee OA, n (%)	64 (68)	54 (51)
Adherence, % (SD)	72 (23)	71 (23)
BMI (SD)	28 (6)	29 (6)
Baseline pain (SD)	6.3 (1.7)	6.7 (1.4)
6 month pain (SD)	3.3 (2.0)	5.3 (2.1)

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OUTCOMES FOLLOWING THE GLAD PROGRAM FOR PATIENTS WITH SYMPTOMATIC KNEE AND HIP OSTEOARTHRITIS IN DENMARK, CANADA AND AUSTRALIA. A LONGITUDINAL ANALYSIS INCLUDING 28,370 PATIENTS

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Purpose: Exercise therapy and patient education is recommended as first line treatment for patients with knee and hip osteoarthritis (OA). Good Life with osteoArthritis from Denmark (GLA:D®) is an 8-week structured patient education and exercise program targeting patients with knee and hip OA. The program is implemented in clinical practice in different countries and reporting outcomes across countries may show what to expect when implementing such a program. The aim of the study was to report and compare outcomes and predictors across three countries for patients with symptomatic knee and hip OA attending the evidence-based education and exercise therapy program GLA:D®.

Methods: GLA:D® is a structured treatment program for knee and hip OA including 2–3 patient education sessions and 12 supervised exercise sessions delivered by certified health care practitioners. The program was introduced in Denmark in 2013, in Canada 2015 and in Australia 2016 and data were retrieved from the national electronic GLA:D® databases on August 1, 2019 (Denmark and Canada) and on July 1, 2019 (Australia). Patients with complete baseline measurements no later than the end of February 2019 were included in the study. Baseline characteristics were reported. Mean change in pain intensity (NRS 0–10, best to worst), number of stands in the 30 seconds chair stand test (more is better), time to complete the 40 meter walk test (shorter time is better) and KOOS/HOOS QOL subscale score (0–100, worst to best) from baseline to immediately after treatment were reported as means and 95 % CIs for each country. The analyses were conducted as complete case analyses supplemented by a sensitivity analysis using multiple imputation where follow-up values were missing. The association of age, gender, BMI, hip/knee joint as primary complaint, symptom duration and