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Abstract book

SDM in real life: Connecting the practical elements

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1: Hip and Knee Total Joint Arthroplasty Online Resources for Patients and Healthcare Professionals: A Canadian environmental (Oral presentation)

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Background

The aim is to identify and appraise the quality of publicly available online hip and knee total joint arthroplasty (TJA) Canadian resources for patients with hip or knee OA considering TJA and healthcare professionals participating in TJA decision-making processes.

Methods

An online environmental scan was conducted of Canadian governmental and healthcare association websites. Two independent authors appraised: a) patient resources against the International Patient Decision Aids Standards (IPDAS) criteria and the Patient Education Material Evaluation Tool (PEMAT); and b) healthcare professional resources against six appropriateness criteria for TJA and eight elements of shared decision making.

Results

Of 84 included resources, 71 were for patients, 11 for healthcare professionals, and 2 for both. For patient resources, 69 met a mean 2.4 of 7 IPDAS defining criteria and 4 were patient decision aids meeting all defining criteria. Patient decision aids and patient resources had mean PEMAT understandability scores of 88% and 78% and mean PEMAT actionability scores of 80% and 53%, respectively. All patient resources were understandable for diverse health literacy levels, but only 3 resources provided a summary of key points and 26 achieved good actionability scores. The 13 healthcare professional resources met a mean 2.9 of 6 TJA appropriateness criteria and a mean 2.8 of 8 shared decision making elements.

Discussion

Only 5% of patient education materials were structured as a decision aid to help patients consider their options (benefits/harms) and reach a decision based on their preferences. Healthcare professional resources were limited to traditional criteria for determining TJA appropriateness (evidence of osteoarthritis, previous use of conservative treatments) and poorly met key elements of shared decision making.

Conclusion

Future patient resources need to better support informed decision making with actionable resources, while healthcare professional resources need to better consider patient perspectives with elements of shared decision making.

2: Development of a new shared decision-making intervention 'VOLITION': To facilitate the involvement of older people with multiple long-term conditions in decision-making about their healthcare during UK general practice consultations (Oral presentation)

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Introductions
The population is ageing and two thirds of people in the UK have multiple long-term health problems (multimorbidity). These patients consult GPs frequently. They live with a burden of illness and treatments, poor quality of life and associated healthcare costs. Ensuring high-quality personalised care for these patients is challenging. Potential benefits of shared decision-making (SDM) have been acknowledged, however, there are few existing SDM interventions in this field.

The aim of VOLITION is to facilitate the involvement of older people with multimorbidity in decision-making about their healthcare during UK general practice consultations.

Methods
An Intervention Mapping (IM) framework was a means of systematically applying existing literature, new data and relevant theory in the development, refinement and planning the evaluation of VOLITION.

Patient and public involvement was central and expert stakeholder opinion was sought. A Cochrane review of similar interventions was published, and VOLITION components were subsequently drafted. Focus groups with patients and GPs enabled the refinement of behaviour-change objectives. A mixed-methods exploratory-explanatory study informed plans to implement VOLITION in the context of remote vs. face-to-face consultations.

Results
VOLITION consists of i) a prompt to patients, inviting them to express their personal preferences for involvement and ii) training for GPs, delivering a responsive patient-tailored approach to SDM, tackling challenges perceived by GPs regarding implementation in practice.

Discussion
This project addresses recommendations from the UK National Institute for Health and Care Excellence; for SDM research targeting patient groups who often believe in the decisional authority of the clinician. VOLITION adheres to NHS England's universal personalised care plan; to empower patients in the management of their healthcare and to train clinicians in SDM.

Conclusion
A full, definitive trial of VOLITION is planned. An effective intervention, designed using end-user perspectives, has the potential to influence high-quality patient-centred care for older people with multimorbidity.

4: Evaluation of the intention to use an online decision aid related to housing decisions among seniors (Poster)

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Background

Canada's older population continues to grow and the loss of autonomy in the elderly exposes them to difficult decisions like staying home or moving out. As we are living in the digital era where e-Health interventions are becoming more and more frequent, an online decision aid (eDA) seems to be useful. However, we do not know whether seniors have the intention to use an eDA when it comes to making a housing decision.

Methods

Our main objective is to estimate the mean of the intention to use an eDA related to housing decisions. Our secondary objective is to explore the influencing factors of the intention to use the eDA in the elderly.

Results

We will launch a pan-Canadian online survey. We will recruit participants from a panel of anglophone and francophone Canadian adults with the help of a Canadian-owned market research and analytics company. The inclusion criteria are : 1) be 65 years old or older; 2) have access to an electronic device with a stable internet connection; 3) be able to understand english or french; 4) be able to consent to the study; 5) have made the decision or planning to make the decision of staying home or moving out. We will collect data from 829 participants using a self-administered questionnaire based on the "Unified Theory of Acceptance and Use of Technology". We will also assess participants' level of e-health literacy. Then, we will conduct descriptive, bivariate, and multivariate analyses.

Discussion

The results of this study will be used to develop effective strategies for implementing the use of the eDA in the elderly. Ultimately, this eDA will empower seniors and involve them in the decision-making process regarding their housing decisions.

10: Colorectal cancer screening decisions based on predicted risk: the PREcision ScreENing randomized controlled Trial (PRESENT). Study protocol (Poster)

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Introduction

Colorectal cancer (CRC) can be effectively prevented by screening with faecal immunochemical tests (FIT) and colonoscopy. Individual risk to develop CRC within 15 years varies from <1% to >15%. Communicating personalized CRC risk scores and appropriate screening recommendations could improve the risk-benefit balance of screening tests allocation and optimize the use of colonoscopy resources. However, significant uncertainty exists regarding the feasibility and efficacy of risk-based screening. We will measure the effect of a brochure providing individual CRC risk score and screening recommendations on appropriate screening uptake at six months in individuals at low, moderate and high risk for CRC.

Methods

We will perform a pilot randomized controlled trial (RCT) of 880 residents from the canton Vaud (Switzerland) aged between 50 and 69 years. The personalized risk score will be calculated using the QCancer calculator. Participants will be stratified into low (<3%), moderate (3-6%) and high (>6%) risk groups according to their 15-year CRC risk, and randomized within each risk stratum. The intervention group participants will receive a newly designed brochure with their personalized risk score and appropriate screening recommendations. The control group will receive the standard brochure of the Vaud CRC screening program. We will measure appropriate screening uptake six months after the intervention using a short self-administered questionnaire. Screening will be considered as appropriate if high-risk participants undertake colonoscopy and low-risk participants undertake FIT. Both tests are appropriate for moderate-risk participants. We will also measure acceptability of the risk score and the screening recommendations, psychological factors influencing screening behaviour, as well as feasibility of a full-scale RCT.

Discussion/Conclusion

This study should advance our knowledge of risk-based screening. This may allow screening programs to offer screening options with a better risk-benefit balance for participants and optimize the use of limited colonoscopy resources.

11: Accuracy of risk prediction by surgeons and anaesthetists compared to risk prediction tools for outcomes 30-days after major lower limb amputation: implications for shared decision-making (Oral presentation)

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Introduction

Accurate risk information is essential to describe options for patients. In vascular surgery several risk prediction models exist, such as for major lower limb amputation (MLLA) but whether these or predictions by healthcare professionals (HCPs) are most accurate is unknown. We sought to evaluate the accuracy of HCPs and existing risk prediction tools in predicting mortality, morbidity, and MLLA revision at 30-days postoperatively.

Methods

An international (OECD countries) 39-centres cohort study (2020-21) of 537 adult patients undergoing MLLA (mean age 67.2+/-11.5 years, 80.4% male, 90.3% white ethnicity; 50.4% had below-knee amputations, 46.4% above-knee amputations, 3.2% through-knee amputations; 7.4% had active COVID-19 infection). Preoperative predictions of 30-day mortality, morbidity, and MLLA revision at 30-days by HCPs (surgeons, anaesthetists, rehabilitation physiotherapists; n=1-7 staff per centre) were recorded, and data collected to calculate probabilities from 13 risk prediction tools identified by systematic review. Evaluation of accuracy included measures of discrimination, calibration and overall performance.

Results

HCPs had acceptable discrimination when predicting mortality (C-statistic=0.758) and MLLA revision (C-statistic=0.756) but poorer for morbidity (C-statistic=0.616). However, HCP predictions were mis-calibrated, over-predicting all outcome risks. All except two risk prediction tools had worse discrimination than HCPs when predicting mortality (C-statistics=0.773 and 0.778), but these also had significant miscalibration (overestimating risks). The tools predicting morbidity and MLLA revision had poor discrimination compared to HCPs (C-statistics=0.520 and 0.679 respectively), despite the MLLA revision tool being well calibrated and good overall performance (Brier score=0.077).

Discussion

HCPs predict mortality and revision surgery well but are poorer at predicting morbidity after MLLA. Clinical utility of currently available short-term risk prediction tools in MLLA surgery is dubious, given either poorer discrimination or mis-calibration compared to HCPs.

Conclusion

HCPs should be aware of tendencies to overestimate short-term risks when describing options for this patient group as part of shared decision-making.

12: Shared Decision Making: Best Practices for Pediatric Service Delivery' (Poster)

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Introduction

Since implementation of Shared Decision Making (SDM) Decision Coaching services in 2018, the SDM model at Children's Hospital LHSC, has impacted a number of pediatric clinical practices by facilitating decision making through decision coaching services via an unbiased decision coach outside the direct circle of care. Caregivers are offered direct coaching sessions and they are offered by secure virtual services with on line videoconferencing. Virtual remote services have made SDM/Decision Coaching accessible, more readily available, and convenient for many such as those who live in remote areas, those with transportation issues, those with disabilities, and those who may be socially compromised during COVID 19.

Methods

The impact of COVID 19 and the move to offer virtually remote services with online videoconferencing attracted new areas of expansion and partnerships that include:

- Province wide service partnership with Muscular Dystrophy of Canada
- London Family Court Clinics to support co-parenting families with conflictual decisions about COVID-related parenting,
- SDM intervention in parental Pediatric Epilepsy Surgery Decision Making
- Education sessions to parents/caregivers to learn about SDM

Results

We recognize that telehealth is still relatively new, and more research is needed to fully understand the most effective practice.

Discussion

Pediatric patients and their families may struggle to make a range of medical treatment decisions. This is particularly true of decisions with uncertain outcomes. This innovative virtual care SDM program delivers an important best practice patient centred care clinical service. The program measures clinical outcomes including: knowledge, decisional satisfaction, decisional conflict and readiness before and after all SDM coaching consultations.

Conclusion

The offering of virtual services with on line videoconferencing decision coaching services brings a new dynamic to the engagement of patients/families in their health care decisions, and enables a geographically wider engagement of families, while consistently maintaining shared decision making as the focal point of true patient centred care.

13: Innovations that foster Education of Shared Decision Making for Patients/Families (Oral presentation)

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Introduction

Providing Shared Decision Making (SDM) education sessions proactively for patients/families who are at a high likelihood of having multiple and challenging health care decisions is anticipated to be a valuable intervention. Such sessions would encourage patients/families to explore, research and use all the SDM tools available to them along their health care journey. Rather than just involving decision aids or coaching at the time of a decision, provide proactive education take a different approach to gaining the skills of how to come to a preferred decision with challenging health decisions and strengthen their problem - solving skills.

Methods

This learning will unpack the concept of SDM, through a series of patient/family focused education sessions to high risk NICU, inpatient and outpatient groups through regular chat rooms, workshops and didactic lessons including post-session follow up support and communications. Pre and post evaluations will be done via a short questionnaire to participants. All participants will have the contact for the decision coach to support their newly acquire decision making skills going forward.

Results

Our goal is to give patients/families the confidence, knowledge, empowerment, and tools to use SDM paradigms and techniques proactively to inform how they make medical decisions and alter the trajectory of their health care journey by taking a more systematic approach to decision making.

Discussion

Providing education sessions, training and awareness that builds the skills needed for SDM and fostering a culture that embeds patient/family values and engagement in the decision process will help to improve patient/family knowledge about their children's care options as well as increase participation in treatment decisions.

Conclusion

This innovative approach to creating a SDM environment will be evaluated in a QI research framework and the outcome will be presented in our presentation.

14: Patient-targeted resources to support decisions about Medical Assistance in Dying in Canada: An online environmental scan (Poster)

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Introduction
Medical Assistance in Dying (MAiD) was legalized in Canada in June 2016. In March 2021, legislation was extended to permit the assisted death of persons whose natural death is not reasonably foreseeable. Little is known about the quality of resources to support patients and families making this decision. The aim of this study is to identify and quality appraise patient-targeted MAiD resources to support patients facing this decision.

Methods
An online environmental scan was conducted of Canadian MAiD resources in July-August 2021. Two independent reviewers appraised resources against the International Patient Decision Aids Standards (IPDAS) criteria and health literacy level was evaluated using the Patient Education Material Evaluation Tool (PEMAT). Adequate PEMAT scores for understandability and actionability were ≥70%. Scores were compared and consensus was reached.

Results
Of the 63 patient-facing resources for MAiD, none met all IPDAS defining criteria to be patient decision aids (PtDAs) (mean: 2.6 out of 7; range: 0-5). None reported benefits and harms of options. For PEMAT 32/63 scored adequate for understandability (mean: 73%; range: 47-100%) and 11/63 scored adequate for actionability (mean 47%, range: 0-80%). Thirty-five (56%) of resources provided information on the legislative changes of March 2021.

Discussion
Appraisal of resources revealed no PtDAs related to MAiD and few of the minimal criteria for PtDAs were evident. These findings are consistent with the absence of MAiD-related PtDAs in the International A to Z Inventory of PtDAs. Health literacy scores revealed the need to improve MAiD resources to enhance the understandability and actionability for intended users. Most MAiD resources provided information on the new legislation.

Conclusion
Approximately half of the resources provided information on the 2021 legislative changes. From the publicly available Canadian resources on MAiD, none were PtDAs. Few would help improve health literacy, given only half received an adequate score for understandability and 16% for actionability.

15: Feedback (Poster)

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Introduction

The implementation of shared decision making (SDM) requires training of the clinicians' micro-skills in terms of being able to arrive at a shared decision with the patient. By providing positive, appreciative feedback after the patient-clinician consultation, it is possible to reduce the gap between the clinician's current level of SDM and the clinician's desired level and thereby facilitate learning and insight.

Methods

A supportive feedback framework was developed with inspiration from validated measurement instruments and models such as Glyn Elwyn's three-talk model, "Preparation for Decision Making Scale", the questionnaire SDM-Q-9, and OPTION 12. The analysis model SUMO was chosen as the underlying structure of the feedback, and the framework was then tested in practice, with junior and senior doctors. An observer with SDM skills attended real-world consultations with clinicians and patients.

After the consultation, short oral feedback of about 5 -10 minutes was provided by the observer using the SUMO model and any follow-up was agreed upon. The feedback provided was evaluated by a short questionnaire to each physician asking for their SDM readiness and experience.

Results

Nine physicians were invited to receive feedback and six accepted the offer. Eigthy percent of physicians expressed that feedback, based on the framework developed, was useful in relation to increasing own competencies in the use of SDM. In addition, they expressed a desire to make use of the feedback model in the future to maintain the acquired competencies.

Discussion

The advantage of feedback is that it increases the physicians' reflection on own SDM practice, but it is important feedback is systematic and follows the framework provided.

Conclusion

Physicians experienced the feedback framework as useful and expressed that feedback gave food for thought and highlighted opportunities for improvement within the consultation, they hadn’t spotted themselves.

18: Experiences with information provision and preferences for decision making of patients with acute stroke (Oral presentation)

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Introduction

The aim of this study was to gain insight into experiences of patients with acute stroke regarding information provision and their preferred involvement in decision-making processes during the initial period of hospitalisation.

Methods

A sequential explanatory design was used in two independent cohorts of patients with stroke, starting with a survey after discharge from hospital (cohort 1) followed by observations and structured interviews during hospitalisation (cohort 2). Quantitative data were analysed descriptively.

Results

In total, 72 patients participated in this study (52 in cohort 1 and 20 in cohort 2). During hospitalisation, the majority of the patients were educated about acute stroke and their treatment. Approximately half of the patients preferred to have an active role in the decision-making process, whereas only 21% reported to be actively involved. In cohort 2, 60% of the patients considered themselves capable to carefully consider treatment options.

Discussion/Conclusion

Active involvement in the acute decision-making process is preferred by approximately half of the patients with acute stroke and most of them consider themselves capable of doing so. However, they experience a limited degree of actual involvement. Physicians can facilitate patient engagement by explicitly emphasising when a decision has to be made in which the patient's opinion is important.

19: SDM in outpatient treatment of adult people with anorexia nervosa and bulimia nervosa (Poster)

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Introduction

As part of the implementation of SDM in the Eating Disorder Treatment Team of the Mental Health Unit Odense, we discovered that although an exploration of patient preferences was a central and early part of the dialogue with patients referred for treatment, we did not use the preferences explicitly or systematically in the further dialogue on treatment decisions. At the same time, treatment decisions were predominantly clinician-driven. This led to a process of developing a decision aid (DA) in accordance with the IPDAS criteria's.

Methods

To integrate patient preferences and support patient and provider in making shared decisions in the treatment of people with anorexia nervosa and bulimia nervosa, we developed the DA by using the generic frame of the Decision Helper in the Southern Region of Denmark and by involving people with lived experiences of a diagnosis of an eating disorder.

Results

The development resulted in a DA that enables an ongoing presentation of treatment options at different times in the patient's course with joint discussion of their advantages and disadvantages in relation to the patient's preferences. Today, the DA is increasingly an integral part of practice in the outpatient treatment of eating disorder and used as far as possible in all decisions at both the beginning of treatment and during the often long-term treatment in collaboration with people with anorexia nervosa and bulimia nervosa.

Discussion

Developing a DA promotes awareness of what shared decision-making entails in practice and can sharpen professional focus on presenting opportunities and discussing preferences in the decision-making process.

Conclusion

SDM implementation has led to integrating patient preferences more fundamental in our practice and developing the decision-making structure to be more in accordance with SDM in the outpatient treatment of adult people with anorexia nervosa and bulimia nervosa.

20: Clinicians view on barriers and facilitators before implementing Shared Decision Making, a Pareto analysis (Oral presentation)

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Introduction

Implementing Shared Decision Making (SDM) in a hospital department requires specific implementation actions. Knowledge of barriers and facilitators will help determine these actions and thus provide stakeholders with key information on where to focus sparse resources. In this quality improvement project, we investigated factors with greatest potential impact on improvement on SDM, before an implementation process of SDM.

Methods

A Pareto analysis is a statistical technique in decision-making used to select a limited number of tasks that produce a significant overall effect. The Pareto analyses were carried out using an electronic questionnaire. We asked doctors, nurses and other clinical staff to consider qualitative statements on barriers and facilitators related to implementing SDM. The qualitative statements were based on research of SDM barriers and facilitators. We then pooled data from the questionnaires and displayed them in a frequency plot.

Results

Eight Pareto analyses were carried out in 4 specialities across 4 hospitals in Denmark. In all, 263 respondents took part in the Pareto analysis. Overall, the “vital few” facilitators were “We have patients and patient courses suited for SDM”, “We are used to working with patient involvement” and “My colleagues have knowledge of SDM”.

The “vital few” barriers were “I need knowledge and teaching”, “I need decision-aids” and “My patients gets insecure”.

Discussion

Results indicate a need for knowledge. Meanwhile, a facilitator was that one’s colleagues have knowledge of SDM. This states the importance of putting together the right implementation team to support the process of implementing SDM.

Conclusion

The Pareto analysis provides an insight into which barriers and facilitators, according to the clinicians, were the “vital few”. Focusing on these factors, can lead an SDM implementation process towards actions with greatest impact.

22: Delivering Prognosis to Patients with Chronic Kidney Disease they Way they Want it Delivered. – Design of the CKD Journeys Decision Aid (Oral presentation)

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Background

Prognostic information is an important component of shared decision making (SDM) in life limiting illness. Studies suggest that patients with chronic kidney disease (CKD) desire prognostic information, however little is known about how and when this information is best delivered.

Methods

To meet the needs of both patients and clinicians, we conducted separate focus groups with each, and qualitative semi-structured interviews with CKD patient. . Patients were asked about their experiences and perspectives related to End Stage Kidney Disease (ESKD) risk and life expectancy prediction. We also elicited their communication preferences for this information.

Results

Most but not all patients wanted information about their prognosis. More were interested in knowing their risk of ESKD than their life expectancy but frequently confounded the two. Patients wanted the information shared early, with suggestions of what they could do to improve their prognosis and slow down disease progression. They wanted straight forward answers, yet with a message of hope, ideally delivered by a clinician who knew them and understood when the time was right and what the patient could handle. The valued the ability to plan.

Discussion

CKD journeys interactive decision aid is designed to deliver individualized prognostic information, on demand, both for ESKD risk and life expectancy. Intuitive imagery is used to deliver the disease trajectory and comparative effectiveness of different treatment options, uncovering more detail if desired. It is designed to be used early and repeatedly to allow for exploration of the patient's goals of care and the maturing of preferences. It is currently undergoing pilot testing.

Conclusion

Meeting the needs of patients and clinicians, we have designed a unique and interactive DA to promote shared decision making for patients with advanced CKD.

23: “None of us wants to hear it, but it’s nice to know what the future holds” - Uncovering the value of prognostic information for African American patients with chronic kidney disease (Oral presentation)

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Introduction
African Americans (AA) are at a higher risk of developing chronic kidney disease (CKD) and require dialysis or transplant at younger ages. Research shows AA have poor understanding and struggle to manage their CKD and avoid thinking about risk of disease progression.

Methods
We conducted a qualitative study among AA CKD patients, in 2019 - 2020, using a combination of focus groups and interviews about perceived value of knowing their risk of progression to kidney failure and life expectancy, and how they might use such information. Data were analyzed using thematic analysis.

Results
We recruited patients for 2 focus groups and completed semi-structured interviews for a total of 14 participants, 9 women, age 63.5 (range 59-68).

Themes identified were: 1) desire for information in the information vacuum, 2) managing uncertainty, 3) tradeoffs and 4) race and prognosis.

Discussion
In this small study many, but not all, AA participants were interested in learning about the risks of progression to ESKD; some were interested in life expectancy information. Patients expected to use this information to motivate them for better disease management and to influence their prognosis but acknowledged this came with a potential emotional cost. Several participants felt that race was extraneous to conversations about prognosis. Patients uniformly reported high trust in their clinicians which may represent a selection bias that could influence the patients’ perception of differential communication based on race.

Conclusion
Our findings highlight the complexity of conversations about CKD and its prognosis. It is important to offer and answer patients’ questions about prognosis while avoiding giving information that is not desired. Patients believe that prognostic information can help improve CKD management and shared decision making around treatment choice for end stage kidney disease.

24: Decision-making processes on medical assistance in dying: study protocol and first results of the development of a framework from different perspectives (Oral presentation)

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Introduction

Medical assistance in dying (MAID, also assisted suicide) means the support of a freely responsible suicide, e.g. by the provision of a lethal drug, which the person willing to die takes him/herself. Following a ruling by the German Federal Constitutional Court in February 2020, a new legal regulation of MAID in Germany is currently pending and is widely debated in public. To date, there is a lack of scientific research on this topic in Germany - especially with regard to decision-making. Hence, this study aims to conduct a multi-perspective analysis of the current state and needs regarding decision-making processes on MAID in Germany from different professional perspectives.

Methods

A mixed-methods explorative study will be conducted. In the first study phase, a scoping review will be prepared to synthesize previous national and international scientific findings on decision-making processes on MAID. In phase two, multi-perspective, explorative analysis of the current state and needs regarding MAID decision-making processes will be completed with 30 to 50 qualitative interviews with various stakeholders (e.g., physicians, nurses, clinical ethicists, pastoral care providers, psychologists; theoretical sampling). The third phase includes the development of a framework of decision-making processes on MAID in Germany. This will include potential actors and process paths and will be discussed in a half-day workshop with representatives of the above-mentioned professional groups.

Results/Discussion/Conclusion

Preliminary results of the scoping review will be presented at the conference. The knowledge gained in this study can be used to structure future research on MAID and as a basis for implementation in routine health care. In addition, scientific research on MAID can support the socio-political debate.

25: Influencing factors on routine implementation of shared decision-making in cancer care: qualitative process evaluation of a stepped-wedge cluster randomized trial (Oral presentation)

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Introduction
Shared decision-making (SDM) is highly relevant in oncology but rarely implemented in routine care. Several factors have shown to influence implementation success. The aim of this study was to investigate influencing factors on SDM implementation in the context of a theoretically and empirically based multi-component SDM implementation program through pre-planned process evaluation.

Methods
We conducted qualitative process evaluation of a stepped-wedge SDM implementation trial. Qualitative data included process interviews with healthcare professionals (HCPs), field notes by the study team, and meeting minutes. Data were analyzed via deductive and inductive qualitative content analysis on basis of the Consolidated Framework for Implementation Research (CFIR).

Results
Transcripts of 107 process interviews with 126 participants, 296 pages of field note documentation, and minutes of 39 meetings were included in the analysis. Major influencing factors on SDM implementation included perceived personal relevance of SDM for own clinical practice, individual motivation to change, leadership engagement, interdisciplinary cooperation, available resources, compatibility with clinical routines, reliability and predictability, integration of SDM into existing structures, applicability of SDM in certain situations and with certain patients, and organizational priorities.

Discussion/Conclusion
This comprehensive process evaluation provides approaches for the interpretation of the outcome evaluation of the SDM implementation study. The identified influencing factors can be used for planning, conducting and evaluating future SDM implementation studies. Future studies should investigate which of the influencing factors are predictors for implementation success.

27: Effects of a shared decision-making implementation program on patient-centered communication - a secondary analysis of doctor-patient conversations in oncology (Oral presentation)

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Introduction
Shared decision-making (SDM), a key element of patient-centeredness, is currently poorly implemented in oncology. The aim of this study was to assess whether an implementation program to foster SDM in oncology also had secondary effects on patient-centered communication in medical encounters.

Methods
This is a secondary analysis of data from an SDM implementation trial that included several implementation strategies (e.g. clinician training and coaching). We analyzed audio-recordings of doctor-patient conversations collected in three participating departments of a comprehensive cancer center in Germany before and after implementation. Each file was rated by two researchers using the German version of the Four Habit Coding Scheme (4HCS), an observer tool to assess patient-centered communication (23 items grouped in four habits). Data was analyzed using descriptive statistics and a linear mixed-effects model.

Results
146 encounters, 74 before and 72 after implementation, were evaluated. Descriptive analyses indicate little change in the scores for habit 1 (“invest in the beginning”), habit 2 (“elicit the patients’ perspective”), habit 3 (“demonstrate empathy”), and habit 4 (“invest in the end”). This is also the case for the total score of the 4HCS. Results of the linear mixed-effects model will be presented at the conference. No statistically significant difference between before and after the implementation.

Discussion
The results indicate that the implementation program to foster SDM in oncology also had no secondary effects on patient-centered communication in audio-recorded medical encounters. These results are in line with other studies that showed difficulties in implementing SDM and patient-centered communication.

Conclusion
Further research is needed to develop implementation strategies that increase the uptake in SDM and patient-centered communication, for example targeting clinicians’ attitudes.

28: "The challenge of involving old patients with polypharmacy in their medication during hospitalization in a medical emergency department: An ethnographic study" (Oral presentation)

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Introduction

More than 70% of patients admitted to emergency departments (EDs) in Denmark are older patients with multimorbidity and polypharmacy vulnerable to adverse events and poor outcomes. Research suggests that patient involvement and shared decision-making (SDM) could optimize the treatment of older patients with polypharmacy. However, implementing SDM in clinical practice is challenging if it does not fit into existing workflows and healthcare systems

The aim was to explore the determinants of patient involvement in decisions made in the ED about the patient's medication.

Methods

The design was a qualitative ethnographic study. We observed forty-eight multidisciplinary healthcare professionals in two medical EDs focusing on medication processes and patient involvement in medication. Based on field notes, we developed a semi-structured interview guide. We conducted 20 semi-structured interviews with healthcare professionals to elaborate on the findings. Data were analyzed with thematic analyses.

Results

We found five themes (determinants) which affected patient involvement in decisions about medicine in the ED: 1) blurred roles among multidisciplinary healthcare professionals, 2) older patients with polypharmacy increase complexity, 3) time pressure, 4) faulty IT- systems, and 5) the medicine list as a missed enabler of patient involvement.

Discussion

A tailored medication conversation guide based on the SDM methodology may potentially function as a boundary object, supporting older poly-medicated patients and healthcare professionals during medication reviews in the ED and support communication across healthcare sectors to ensure that older patients receive medication aligned with their preferences and goals.

Conclusion

There are several barriers to patient involvement in decisions about medicine in the ED and some facilitators. A tailored medication conversation guide based on the SDM methodology combined with the patient's printed medicine list and well-functioning IT-systems may ensure that the medical treatment is optimized and aligned with the patient's preferences.

29: Shared decision making for supporting women's decisions about breast cancer screening: a Cochrane systematic review (Oral presentation)

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Introduction

Breast cancer screening programmes are associated with both advantages and disadvantages valued differently by women. Shared decision making (SDM) is a patient-centred approach suggested when facing preference-sensitive decisions such as screening for diseases. We aimed to assess the effects of shared decision making for women deciding whether to participate in breast cancer screening.

Methods

We searched CENTRAL, MEDLINE, Embase, CINAHL, PsychINFO, WHO International Clinical Trials Registry Platform and Clinicaltrials.gov registries and the Cochrane Breast Cancer Group Specialised Register, to December 2020. We included parallel and cluster-randomised controlled trials, quasi-randomised controlled trials, controlled before-after studies, and interrupted time series. We included interventions focusing on all the key components of SDM or at least some of them, including risk communication to support their decision. We also included studies focused on enhanced communication strategies or shared information. We used standard Cochrane methods. Our core outcomes included: satisfaction, confidence in the decision, knowledge, adherence to the chosen option, involvement in the SDM process, and patient-clinician communication.

Results

We screened 6494 studies and then assessed 119 full-text articles. We included 25 studies with results, 2 ongoing studies and 1 study awaiting classification. The included studies used different strategies to support women's decisions, mostly by the use of decision aids or other types of information materials. One study targeted only healthcare professionals, whereas the majority targeted women only or both. The final results of the review will be presented at the ISDM2022 Conference.

Discussion/Conclusion

The results of this review will contribute to the understanding of the growing body of evidence focusing on SDM interventions for different health conditions.

30: General practitioner opinions and practices regarding vaping for smoking cessation: could a decision aid help? (Oral presentation)

Author(s): *Ines Habfast-Robertson, Christina Hempel-Bruder, Eva Guttinger, Julian Jakob, Reto Auer, Kevin Selby*

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Introduction
Electronic cigarettes are the most frequently used smoking cessation tool in Switzerland. Many general practitioners (GPs) are reluctant to recommend e-cigarettes as they are not as regulated as medications and addictive due to nicotine. Conversely, many GPs adopt a harm-reduction approach because vaping is popular, less harmful than smoking and aids with tobacco cessation. We sought to describe GP's knowledge and practices regarding vaping for tobacco cessation in Switzerland.

Methods
We administered questionnaires to GPs in Sentinella, a national network of GPs that monitors seasonal influenza. We queried if they recommended vaping for smoking cessation, their perceived harm of e-cigarettes compared to conventional cigarettes and nicotine replacement on a scale of 0 to 9 (9 most harmful), and their interest in a decision aid (DA) for the choice of smoking cessation therapy.

Results
Of 170 GPs in Sentinella, 70 (41%) completed the survey. Most were men (70%), 66% were aged >50, 74% were from Germanophone and 26% from Francophone areas. The proportion of GPs who gave a score ≥7/9 for perceived harm was 10% for NRTs, 54% for e-cigarettes, and 98% for conventional cigarettes. A minority (31%) recommended e-cigarettes for smoking cessation with regional differences (56% Francophone and 23% Germanophone areas). Most GPs stated they were interested in using a DA (68%).

Discussion
While most participating GPs estimated e-cigarettes to be less harmful than conventional cigarettes, a minority recommended e-cigarettes for smoking cessation. Most were interested in using a DA for smoking cessation counselling. Future studies should explore the reasons for this reluctance and test interventions enabling patients to get balanced information on smoking cessation therapies.

Conclusion
A DA presenting balanced information about e-cigarettes for tobacco cessation could help GPs to discuss the potential benefits, risks and uncertainties of this tool for tobacco cessation, regardless of their personal beliefs.

31: Is SR used as evidence source for PDA up-to-date? Review of applicable EBM methods to assess SR currency (Poster)

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Introduction
A 2021 IPDAS review and analysis of all publicly available PDAs (n=471) found that 86% did not report any step in the evidence summarization process, and concluded "…High-quality patient decision aids should be based on comprehensive and up-to-date syntheses of critically appraised evidence". Ideally, a high-quality systematic review (SR) will already be available that matches the PDA topic. However, if the SR is not up-to-date it may lead to outdated and sometimes misleading conclusions.

Methods
We identified and summarized methods developed to determine whether new studies provide a "signal" for the need to update an SR conclusion, with the expectation that change in the conclusion may yield change in clinical practice.

Results
We included two methods, which although developed independently, converged in the most current iteration to both use as signals/triggers for updating objective and pre-specified qualitative judgments about the language used to describe the results and quantitative thresholds for differences in effect magnitude. One example of a qualitative signal includes finding a newly published pivotal trial with results opposite to that of original SR with respect to efficacy outcome (e.g., effective versus ineffective or vice versa). One example of a quantitative threshold would be if incorporation of new studies into SR's original meta-analysis changes statistically non-significant pooled estimate into statistically significant one or vice versa. We will summarize the characteristics of each of the two methods, as well as the qualitative and quantitative signals and examples.

Discussion
Qualitative and quantitative signals of potential changes in evidence that are sufficiently important to warrant SR updating can be applied to SRs used in the evidence summarization process for PDAs.

Conclusion
If the qualitative and quantitative criteria do not show a signal for updating, it provides assurance that an SR is an up-to-date source for PDA evidence summarization.

32: Retrospective evaluation of shared decision making in potentially life-threatening situations in the nursing home setting: reliability of a newly developed tool (Oral presentation)

Author(s): *Jürgen in der Schmitten, Kornelia Götze, Eva Hummers, Stephanie Klosterhalfen, Änne Kirchner, Gabriele Meyer, Michael Pentzek, Tanja Riester, Nancy Thilo, Jenny Zimprich and Georg Marckmann*

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Introduction

Nursing home (NH) residents are frequently subject of treatment decisions (TDs) in potentially life-threatening events (PLE). We developed a comprehensive tool to retrospectively evaluate the degree of SDM in PLE, and, in a pilot sample, tested its inter-rater reliability.

Methods

Charts of NH residents were screened for pre-defined PLE and related TDs in the past three months. Retrospective evaluation of each of four pre-defined sequential SDM steps was reached by an integrative judgment based on a systematic analysis of four separate sources: (a) photocopies of relevant passages of resident charts, and audio recordings of short interviews with, as far as available, (b) the resident, (c) the surrogate, and (d) the attending nurse. Altogether 27 such TD sets of photocopies and audios were presented to five raters, and inter-rater reliability was calculated (SPSS) using Randolph´s κ. Besides SDM, the raters evaluated retrospectively whether care delivered had been consistent with care preferences.

Results

Inter-rater reliability of the item *care delivered consistent with care preference* was good (κ=0.71 [KI:0.55-0.86]); of the items SDM-1 and SDM-2, *explaining the situation* and *discussing options,* was acceptable (κ=0.45 [0.28-0.62]; κ=0.43 [0.25-0.62]); and of the items SDM-3 and SDM-4, *opportunity to deliberate alternatives* and *support to reach one's own decision,* was insufficient (κ=0.37 [KI: 0.24-0.50]; κ=0.32 [KI: 0.19-0.45]).

Discussion

Retrospective evaluation of SDM in NH residents is possible using a newly developed tool that bases an integrative judgment on the systematic analysis of four separate sources. This pilot study provides insights regarding possibilities and challenges of the retrospective evaluation of SDM, and regarding possible improvements of the tool.

Conclusion

We have adjusted our tool and now plan a full-scale reliability test.

33: An experienced-based toolbox to facilitate large-scale SDM-implementation (Poster)

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Introduction

To execute the strategy on large-scale implementation of Shared Decision Making (SDM) in the Region of Southern Denmark, SDM-implementation consultants are employed at the five regional hospital units. The consultants have established a professional network to exchange experiences and facilitate a successful local implementation of SDM. The regional strategy comprises an overall model with both mandatory and adaptable components as well as overall recommendations concerning the process, education of teachers (teach-the-teacher concept), teaching of clinicians and leaders, development of Patient Decision Aids. To operationalize the regional model the network has during the past 2.5 years generated useful tools and launched different initiatives.

We hereby aim to present some of the tools and initiatives.

Methods

The professional network has supported implementation in 28 different in- and outpatient clinics where more than 1000 clinicians across professions (e.g. Nurses, doctors, physiotherapists, dietitians, etc.) have completed a course in SDM led by trained teachers. Various tools and initiatives, developed by the network, to accommodate specific needs in the different local contexts, have been consolidated and presented in a preliminary toolbox.

Results

Tools and initiatives are presented in Table 1.

Discussion

The tools and initiatives presented in the toolbox can hopefully inspire others working with SDM-implementation and illustrate that there are many different needs to be addressed to succeed in large-scale SDM- implementation.

Conclusion

A toolbox with various tools and initiatives to support the large-scale implementation of SDM hereby exists. Continuing experiences within the professional network will continuously expand the content in the toolbox.

Table 1: An experienced-based toolbox for Shared Decision Making implementation

Tool	Purpose	Description
Phrases in the patient record and a template for documentation	To support clinicians' documentation of SDM application. To align documentation of SDM in patient records.	Documentation templates containing pre-defined sentences following the elements in the Three talk model.
Catalog of measurement methods	To list different measurement instruments on progression in or effect of the implementation.	The catalog presents different measurement instruments like OPTION12 and CollaboRATE, and suggests methods on how to follow the progression of the implementation.
Local newsletter	To exchange experiences and give inspiration across clinics to ensure continuous attention to SDM.	The newsletter covers short reports on successes and challenges at the various clinics, presents publications from the hospital, and other relevant news.
Short SDM presentations and events	To increase awareness of SDM at different levels of the organization and to facilitate stepwise implementation.	Short SDM presentations and events held at different meetings, in different settings, or/and in different clinics.
Observations and feedback	To promote transfer from SDM theory into SDM practice.	After the teaching of clinicians, an observer participates in the clinical encounter and provides structured feedback to the clinician on the SDM practice.
Template for a Gantt chart	To plan and visualize the different steps in the implementation process.	A template helps the clinics to organize the implementation by visualizing the different steps in the process.
Evaluation of Teach-your-Colleagues	To ensure a high standard when trained teachers teach their colleagues. To discover if changes are needed in the teaching setups. To be able to compare the quality and benefits of the "Teach-your-Colleagues" lessons across clinics.	A questionnaire developed to evaluate "Teach-your-Colleagues" lessons. Participants scan a QR code at the end of the lesson, which will forward them to the questionnaire.
Guideline(s) for development and use of a Decision helper	To ensure organizational alignment in the development of PtDA´s. To ensure clear and distinct roles and responsibilities concerning the clinical content in the PtDA.	A guideline with a clear description of the development process, version control of the PtDAs, roles and responsibilities.
Support materials and FAQ´s	To increase awareness of SDM.	Supportive material to print and display.
Film about SDM in health promotion	To present how SDM can be used for health promotion.	Short film on hospitals local intranet.
Animated film about SDM in psychiatry	To present SDM so that it relates to a psychiatric context.	Short film on hospitals local intranet.
Template to elaborate the elements in the Three talk model	To support the clinicians in the practical application of SDM.	The template provides instructions to the clinicians on SDM performance, supporting sentences to each element of the Three talk model as well as pre-defined sentences for documentation.
Implementation guide	To provide an overview of the different steps of the implementation process.	The guide describes and expands each of the different mandatory and adaptable components in the regional implementation process. The guide is a reference work for coordinators, leaders, teachers, or clinicians involved in the development of PtDAs etc.
Application of various quality development methods	To ensure that the implementation of SDM is not "a stand-alone initiative" but linked to other quality development methods e.g. The South Danish Improvement model.	Plan-Do-Study-Act (PDSA), which is a framework for the development, test, and implementation of changes. Organizational user involvement e.g. feedback meetings.
Template to support interdisciplinary learning and quality assessment	To support clinics in SDM-implementation by using an interdisciplinary quality assessment tool that combines the elements of a patient **tra**cer (interview) and a patient records au**dit** (TRADIT).	TRADIT consists of a set of indicators for audit of patient records and patient interviews. An interdisciplinary team led by trained internal surveyors conducts 12 annual TRADITs on selected patient cases in each hospital clinic.
Intranet site	To support local communication about SDM and give simple and efficient access for clinicians and clinics to documents, services, and news.	The local Intranet sites presents latest news, documents for use in the clinics, publications, etc.
E-learn on SDM theory (work in progress)	To accommodate the clinics need for flexibility in how to plan and when to carry out the teaching of clinicians.	Teach-your-Colleagues, in its original form, requires presence of the clinicians. E-learn material on the theoretical part of SDM provides more flexibility in how to plan and when to carry out the teaching in the clinics.

34: Early evaluation of “Teach-your-Colleagues” sessions at Odense University Hospital (Oral presentation)

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Introduction

Odense University Hospital (OUH) adheres to the Region of Southern Denmark’s implementation strategy of Shared Decision Making (SDM). Health care professionals from each hospital department are trained by SDM teachers to teach their own colleagues. These “Teach-your-Colleagues” sessions varies from 4-6.5 hours in groups of 7-20 participants. The purpose of this inventory is to present preliminary data from the participant evaluation of “Teach-your-Colleagues.”

Methods

Data were collected in November/December 2021. Five SDM-sessions in three different departments were evaluated. After the first three sessions, a link to the questionnaire was distributed to the participants by mail 2-3 weeks after participation. However, due to a low response rate, the evaluation of the two last sessions was completed at the end of the sessions using a QR code.

Results

33 of 41 participants filled in the questionnaire. Answers to open-ended questions showed that the participants appreciated the alternation between theory, discussion and simulation exercises and found that room for discussion and reflection on their clinical practice was essential. Participants overall rated the teaching as *good* or *very good*. One-fifth of the participants rated the facilities as *okay* or *less good*. The remaining results are presented in figure 1.

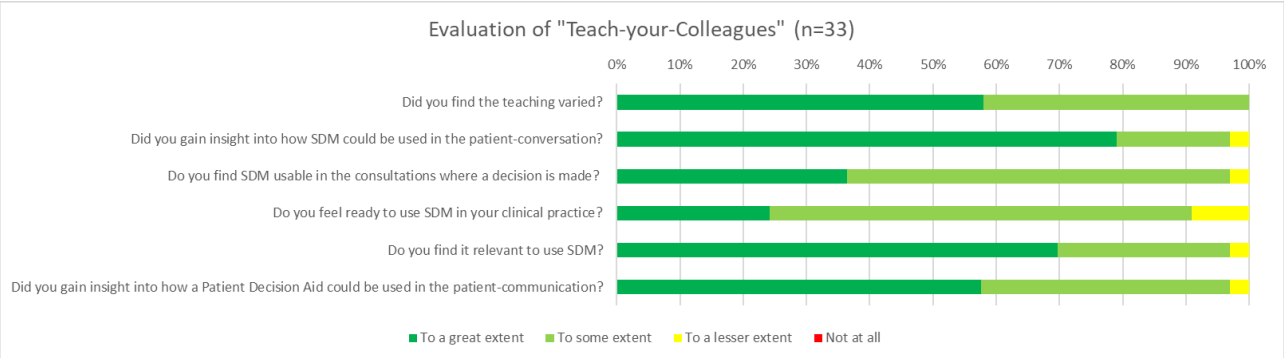
Discussion

Evaluation of “Teach-your-Colleagues” sessions is essential in order to continuously adapt the teaching and thus ensure the quality and benefits of the teaching. Mandatory evaluation of teaching sessions will allow us to compare different teaching setups internally as well as across departments.

Conclusion

Respondents in general evaluated “Teach-your-Colleagues” sessions as being good, varied and found SDM relevant to their clinical practice.

Figure 1: Early evaluation of “Teach-your-Colleagues” sessions at Odense University Hospital



35: Assessing efforts of making care fit for each patient – A systematic review (Oral presentation)

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- Mayo Clinic Libraries, Rochester, MN, USA.

Introduction

The recently published 'Making Care Fit Manifesto' calls to foster efforts to make care fit for each patient. We aimed to summarize measures of patients and clinicians working together to design care plans that fit.

Methods

We systematically searched several databases from inception to Sept-2021 for studies using quantitative measures to assess, evaluate or rate behaviour (of any party) during real-life encounters. We extracted all items from relevant measures and coded them deductively on themes relevant to Making Care Fit, and inductively on main action described.

Results

We included 189 of 13.338 papers, reporting on the use of 1243 measurement items from 151 measures. We identified the most items in themes "Patient-clinician collaboration-content" (N=396, 31.8%) and "-manner" (N=382, 30.7%). We identified the least items in "Ongoing and iterative process" (N=22, 1.8%) and in "Patient lives" (N=29, 2.3%). The most often identified action terms were "Informing" (N=308, 24.8%) and "Exploring" (N=93, 7.5%). The least often identified action terms were "Following up", "Comforting", and "Praising" (each N=3, 0.2%) (see Figure).

Discussion

Assessing efforts of Making Care Fit focuses heavily on the content of patient-clinician collaborations and on the act of informing. Other themes and efforts previously identified as crucial to Making Care Fit are hardly assessed, or not at all.

Conclusion

Our review suggests that research to date is not assessing the full breadth of Making Care Fit and that appropriate measures seem to be missing. This may limit the assessment and successful implementation of efforts to improve patient care.

Figure 1: Distribution of included measurement items across themes and action terms relevant to Making Care Fit.

		THEMES						
		Patients' unique situation	Patient priorities	Patient lives	Patients' loved ones and social networks	Patient-clinician collaboration (content)	Patient-clinician collaboration (manner)	Ongoing and iterative process
ACTION TERMS	**N**	**198**	**89**	**29**	**32**	**396**	**382**	**22**
Facilitating patient involvement								
Involving	**60**	2	8	0	3	46	1	0
Co-creating	**13**	0	2	0	0	10	0	1
Encouraging	**31**	6	1	0	3	15	6	0
Allowing	**43**	10	6	0	1	16	9	1
Adjusting to individual patient								
Tailoring	**5**	2	0	0	1	1	1	0
Tailoring care	**14**	4	10	0	0	0	0	0
Tailoring language	**44**	0	0	0	0	0	44	0
Providing information								
Informing	**308**	35	14	7	10	225	4	13
Being transparent	**15**	1	0	0	0	13	1	0
Addressing	**41**	14	2	0	1	20	4	0
Gathering/having needed information								
Exploring	**93**	35	24	8	4	18	4	0
Understanding	**58**	40	3	1	1	3	10	0
Checking	**30**	5	2	2	0	21	0	0
Following Up	**3**	0	0	0	0	0	0	3
Making human connection								
Caring	**26**	3	2	3	0	0	18	0
Connecting	**52**	3	0	0	0	1	48	0
Sympathizing	**22**	5	1	0	0	0	16	0
Respecting	**61**	12	2	0	0	0	47	0
Being courteous	**70**	1	0	0	0	0	69	0
Comforting	**3**	0	0	0	0	0	3	0
Giving attention								
Showing interest	**45**	10	7	2	1	0	25	0
Listening	**49**	4	1	0	0	0	44	0
Noticing	**15**	2	2	1	2	0	8	0
Ignoring	**9**	2	0	0	0	1	6	0
Self-Efficacy building								
Praising	**3**	0	0	1	1	0	1	0
Reassuring	**6**	1	0	0	0	2	3	0
Supporting	**29**	1	2	4	4	4	10	4

36: Shared decision making for Atrial Fibrillation: An overview of seven studies within an encounter- randomized trial (Oral presentation)

Author(s): *Marleen Kunneman, Megan Branda, Ian Hargraves, Angela Sivly, Alexander Lee, Haeshik Gorr, Bruce Burnett, Takeki Suzuki, Elizabeth Jackson, Erik Hess, Mark Linzer, Sarah Brand-McCarthy, Celia Kamath, Juan Brito, Peter Noseworthy, Victor Montori for the Shared Decision Making for Atrial Fibrillation (SDM4AFib) Trial Investigators*

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Introduction

Shared decision-making (SDM) about anticoagulant treatment in patients with atrial fibrillation (AF) is widely recommended but its effectiveness is unclear. We assessed the extent to which using an SDM tool promotes high-quality SDM.

Methods

In this multicentre encounter-randomized trial, we included patients with nonvalvular AF considering starting/reviewing anticoagulation, and their clinicians. We compared usual care with or without ANTICOAGULATION CHOICE, an SDM conversation tool for use during the clinical encounter that presents individualized risk estimates and compares anticoagulation options across patient important issues.

Results

We enrolled and video-recorded 922 patient-clinician encounters.

- Participants in both arms reported near-optimal communication quality, knowledge, and decisional conflict (JAMA IM-2020).
- Patients in intervention-arm estimated their stroke risks more accurately and were more involved in decision-making (JAMA IM-2020), clinicians were more satisfied (JAMA IM-2020), and cost conversation were more common (JAMA NO-2021).
- Use of the intervention had no effect on treatment decisions, encounter duration (JAMA IM-2020), treatment adherence, clinical outcomes (JAHA-epub) or patient-perceived sense of the care plan (PEC-epub).
- Compared to eligible white participants, black participants more frequently did not enrol to the study. Enrolment of Black, indigenous, and people of colour benefited most form including and prioritizing practices most likely to care for them (submitted).
- We found no evidence of contamination (tool use, functional, or learned) between study arms (forthcoming).
- Clinicians' recommendation on whether or how to anticoagulated had no influence on patient involvement (forthcoming).

Discussion

Use of an SDM tool improved some measures of SDM quality, without affecting treatment decisions and their sensibility, encounter duration, patient adherence, or clinical outcomes.

Conclusion

Our results should calibrate expectations as to what could be accomplished by implementing SDM tools about anticoagulation in the care of patients with AF.

37: User experience of a digital decision aid for prenatal trisomy screening: assessment of its utility and usefulness (Oral presentation)

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Introduction

We developed a digital decision aid (dDA) to help parents make informed value congruent decisions about prenatal trisomy screening. We aimed to assess the usability and usefulness of our dDA among parents, health professionals and decision-makers.

Methods

Embedded in a mixed-methods sequential explanatory study, we planned to recruit a convenient sample of 45 pregnant women with/without their partners, 45 health professionals, and 15 decision-makers. Women were >18 years old and >16 weeks pregnant or had given birth recently. Health professionals and decision-makers were involved in prenatal care. We asked participants to navigate the dDA, and using validated tools, we collected data: 1) from parents on perceived usefulness and self-efficacy; 2) from all participants on usability, quality, and sociodemographic data. We performed descriptive analysis for each category of participants.

Results

66 participants were surveyed (45 pregnant women with/without their partners, 14 health professionals and 8 decision-makers). Most women (76%) and partners (51%) were 25-34 years old and Caucasian (93% women, 89% partners). Health professionals (7 midwifes, 3 obstetrician-gynecologists, 3 family physicians and 1 neonatologist) were mostly 35-44 (36%), female (79%), and all Caucasian. Most decision-makers were 45-54 (36%), female (62%) and all Caucasian. Main results are presented in Table 1.

Discussion

Participants found that the dDA improved self-efficacy for decision making, was helpful for preparing for decision making, usable, and overall of good quality and were satisfied with its content.

Conclusion

We found that the dDA has the potential to help parents make informed decisions about prenatal screening for trisomy.

Table 1: Participants' perceptions of usability, quality and satisfaction with the content of the dDA

Variables, Score means (SD)	**All three populations (n=65)***	**Pregnant women & partners (n = 45)**	**Health professionals (n = 13)***	**Decision makers (n = 8)**
Perceived usefulness	NA	79.9 (13.4)	NA	NA
Self-efficacy	NA	88.0 (10.6)	NA	NA
Usability (S.U.S)	82.6 (14.4)	83.9 (14.3)	76.5 (14.0)	79.4 (22.5)
Engagement	62.7 (14.4)	64.7 (13.5)	*58.4 (14.0)*	*57.9 (17.0)*
Entertainment	*52.9 (22.5)*	*55.0 (23.0)*	*41.7 (20.4)*	60.7 (18.2)
Interest	82.2 (20.3)	84.4 (18.7)	71.2 (23.7)	89.3 (18.2)
Customizable	*44.7 (23.0)*	*44.8 (24.2)*	*47.5 (18.2)*	*39.3 (26.2)*
Interactivity	*52.9 (24.9)*	*55.6 (23.8)*	*51.9 (18.2)*	*39.3 (37.5)*
Target group	78.1 (21.4)	83.3 (18.5)	71.2 (19.2)	60.7 (29.4)
Functionality	90.5 (9.9)	92.4 (7.9)	82.7 (13.3)	92.9 (9.2)
Aesthetic	82.1 (13.6)	83.5 (12.4)	74.4 (16.5)	86.9 (11.6)
Information	79.6 (13.1)	81.1 (11.6)	72.4 (17.5)	83.4 (10.1)
Global evaluation	78.7 (9.9)	80.4 (8.9)	71.9 (11.7)	80.3 (8.7)
Satisfaction	81.5 (13.7)	84.4 (12.6)	72.8 (16.3)	73.4 (19.8)

All scores are out of 100
*Missing data=1
NA = not applicable, SD = standard deviation
Lowest scores (below 60) are in italics

38: Web-Based Training for Nurses on Using a Decision Aid to Support Shared Decision-Making About Prenatal Screening: Parallel Controlled Trial (Oral presentation)

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Introduction

We developed a web-based training program on shared decision making (SDM) with pregnant women about prenatal screening. We assessed its impact on nurses' intention to use a decision aid (DA) for this purpose.

Methods

In this 2-arm parallel controlled trial, a survey firm recruited nurses working with pregnant women. They were allocated by convenience either to the intervention (web-based course on prenatal screening with SDM) or to the control (web-based course on prenatal screening without SDM). The primary outcome was intention to use a DA. Secondary outcome were psychosocial variables of intention, knowledge, satisfaction, acceptability, perceived usefulness and reaction to the pedagogical approach. Outcomes were self-assessed using online questionnaires. We used Student's t test and Fisher's exact test to compare variables between groups.

Results

Of 57 participants assessed for eligibility, 40 were allocated to the intervention (n=20) or control group (n=20) and 36 (n=18 in each) completed the courses. Mean age of participants was 41 years (SD=9). Most were women (97.5%), Caucasian (95%), and clinical nurses (70%). Post-intervention, the mean score of intention was 6.3 (95%CI: 5.9;6.7) for the intervention group and 6.0 (5.42;6.64) for the control group. Differences in intention and other psychosocial variables were not statistically significant. The intervention group gained higher knowledge scores about SDM (79% [70;89] versus 64% [57;71], p=0.009), found their course more acceptable (4.6 [4.4;4.8] versus 4.3 [4.1;4.5]; p=0.02) and reacted more positively to the pedagogical approach (4.7 [4.5;48] versus 4.4 [4.2;4.5], p=0.02). There was no significant difference in satisfaction or in perceived usefulness.

Discussion

This study showed that nurses' intention to use a DA to enhance SDM in prenatal care is already high, with SDM training or without. Knowledge about SDM was higher after training with SDM than after training without.

Conclusion

Our results will inform future strategies for implementing SDM behaviors.

39: How to best work towards a structured conversation with the Outcome Prioritization Tool: an implementation study (Oral presentation)

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Introduction

Understanding values and preferences of patients suffering from cancer is essential and should be considered when making treatment decisions. The preference step of shared decision making (SDM) is often neglected. Effective measures to support SDM should be integrated efficiently into routine clinical practice and the patient journey. This study aimed to support elicitation of patient preferences and values and to co-design strategies for implementation for the use of a short conversation tool, the Outcome Prioritization Tool (OPTool). The OPTool facilitates the exploration of which treatment outcomes matters most to the patient during a guided conversation with the nurse.

Methods

This mixed method study uses a co-creation method informed by nurses. Oncology nurses of three Dutch hospitals and their patients participated. Focus groups gave insight in nurses' views and needs concerning the implementation of the OPTool. Tools such as a manual for the conversation and how to report the outcome in the patient file for the nurses and an information leaflet for patients were created. An educational session supported implementation. Nurses tried to work according to the guidance and 15-25 structured OPTool conversations between them and their patients were audio-taped. Content analysis was used.

Results

Application of the OPTool conversation and reporting the outcome in patient files seems acceptable and feasible in daily clinical practice for certain subgroups of patients. The OPTool conversation helped these patients to reflect on what matters to them.

Discussion

The OPTool seems a meaningful support in the preference talk of SDM. This study explored barriers and needs to the OPTool conversation and is a first step for implementation in clinical practice.

Conclusion

Further steps are needed to integrate the outcome of the OPTool conversation in other parts of the clinical pathway such as in multidisciplinary team meetings and to inform the final treatment decision.

40: Analyses of Dutch Patient Decision Aids on performance of risk communication for patients with limited health literacy: a mixed method study (Oral presentation)

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Introduction

Patient decision aids (PtDAs) support shared decision making (SDM). They provide information about medical options by presenting their pros and cons verbally, numerically or visually. It is known that communication of options and risks is a challenge for the relevant subgroup of patients with limited health literacy. This study examined how well Dutch PtDAs seem aligned to the needs of patients with limited health literacy and the recommendations for risk communication for these vulnerable patients.

Methods

In a descriptive document analysis, we analyzed N=206 Dutch PtDAs that meet the minimum International Patient Decision Aid Standards criteria for PtDAs. Based on key literature we created a data extraction sheet and extracted general characteristics and risk communication aspects.

Results

Patients with limited health literacy were mostly not involved in development of PtDAs. Verbal risk communication is often used, without contextualization. Neutral framing is not applied. Natural frequencies and percentages are frequently used, and the reference group is usually named. For visual risk communication mainly icon arrays are utilized. Uncertainty is presented verbally, if communicated. Other innovative manners (e.g. graphical animation) are seldomly used. A small subsample of PtDAs was developed together with patients with limited health literacy. Those PtDAs did not include the typical matrix format with choice table or option grid and numerical risk communication but verbal risk communication and illustrations about behavior and treatment.

Discussion

Current risk communication performance in Dutch PtDAs seems to be too sophisticated for patients with limited health literacy. The effectiveness of the PtDA format developed together with this patient group, that did not include a matrix and no numerical and visual risk communication is unclear.

Conclusion

Adapting PtDAs to the needs of patients with limited health literacy will be beneficial to involve all patients in SDM. More research is needed to examine suitable formats.

41: What type of thing are we talking about, anyway? (Oral presentation)

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Introduction

In COVID vaccination stand-offs, “fact” for one person is “fake” for another. Describing the effects of vaccines is counter-productive against positions or beliefs. Most patient-clinician interactions aren’t this extreme. Yet, the issue of what types of things can productively be discussed to make good decisions remains. Broadly, SDM discusses problems, options, and preferences. Yet one person’s problem, “your blood sugar is too high” is not another’s “I can’t afford my insulin”. It’s not that they don’t share priorities, what type of problem diabetes is, is different. For the clinician diabetes is the effects of excessive blood glucose, for the patient, the day-to-day impediment to life. SDM is unlikely to be productive unless the clinician can switch from talking about effects to situations. Otherwise, they’re discussing fundamentally different things.

Methods

Using a directed-content analysis based on Purposeful SDM and McKeon’s interpretive-orientations model we identified different types of things that are problems, options, and desires in video-recorded encounters.

Results

Patients and clinicians commonly talk about different types of things. E.g. The clinician describing a problem as the effects of osteoporosis, and the patient expressing the problem as a position “I won’t take medicines”. It was unproductive when this was unrecognized or not responded to. We produced a table distinguishing different “things” patients and clinicians talk about.

Discussion

While discussing the same topic, patients and clinicians may be talking about different things.

Conclusion

Evidence, decision aids, and medical science mostly discuss effects. Inclusiveness of other types of “things” is important in SDM.

Figure 1: Types of "things" in patient-clinician conversations

Types of things discussed	What type of thing is a problem?	What type of things is an option?	What type of thing is a preference?
Effects	**The effects of an illness process** E.g., the effect of blood pressure on stroke risk, the effect of smoking on lungs, the effect of breast cancer on mortality. Effects are commonly expressed as risks.	**A counter-effect** E.g., Statins lower your risk of heart attack, chemotherapy fights cancer, vaccinations prevent infection. **With side-effects:** E.g., May cause: weight loss, insomnia, require you to inject the medicine twice daily	**A reaction.** The effect that the likely effects of illness and options has on the person
People's **positions**	**An unacceptable or conflicted position**. *I can't accept all this acne.* *It's unacceptable that I can't have a child.* *My husband's alcohol use is unacceptable.*	**A possibly acceptable position.** *Could you accept adoption?* *Would you be willing to ask your husband to talk to someone about his alcohol use?* **Requiring compromises or acceptances** *I have my heart set on being pregnant, but if adoption allows me to have a family…*	**An (un)willingness to accept**
Problematic **situations**	**An unworkable and emotionally fraught situation.** *I can't get the joint replacement I need because I am too heavy for surgery, but I can't exercise to lose weight because my hip hurts.*	**A potential way of resolving** the situation expressed as a hypothesis: *Would having a physical therapist come to your home to work on your hip be possible?* With **limitations** to be problem solved: *I don't think that I can afford a physical therapist.*	The **(un)desirable qualities** of a hypothetical course of action and how it might change the situation.
Existential **Truths**	**A fracturing of self** *I can't be who I am living as woman.* *Dialysis is turning me into someone I am not.*	**A glimpse of an existential truth** *It's time to stop dialysis.* **With existential doubt** *My family would give up on me if I stop fighting.*	A **recognition** that what is said is existentially true or untrue.

42: SDM from a problem-based perspective. Summarizing Purposeful SDM (Oral presentation)

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Introduction

SDM has been conceptualized in several ways throughout its development, with each orientation furthering research and SDM practice in new and fruitful directions. Recently, a new perspective on SDM was formed by asking “What problem is SDM the solution to?” and proposing as a response “The problem that the patient is experiencing.” This casts the purpose of SDM as figuring out how best respond to that problem. This perspective led to the development of the Purposeful SDM schema, opened up new research questions, insights into SDM, approaches to SDM education, and directions for intervention development.

Methods

We sought to summarize the key findings of research drawing on the Purposeful SDM schema.

Results

This body of research has shown that:

- There are several distinctly different types of problems that require patients and clinicians to make decisions together. (PEC 2019)
- Each of those problems utilize fundamentally different SDM methods of working out how to respond to the problem
- (weighing, negotiation, problem-solving, insight-development). (PEC 2019)
- Generalized models of involving patients in making decisions do not account for necessary problem-specific variation in deliberation methods. (PEC 2020)
- Each SDM method conceives of, and utilizes, key SDM terms (e.g. option, preference, involvement etc.) in different ways. (PEC 2020)
- Current SDM observer measures only detect the use of 1 of 4 SDM methods—weighing (PEC 2021)
- Change in SDM method is discernable in clinical encounters (Forthcoming)
- The method of weighing pros/cons/preferences is often not the most common form of SDM in encounters. (Forthcoming)

Discussion

The Purposeful SDM schema has usefully distinguished different kinds of SDM that correspond with different types of patient problems. The model’s conceptual framework is consistent with empirical findings.

Conclusion

Purposeful SDM schema provides an additional perspective that can be used to advance SDM research and practice in new directions.

43: Shared decision-making between paediatricians and children with sickle cell disease or thalassemia (Oral presentation)

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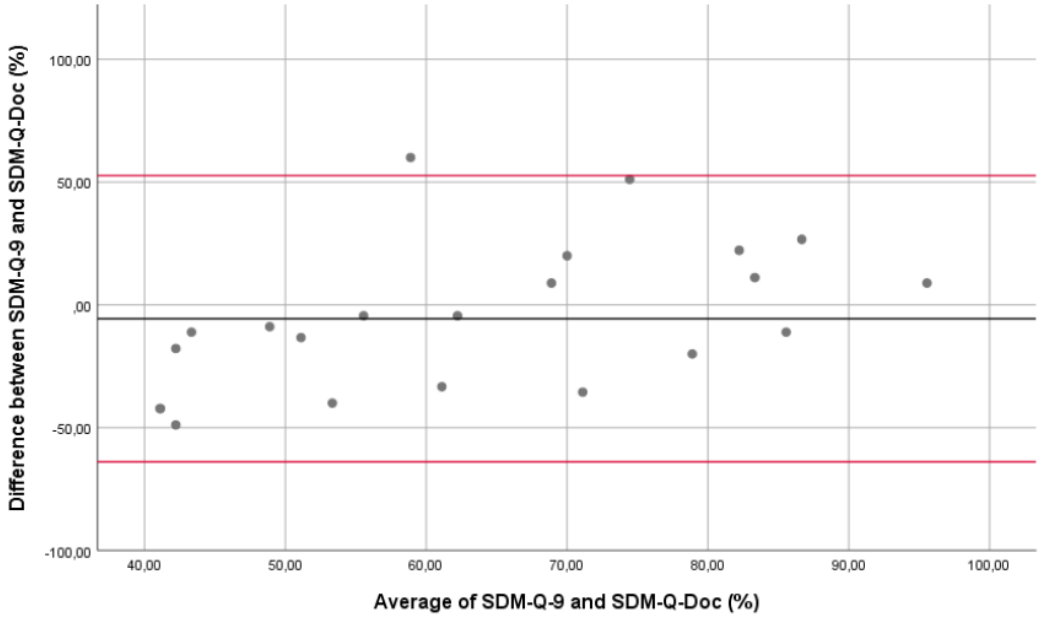
Introduction
Shared decision-making (SDM) in paediatrics is still relatively new. In children with sickle cell disease (SCD), many decisions need to be taken over time. The objective of this study was to assess if and to what extent paediatricians engage (parents of) children who suffer from SCD in the decision-making process during consultations.

Methods
Children suffering from SCD and visiting the outpatient paediatric clinic were studied after informed consent. Two evaluators analysed audio-recordings of the consultations to score the level of patient involvement in the decision-making process, using the OPTION-5 instrument. Also, patients (or parents) were asked to fill in the SDM-Q-9 questionnaire, while paediatricians were invited to complete the SDM-Q-Doc questionnaire. None of the paediatricians had attended SDM-training previous.

Results
Twenty-four consultations were audiotaped, with a minimum of 5 from each paediatrician. Children's ages ranged from 2 to 17 years. Patients median SDM-Q-9 scores were moderate: 56,6% (IQR 36,7 – 88,9%) and 3 out of 22 patients (13,6%) gave the maximum score of 100%. Physicians SDM-Q-Doc median scores were higher 63,6% (IQR 56,7 – 77,8%). In comparison the median OPTION-5 scores were lower: 25% (SD: 12%). Questions regarding patients and parents preferred involvement in SDM and doublechecking their understanding of the information, were underrepresented.

Discussion
SDM in children with chronic diseases like SCD shows room for improvement, possibly because of cultural barriers and the fact that three stakeholders are involved: child, parent and the clinician, who may not always agree upon the course of action regarding the treatment policy.

Conclusion
Currently, (parents of) SCD patients are insufficiently involved in the decision-making process during their care path. This is reason for future interventions to improve patients', parents' and paediatricians' awareness and skills regarding SDM.



44: Challenges and opportunities for shared decision-making in paediatrics (Oral presentation)

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Introduction

Both children's legal age and cognitive capabilities pose unique challenges for shared decision-making (SDM) in paediatrics. Principles like the 'Best interests of the child', the right to be heard, and the right to participate, call for SDM. However, it is unclear how and to which extent SDM takes place in paediatrics in various countries, especially among chronically ill children.

Methods

A systematic review was conducted, including studies that applied a SDM-intervention for (parents of) children between 4 and 18 years old with a chronic disease.

Results

Nine experimental and observational studies, conducted in USA, Canada, Australia, and Egypt and involving 2007 children, were found that applied patient or parent decision aids, questionnaires or an SDM-toolkit. Most of these were not adapted to the paediatric setting. Overall risk of bias in these studies was moderate. Children suffered from chronic disorders such as neuromuscular scoliosis, diabetes, asthma, juvenile inflammatory arthritis, obesity, and depression.

Perceived involvement in SDM and disease-related knowledge increased amongst children, adolescents, and caretakers following these interventions. Two studies addressed decisional conflict scores and found reductions of 15.9 out of 100 and 17.8 out of 100 points, respectively, which was associated with higher satisfaction with the decision aid among children, parents, and clinicians.

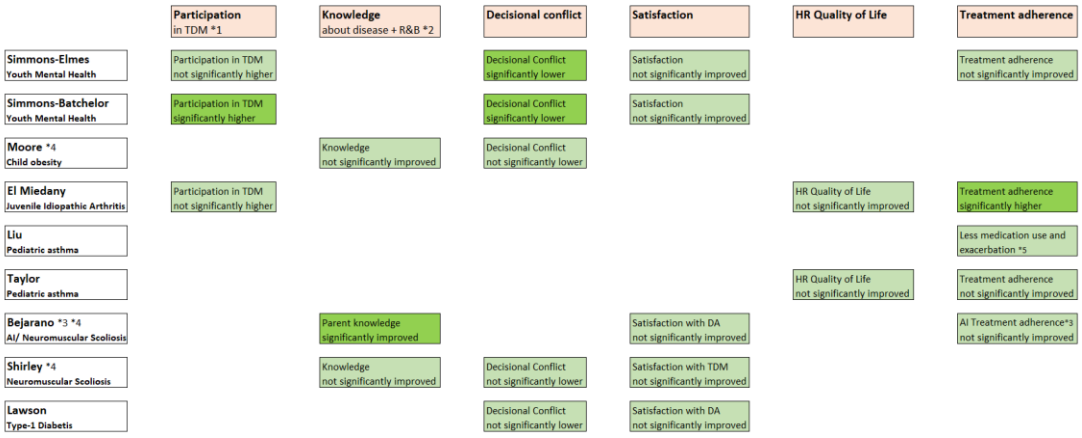
Discussion

Currently, underage patients with chronic illnesses are insufficiently involved in the decision-making process during their care path, possibly because of ethical, practical and cultural barriers. Given the rapid developments in medical technology, more research is also needed to explore how technologically advanced decision aids could help facilitate the quality of pediatric SDM, without excluding socially marginalized or otherwise disadvantaged groups.

Conclusion

Stakeholders should advocate initiatives to incorporate a child's participation preferences regarding paediatric SDM. Decision-making support tools help chronically ill children from all backgrounds to be more involved in SDM as these increase their knowledge and satisfaction and reduce decisional conflict.

Figure 1: Statistical significance of health outcomes after the use of decision aids in pediatric SDM.



** 1 TDM, treatment decision-making. *2 R&B, risks and benefits of treatment options.*3 AI, allergenic immunotherapy. *4 Combined child and parent scores.*5 Delayed time to exacerbation and decreased risk of exacerbation*

45: User-centered design of a tool for shared agenda-setting for people with type 2 diabetes (Oral presentation)

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Introduction
The care of people with type 2 diabetes (T2D) requires regular attention to a wide range of issues. There is a risk that clinic visits become dominated by topics defined by healthcare professionals at the expense of concerns of importance to service-users. We designed a tool for shared agenda setting.

Methods
At the T2D clinic at SDCC and based on the nurses' desire to improve their practice, we focused on their annual check-up encounters with service-users. Our design thinking process involved emphasizing, defining, ideating, and iterative prototype user-testing of the tool. We conducted workshops, interviews, focus groups, and a questionnaire.

Results
Seven pocked-format 2-sided Conversation Cards on topics of high potential relevance was designed. The content was informed by clinical experiences, international guidelines, and adapted after critically assessment by service-users (See Figure 1). An instruction card was added on how to introduce the cards to service-users.

The cards successfully enabled service-user to engage in agenda setting and to influence the content of the check-up encounters. In order of priority, the common agenda dealt with Medicine, Symptoms, My health, Life with diabetes, Thoughts and feelings, Sexual intimacy, and Other things.

Discussion
The readiness among service-users was mixed. A clear invitation is needed for them to consider and articulate their needs. The intervention was demanding for the nurses because their performance of tasks took on less predictable dimensions. The cards led to recognition by the nurses of what competencies they need, e.g. for conversation about sexual issues.

Figure 1: The initial and the adapted conversation Cards

46: A systematic approach to develop clinicians Shared Decision Making skills using the OPTION12 instrument (Oral presentation)

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Introduction

When practicing Shared Decision Making (SDM), important elements include choice, option, preference and decision talk. Nevertheless, clinicians do not always make effort in addressing all four elements or they conceive they are already practicing shared decision making to the right extent already. This study aimed to investigate which SDM elements are given the least focus and how/if they change before and after an SDM implementation effort.

Methods

A project nurse performed observations of clinical encounters in four different departments using the OPTION12 observational tool, before and after implementation of SDM methods in oncology clinics. All twelve OPTION12 items were scored according to the scoring manual and afterward each was allocated to the four elements of choice, option, preference, and decision talk to assess how the clinicians performed on the four key elements.

Results

A total of 117 observations were performed before (n=63) and after (n=54) the implementation of SDM. Choice and decision talk showed the lowest mean score at baseline (2.87 and 3.21, respectively). Choice and option talk showed the largest improvement (1.67 and 2.1, respectively). Individually, all four categories showed a significant difference in mean; choice (1.67, p=0.0001), option (2.1, p=0.0000), preference (1.18, p=0.0240) and decision (1.35, p=0.000).

Discussion

Performing live observations creates a focus on the SDM implementation process from the start and is a way for management to visibly indicate a transition phase where the old approach needs to be abandoned and a new one adapted.

Conclusion

Real-life observations combined with the four vital SDM elements are a way to provide insight and useful knowledge for further SDM implementation. Subsequently, it can potentially pinpoint the opportunity for a more targeted effort for further development of the clinicians' skills.

47: Development and evaluation of a concept for training of leaders preparing them for shared decision-making implementation (Oral presentation)

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Introduction

Shared decision-making (SDM) research projects concludes that leadership in SDM implementation is essential for implementation success. As part of a large-scale real-world SDM implementation effort in Denmark, this cornerstone was made a mandatory and prominent part of the effort. The implementation effort was facilitated by the Regional Center for Shared Decision Making (CFFB).

Methods

A concept for "Training of Leaders" (ToL) was developed by the SDM trainer and COO from CFFB. It aimed to provide knowledge of SDM and awareness of the role of leadership. A three-hour course with a workshop format was deemed feasible. It included evidence of SDM, goals of implementation, time for reflections, and discussions in plenary.
ToL was tested and adjusted at one hospital, before spreading to four other hospitals. The course was evaluated one month after the course, using an electronic questionnaire.

Results

165 department leaders participated in ToL. 147 were sent the questionnaire. 48 % were nurses, 38 % physicians and the rest represented other groups of leaders. 71 % rated the course 4 or 5 on a five-point Likert scale where 5 is the best rating. See table 1 on the next page.

Discussion

Even though the majority rated the course highly, the same majority did not all manage to launch activities in their department. This might be related to everyday operations being a barrier for leaders' possibility of working with SDM.

Conclusion

The concept of ToL in the Region of Southern Denmark has proven relevant for leaders, no matter managerial level in the organization.

Table 1: Training of Leaders (ToL)

Training of Leaders (n=90) Response rate 90/147 = 61%	Don't know	Not at all	A little	To some extent	A great deal
To what extent did you achieve sufficient knowledge of Shared Decision Making	0	1	3	30	56
To what extent do you think Shared Decision Making is relevant to your clinical practice	0	1	3	18	68
To what extent did the training make you aware that you are important as a leader for the implementation of SDM in my department	4	0	5	26	55
To what extent did you find the training relevant for you	0	0	12	27	51
To what extent did you after the training launch initiatives or activities related to SDM in your department	3	8	25	33	21

To what extent do you think a duration of three hours is appropriate?	Appropriate	To long	To short	I don't know
	70	11	1	8

Scale: 1 is worst, 5 is best	1	2	3	4	5
What is your overall assessment of the training for leaders	4	2	20	34	30

Which of the following statements describes your attitude towards the coming implementation of Shared Decision Making in your department the best? (several ticks allowed)

I am surprised how much it takes	I think it makes sense	It makes me reflect on my clinical practice	Of course, we are going to do this	It is going to be difficult on a busy day, but I am confident	It is going to be difficult on a busy day, and I don't know how to succeed	I am looking forward to begin-ning	I think it's unmanage-able	It is just another deman-ding task	I don't know
16	75	50	56	44	2	34	3	2	1

48: SDM:HOSP" – a generic model for hospital-based implementation of Shared Decision Making (Oral presentation)

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Background

Shared decision making (SDM) has proved difficult to implement in routine clinical practice. One of five Danish regions responsible for public healthcare set out to develop a model that can ensure lasting SDM based on learnings from large-scale real-world implementation. The study aims to describe process and development of a generic model, SDM:HOSP, for systematic implementation of SDM.

Methods

The implementation was performed in the Region of Southern Denmark with five major hospital units, including mental healthcare. Based on existing theory of SDM, SDM implementation, implementation science and improvement methodology, a process of four phases was launched; development of conceptual elements, field-testing, evaluation, and development of the final model. Field-testing included continuous participant evaluations and an overall evaluation was done.

Results

Evaluations illustrated relevant content of educational training activities and a meaningful development process of Decision Helpers. The overall evaluation pointed at useful systematic elements in the implementation process itself. The final SDM:HOSP implementation model included four elements – please see figure 1.

Discussion

The implementation of SDM is a result of complex interventions, and patients are important partners in this process. Patients were included in all aspects of this study, but there is a need for further focus on education and preparations of patients to participate in SDM.

Conclusion

A feasible and acceptable model for implementation of SDM across hospitals and departments that accounts for different organizations and cultures was developed. The overall design can easily be adapted to other organizations and be adjusted to fit the specific organization and culture.

Figure 1: SDM:HOSP

49: Implementation of Shared Decision Making in a Gynecologic outpatient clinic (Poster)

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Introduction

Implementing Shared Decision making (SDM) is challenging when education has to be put into practice in a busy outpatient clinic. Within an implementation period of one year, our goal was that every clinician in our gynecologic outpatient clinic at Lillebaelt University Hospital of Southern Denmark was educated and ready to practice SDM.

Methods

Centre for Shared Decision Making (CFFB) Lillebaelt University Hospital facilitated an overall implementation plan lead by a local implementation consultant; however, we incorporated a series of supporting initiatives.

One senior consultant and one head nurse managed the implementation process and education of the clinicians. The head nurse functioned as a local project facilitator. A systematic plan for education throughout the year, meetings between the teachers and CFFB was established. In a workshop, we developed two local decision aids to support the implementation process.

To monitor the implementation, we used OPTION12 at baseline and 4 months after education was completed. Monthly we evaluated the education plan to secure the right frequency of education.

Results

OPTION12 showed an improvement from 11.5 (5-19) points to 19 (9-33) point (65.2 %) in the use of SDM in the consultations. Throughout the implementation period, four measurements showed that 100 % of the clinicians either had received or was planned to receive education at every point of measurement.

Discussion

A systematic planning resulted in a successfully implementation of SDM.

However, OPTION12 showed a large variation in the practice of SDM. It is our experience that time, motivation and ownership to SDM is of great importance, in order to practice SDM in a clinical setting.

Conclusion

Local project facilitating, systematic planning and consistence are important to succeed. It is of vital importance that the amount of time allocated to plan and coordinate the implementation process is balanced.

50: Acceptability and usability of a decision aid on fertility preservation in breast cancer (Poster)

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Introduction

Fertility is a quite important issue for the quality of life of young women with breast cancer (BC). The decision-making process about fertility in these women is complex and might be greatly facilitated through shared decision-making between patients and professionals.

Methods

A web-based decision aid (DA) was developed from the review of updated scientific evidence. Subsequently, a group of women with a recent diagnosis of BC was invited to review the DA and provide feedback. The participants received an online questionnaire on acceptability and usability, as well as the link to access the web-based DA.

Results

Finally, 29 women with BC evaluated the usefulness and acceptability of the DA. The mean age of the participants was 36.48±4.16 years. The DA was rated as useful (55.2%), easy to use (75.9%), visually attractive (48.3%) and entertaining (37.9%). 51.7% of women reported they would use it if they had to make a decision on fertility preservation (FP) treatments. The information contained in the DA was clear (75.9%) and useful for choosing a treatment (51.7%). 62.1% would recommend it, 48% would use it to discuss options with their clinician, and 41.4% reported having learned new things about FP.

Discussion

The results obtained suggest that women diagnosed with BC find AD useful to address issues related to FP with their healthcare professional

Conclusion

This DA on FP has been well valued by the participants in different aspects related to acceptability and usability. To improve the potential benefits of DAs, greater efforts are needed to ensure the incorporation of these support resources in the consultations of the professionals in charge of the treatment plans of BC patients.

51: Fertility preservation in women with breast cancer: Information needs and research priorities from the perspective of patients and experts (Oral presentation)

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Background

Progress in early diagnosis and in the efficacy of breast cancer treatments has led to an increase in survival rates and to a greater number of women who, after cancer, have not seen their reproductive desires overcome. Hence, the importance of addressing the possibilities of fertility preservation early once the diagnosis is known.

Objective

To identify the information needs and research priorities that women with breast cancer (BC), their families and BC experts perceive on the fertility preservation.

Methods

We conducted two Delphi-based studies through three online rounds. The first was aimed to identify information and research needs; the second one to assess the importance of those needs and the third one to obtain consensus, defined as an interquartile range ≤2.

Results

The participation rate was 76.2% in study 1 and 53.7% in study 2. The most important information needs were the referral protocol, pregnancy options for women with BC, side effects of tamoxifen and menopause as a consequence of treatment. The most important research priorities were the participation of different health professionals to provide oncofertility information, referral protocols and efficacy and safety of FP options.

Discussion

Information on fertility preservation in the context of BC and the different ways to get pregnant, considering the risks and benefits, has emerged as an unmet need for patients and careers. The need for a participatory and coordinated approach to the provision of information on oncofertility has been prioritized.

Conclusion

Other research needs are described in an attempt to focus future research on the areas most needed.

52: Chosing Together 2.0 – A national project spreading the concept of shared decision making into clinical oncology (Oral presentation)

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Introduction

In 2017 a shared decision making (SDM) project "Choosing Together" was launched supported by the Danish Cancer Society. The project provided knowledge and learnings about implementation of SDM in three departments of gynecological oncology in Denmark. In 2021Choosing Together 2.0 project was launched to ensure sustainability of the SDM implementation and to include three more Danish gynecological oncology teams. The aim is that all Danish women with ovarian cancer experience being involved in important choices related to treatment and care, and that the method of SDM is a known and adapted part of clinical practice.

Methods

The strategy includes activities and deliverables in the six departments such as training of leaders, trainers and staff. All teams are supported from Center for Shared Decision Making (CFFB) at Lillebaelt Hospital and are included at management, clinical, and patient level. To include patients' perspectives, questionnaires asking for patients' advice to clinicians and future patients have been distributed in collaboration with the patient organization for women with ovarian cancer (KIU).

Results

One year into the project 77 leaders have received 3 hours of training. Twenty-seven trainers (clinicians) are trained and ready to teach colleagues in SDM and three departments have held initial training for staff. Ninety-seven patients have responded on the questionnaires until now. Results will be ready for the conference.

Discussion

Despite its complex nature, the implementation and sustainability of SDM stands on a solid foundation that is adjacent to the national strategy of the Danish Multidisciplinary Cancer Groups, who have integrated the use of PtDA's in their national strategy.

Conclusion

The expected impact of the project is for SDM to be implemented into the culture in six departments in Denmark. With Choosing together 2.0, we will be able to generate awareness of SDM to clinicians workings with cancer patients in general.

53: Moving towards creating more value to patients in the Netherlands: Outcome-based healthcare, Shared decision making and Value-Based Healthcare initiatives (Poster)

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Introduction

Outcome Based information, Value Based Health Care (VBHC), Shared Decision Making (SDM), Shared Decision Making with Outcome Information, all these terms/ methods are used in the Netherlands to highlight the importance of the patient and his values. In one method making outcome and cost information available is more evident; in another method patients and healthcare givers are supported to have better conversations in the consultation room. This conversation starts by informing patients that there are choices. Also by equipping and challenging healthcare givers in asking the question: what really matters to your patients? In the end, we all want to maximize the quality of life to all patients.

Methods

Identifying initiatives in the Netherlands that contribute to adding value to patients.

Results

In the Netherlands, more than 18 initiatives are involved in in adding value to patients. Some initiatives are more focused on appropriate care, collecting data, making (outcome) information transparent or public on a website. Some hospitals have their own programs on VBHC for example academic hospitals (NFU), Dutch Hospital Association (NVZ), general hospitals (SAZ) and Santeon hospitals. I will highlight three initiatives:

- Outcome-based Healthcare 2018-2021
- Subsidy scheme Share decision making – National Health Care Institute Netherlands
- Linnean Initiative: Bringing, collecting and creating knowledge on Value Based Health Care

Discussion

In the Netherlands, a lot of initiatives are creating more and quicker value to patients. There are a lot of goals to initiate projects. Now it is time to make adding value for patients a common behavior in the consultation room. Supported by tools with information of the patients and groups of patients.

Conclusion

In the next years the focus will be more on implementation of outcome sets to support shared decision making and change behavior.

56: The work of shared decision making: A systematic review (Oral presentation)

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Introduction
For SDM to be a truly patient-centered technique to make care fit rather than just another 'box to check', we need to shed light on the work, workload and burden that SDM imposes in daily practice. The aim of this review is to investigate whether studies that assess SDM also address or mention the work or burden that may be involved in SDM.

Methods
We performed a citation search of all SDM measures described in Gärtner et al's systematic review (2018), between 2012 and 2019. All papers were screened for eligibility in duplicate. We included all studies of SDM with real-life patients and clinicians, evaluating and reporting whether or how SDM happened in actual decisions about health or care. We extracted all mentions of SDM work or burden, to any party, in any section of the papers and categorized these mentions into domains of potential burden described by Tran et al (2015). We excluded mentions of burden merely related to SDM study participation.

Results
We included 241 of 4095 papers. 95/241 (39%) papers had at least one mention of work/burden of SDM (Md=1, range 0-6). These covered 'Time' (N=60, 63%), 'Expectations (of involvement) (not being met)' (N=44, 46%), 'Paperwork' (N=42, 44%), 'Uncertainty/conflict' (N=32, 33%), 'Cognitive work' (N=28, 29%), 'Emotional impact' (N=26, 27%), 'Engaging others' (N=9, 9%), 'Finances' and 'Access to resources' (both N=8, 8%), 'Relationship with others' (N=4, 4%), or 'Other' (N=3, 3%).

Discussion
Over one-third of included SDM papers included at least one mention of the work or burden of SDM. However, most of these mentions were fleeting, such as a simple report of the time it took to complete a decision support tool.

Conclusion
In the next years the focus will be more on implementation of outcome sets to support shared decision making and change behavior.

57: Intensive care of the very elderly: What do they wish for themselves? (Oral presentation)

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Introduction
Despite high and rising numbers, the benefit of admitting very elderly patients to intensive care is heavily debated and remains controversial. In cases of medical uncertainty, the patients' own wishes and values are of utmost importance. We report the development of a survey tool exploring very elderly patients' life sustaining treatment preferences and their proxies' ability to predict these preferences.

Methods
Survey items were generated by a mapping review of existing literature, and by discussions in balanced panels of laypeople and experts. The survey was pre-tested, piloted and sensibility tested on three consecutive non-probability samples.

Results
The questionnaires are constructed in corresponding pairs for elderly-proxy dyads. The respondents are asked to make treatment choices regarding three representative, hypothetical clinical scenarios. Furthermore, the questionnaires cover demographics, advance directives, intensive care experience, comorbidities, frailty, health related quality of life, and assumed similarity (the proxies' own treatment preferences). The questionnaire validation and testing phases are summarized in table 1.

Discussion
Hypothetical scenario research is a feasible and wellestablished method to study this decisional process, despite its inherent weaknesses. A multi-method approach with both quantitative and qualitative analysis of survey data seems most appropriate with respect to the complexity of the questions addressed.

Conclusion
The questionnaires have acceptable dynamic properties. Survey testing confirmed face validity and clinical sensibility and did not reveal any ethical concerns. Reliability testing on a larger sample is warranted.

Table 1: Questionnaire validation and testing

	Pre-Test	Focus Group Interviews	Pilot-Test	Sensibility Test
N (sample)	20 pairs (convenience)	9 professionals 13 laymen	20 pairs (purposive)	20 pairs (purposive)
Response rate	45%		70%	65%
Purpose / Questions addressed (results*)	Feasibility Data dispersion Ethical issues	Item generation and reduction Face validity Ethical issues	Comprehension Flow Salience Acceptability Administrative ease	Relevance (4; 3-5) Completeness (3; 2-5) Appropriateness (4; 3-5) Overall suitability (4; 3-5)
Instrument version		1	2	3

* Mode and range of answers on a 5-pt Likert response format

59: Development and piloting of an evidence-based consent form for total knee replacement (Poster)

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Introduction

Medical interventions require an informed consent in many countries due to ethical and legal considerations. Currently used consent forms are rather focused on risk-centered information and do not yet provide enough support for an informed decision. The aim of our study was to develop and pilot test evidence-based consent forms for surgery and anesthesia for total knee replacement (TKR) in preparation of an evaluation in a following mixed methods study.

Methods

The consent forms were developed according to the guideline for evidence-based health information. Patients' information needs, research questions and relevant outcomes were derived from the literature, based on systematic searches and from practitioners' expertise. We conducted systematic reviews on the comparative effectiveness and harms of different TKR options, including conservative treatment, and related anesthetic procedures. The qualitative feasibility study focused on comprehensibility, acceptance, and applicability. Data collection was conducted using think-aloud interviews. Focus groups are terminated for February 2022. The consent form will be revised in an iterative process. Data analysis is conducted according to Mayring.

Results

In December 2021, seven think-aloud interviews were conducted for testing the TKR consent form. Preliminary results suggest its general feasibility. The content presented was regarded as important and relevant. Thus, the increased amount of information of the consent form was accepted. Some study participants reported difficulties in understanding the figures showing effectiveness and harms and also problems in transferring the understanding of the concept of scientific comparisons and uncertainty.

Discussion

Preliminary results suggest that some aspects should be further optimized before the consent form can be further tested in the planned mixed methods study.

Conclusion

Overall, the new consent form seems to be applicable, understandable, and acceptable with further adaptations. We expect the evidence-based consent form to support patients in making informed decisions.

60: MAPPinfo - quality assessment of health information – a validation studyreview (Oral presentation)

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Introduction

Health information is a crucial part of any kind of health care. To facilitate informed health choices health information needs to comply with minimal standards of quality as recommended by the guideline evidence-based health information. Responding to a lack of methods for quality assessment applied to health information and rigorously using evidence-based criteria, a checklist, called MAPPinfo, has recently been drafted in German language. The current study aimed at validating this measure of quality.

Methods

The checklist comprises 19 criteria classified in the categories, definitions, transparency, content and presentation. Appraisals are made manual guided by untrained raters based on the health information materials only, not using secondary sources. Five sub-studies were conducted subsequently, at the Universities of Halle-Wittenberg/Germany and Graz/Austria, determining: (1) content validity through expert reviews, (2) feasibility through piloting with untrained users, (3) inter-rater reliability and criterion validity on 50 websites providing information on gonarthrosis or contraception, (4) construct validity through gaining additional information on methods used in the development provided by 50 developers and (5) divergent validity in comparison with the instrument *Ensuring Quality Information for Patients* (EQUIP).

Results

After several minor revisions content validity and feasibility were considered high. Inter-rater-reliability was strong in average; item related T-values ranged from .52 to 1.0. Spearman's correlation coefficient between expert judgement and MAPPinfo ratings was satisfying with .61. MAPPinfo was strongly associated (Spearman's 0.94) with judgements based on more comprehensive investigations of methods used in the development process. Comparison with the quality profile assessed using EQUiP revealed a meaningful pattern of agreement and disagreement.

Conclusion

The concept of quality operationalized by the new instrument is well justified, however, limited to criteria with a clear ethical or scientific evidence, letting many not yet proven features of health information unconsidered. More research on design features of health information is urgently needed.

61: MetroMapping: Development of an innovative methodology to redesign care paths to support Shared Decision Making (Oral presentation)

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Introduction

To support shared decision-making (SDM) in oncology, initiatives are often focussed mainly on communication in the encounter and the use of decision aids. Our previous research (Griffioen 2021) revealed: decision-making as a sequence of (un)planned moments before, during, after the consultation; work for patients and relatives to cquire/understand/recall information; often unclear roles and tasks, and unexpected energy drains (e.g., changes in the trajectory).

We aimed to develop a service design methodology to improve SDM in oncology. The entire patient journey is considered a service. All 'touch points' (leaflets, devices, etc.) become parts of a consistent service, supporting stakeholders' decision making.

Methods

We combined insights from:

- Co-creation and process-mapping, enabling participants to oversee and improve decision-making, cooperation, and task allocation
- Presentation of complex information
- Resilience, of individuals and systems, in terms of anticipation, sense-making, trade-offs, and adaptation

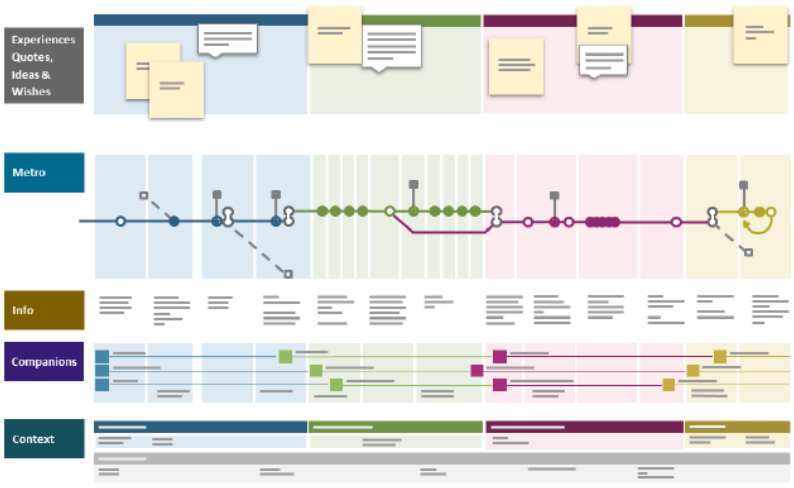
Results

Through MetroMapping (www.metromapping.org/en/), care paths are redesigned in a human-centred, holistic, iterative way, actively engaging patients, significant others, clinicians, and quality-of-care staff throughout the process. MetroMapping addresses five layers: 1) current experiences of patients, significant others, and clinicians, 2) metro line visualizing the entire care trajectory, 3) information needed in every phase, 4) persons involved in care and decision-making, and 5) physical contexts and artefacts (see figure).

Discussion

Important assets of MetroMapping are its flexibility for heterogeneous care paths and its intuitive visual language, enabling multidisciplinary collaboration and engagement of patients with various levels of health literacy. It is currently tested in various care paths in Europe.

Figure 1: Metro Maping (*www.metromapping.org*)



63: Decisional Needs of Parents of Infant Born with a Disorder/Difference of Sex Development: A Survey of Parents and Healthcare Professionals (Oral presentation)

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Introduction

Parents of infants born with disorders/differences of sex development (DSD) face many complex and value-sensitive decisions. As a result, shared decision making (SDM) is recommended. As part of a larger project designed to develop SDM-focused interventions to support parents of young children with a DSD, this study aimed to determine parents' and healthcare professionals' (HCPs) perceptions of parental decision-making needs.

Methods

Two cross-sectional electronic surveys, based on the Ottawa Decision Support Framework, were conducted between October 2020¬¬–December 2021. One survey targeted HCPs' (n = 28) perceptions of parental decisional needs and the other focused on parents' (n = 34) perceptions of their own experience making decisions for their child with a DSD.

Results

For HCPs, all (100%) reported parents experience manifestations of decisional conflict including feeling unsure, worrying about what could go wrong, and fear of choosing a "wrong" irreversible option. Sixty-eight percent of parents reported on past decisions, while the remainder focused on current decisions. The most frequently endorsed decisions related to surgery (97.1%), how much and when to share information about the child's condition to extended family and close friends (88.2%), medications (73.5%), the child or parent seeing a mental health specialist (73.5%), and how much and when to tell the child about their condition (73.5%). Parents also endorsed including others in decision making, including the child (21%), extended family (21%), and friends (3%). Only 1 parent reported making the decision alone.

Discussion

Parents face making numerous important decisions for their child with a DSD. Furthermore, it is important for HCPs to consider that parents may approach decision making differently (e.g., incorporating others outside the immediate family). Overall, HCPs had positive attitudes toward supporting parental participation in SDM.

Conclusion

Findings reflect HCP and parental perspectives of parental decision-making needs.

64: Reflexivity-based online training on shared decision-making for healthcare providers in the context of prenatal screening (Oral presentation)

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Introduction

Shared Decision Making (SDM) has positive effects on patient outcomes, but SDM daily use remains challenging during patients and providers encounters. Training health professionals on SDM is a promising intervention to foster SDM uptake. We believe that integrating reflexivity strategies in SDM training will foster its adoption. Reflexivity is the process where clinicians identify their pre-existing beliefs, feelings or thoughts, and question how they influence the interaction with patients.

Methods

We conducted a systematic review to determine if training programs on SDM have integrated reflexivity strategies and, if so, which of them were effective. In parallel, we developed and evaluated our initial online training for health professionals on SDM and the use of a patient decision aid about prenatal screening for Trisomy. Results provided positive conclusions, and recommendations to improve it were considered to enrich our training program.

Results

We analyzed 32 SDM training programs in our systematic review and eight of them integrated reflexivity strategies. Four of the later were significantly effective, but none were evaluated by health professionals or specifically designed to promote reflexivity. Regarding our upgraded training on SDM, we now propose a whole reflexivity-based training meeting Kolb's 1984 framework. This new version of our training program focuses on communication between health providers and patients, and includes a simulated clinical encounter using SDM. It also includes reflexivity-based exercises with specific cases of pregnant women encouraging participants to reconsider their own beliefs, feelings, and thoughts to better assist patients in their decision process.

Conclusion

Next steps will be: 1) to identify barriers and facilitators to implement our training and 2) to evaluate, through health providers' perspectives, if our reflexivity-based training will promote SDM uptake during patient and provider encounters.

65: Information exchange in doctor-patient-dialogues about advanced lung cancer treatment – a qualitative study (Oral presentation)

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Introduction

Most patients with lung cancer present with advanced disease and are offered non-curative, life-prolonging treatment. Despite novel treatment options, prognosis is still severe. We set up a study to explore information exchange in doctor-patient-dialogues about advanced lung cancer treatment as part of a larger shared decision-making implementation study.

Methods

Qualitative observational data in terms of audio-recordings from doctor-patient/relative-encounters scheduled for CT-evaluation were collected from hospitals in the Western Norway health region. A purposive sample of 15 conversations was analyzed by interpreting speech acts and discourse of the clinical encounter, using the theoretical framework of M.Foucault and J.L.Austin. Further analysis follow the procedure of Systematic Text Condensation, a thematic cross-case analysis.

Results

The main discourses of information exchange in the doctor-patient-dialogues encompassed exploring and explaining prerequisites for further treatment, facing uncertainty and practical needs. Four main categories were identified: 1.The doctors examined the patients' perspectives, trying to create a common agenda and allowing the patients to open up and outline hopes and worries. 2. Negotiating the responsibility of the decision to be made was both implicitly and explicitly embedded in the dialogues. 3. The doctors imparted detailed explanations and uncertainties regarding radiological and oncological status, while the patients and relatives listened and struggled to understand. 4. Facing requirements of practical planning and multiple clarifications, the doctors tried to meet the patients and relatives' needs while struggling to retain focus on the medical choice.

Discussion

Prerequisites for shared decision-making in this setting seems to be acknowledging the power of agenda setting and what level of information the patient requires. The open structure of the dialogues may come at the expense of clear and effective information exchange.

Conclusion

Customized patient information is key, yet may compromise aspects of severity and complexity assessed important to impart by the doctor.

66: Evaluation of a training module for nurses preparing to provide decision coaching (Poster)

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Introduction

Nurses play a crucial role in supporting patients to participate in healthcare decisions. In Norway, training programs aiming to strengthen nurses' decision support skills are lacking and shared decision making (SDM) has not yet been routinely adopted in clinical practice. The aim of this study was to develop and evaluate a nurse-led decision coach training module.

Methods

A descriptive study reporting the first three stages of Kirkpatrick's four-stage model of evaluation. The two-fold training comprised: part A (6 hours) focusing on SDM basics and decision coaching skills and part B (1 hour) a follow-up session involving individualized feedback, based on an analysis of an audio-taped decision coaching session. Participants were conveniently recruited from two hospital trusts. Reaction, learning and behavioral intentions were assessed by questionnaire immediately after part A and B. Mixed methods analyses were performed.

Results

Nineteen nurses from seven different clinical departments completed part A of the training module, while one nurse completed both parts. Nurses perceived part A of the training as relevant, acceptable and were satisfied. Part B which included audiotaping a decision coaching session was challenging. Nurses described several perceived barriers related to providing decision coaching in clinical practice (e.g., time constraints, attitudes). Perceived facilitators identified were interprofessional collaboration, support by management and more practical training to strengthen their decision coaching skills.

Discussion

Part A of the training is feasible, and nurses rated it as acceptable. Part B cannot be evaluated since only one nurse completed the session. Nurses identified structural and personal barriers interfering with them providing decision coaching in practice.

Conclusion

Decision coaching training for nurses needs to be part of a broader SDM implementation strategy to address the identified barriers. The results will inform SDM implementation strategies and further refinement of the Norwegian curriculum called "*Klar for Samvalg*" (Ready for SDM).

67: Patient-reported measurement of shared decision-making in Norway – a cross-sectional survey (Poster)

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Introduction

The South-Eastern Norway Regional Health Authority (one of four regions) is spending efforts in implementing shared decision making (SDM) in secondary health care. Evaluation of this endeavor is urging organizational benchmarking for baseline and comparative purposes.

The study objective was to provide estimates of whether, how and to which extent patients are involved in making decisions about their own health.

Methods

Data were collected as a part of a comprehensive survey distributed to all somatic inpatients >15 years after their stay at selected wards of one hospital trust during a six weeks-period in autumn 2020. Participants were asked whether and what decision was made during their stay. Decisions were categorized and rated with regard to whether SDM was indicated. Preferences regrading roles in decision making were assessed using the control preference scale (CPS, 5-point Likert scale) and patient involvement using the MAPPIN'SDM patient questionnaire. MAPPIN'SDM mean scores were projected on a 0-100 scale, CPS values processed nominally. Data were analyzed descriptively.

Results

Of the 3434 included patients 291 reported SDM relevant decisions. These patients had a mean MAPPIN´SDM score of 68.1 (SD 23.3). An autonomous role in the making of decisions was preferred by 22.3%, a shared role 28.4 % and a more passive role by 49.3%. More results will be provided at the conference.

Conclusion

This is the first cross-sectional survey in Norway providing data on perceived patient involvement in decision making. Patients' degree of involvement and respective preferences need to be better understood in the context of other variables and potential selection biases considered. There is a need for strategies to gain more complete data sets in this kind of survey.

68: Dental students' knowledge, attitudes, and experiences regarding shared decision making (Oral presentation)

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Introduction

The scientific focus of shared decision-making (SDM) has so far mostly been on treatment decisions in human medicine. Few studies on dentistry indicate that SDM is already partly applied there. Research has shown that training medical students has a positive effect on their knowledge and application of SDM, at least in the short term. SDM is increasingly being taught in medical education. However, little is known about dental students' knowledge, attitudes, and experiences with SDM.

Methods

To answer the questions, an online survey is conducted in a cross-sectional study among dental students enrolled in Germany. The questionnaire is composed of validated measures such as the physician version of the 9-item SDM questionnaire (SDM-Q-Doc). In addition, questions from similar studies have been adapted and are used. The study participants are recruited via the student councils of the individual universities and social media. As an incentive for participation, students will receive gift vouchers. There are 30 universities offering dentistry as a degree programme and 15,093 enrolled dental students in Germany in the winter semester 2020/21. With a population size of N=15093 and a confidence level of 90% as well as a margin of error of 5%, the sample size is n=268.
Data will be analyzed by means of descriptive statistics using IBM SPSS.

Expected results

The online survey was launched recently; so far n=20 students have participated. We expect to conclude data collection by March 2022 Final results will be presented at the conference.

Discussion

The study will yield better understanding of the current knowledge, attitudes, and experiences of dental students on SDM. This is highly relevant as national curricula of dentistry in Germany are currently being reformed. It will also give an outlook on the attitude of a future generation of dentists. Possibly, a need for interventions to promote SDM in dentistry can be derived.

69: Communication factors that lead an older adult to resist deprescribing: A content analysisreview (Oral presentation)

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Introduction
Use of inappropriate or unnecessary medications in older adults is common and leads to adverse drugs reactions, hospitalisation and mortality. Deprescribing (withdrawal of inappropriate medications preferably using shared decision-making) is underutilized. Extensive qualitative research highlights the interplay of complex factors that lead individuals to accept polypharmacy or resist deprescribing. Few quantitative studies have examined what factors are important to older adults when they disagree with a deprescribing recommendation.

Methods
We conducted an online, hypothetical scenario-based, randomized study in Australia, United States, and United Kingdom with participants 65+ years. The primary outcome was agreement with the deprescribing recommendation (6-point scale, dichotomized: disagreement (1−3) and agreement (4−6)). We measured demographic, psychosocial, and medication-related variables. Participants provided reason/s for their disagreement with deprescribing in free-text and a content analysis was performed.

Results
A total of 722 of 4,061 participants (17.8%) disagreed with deprescribing. Preliminary analysis found the main themes for participants wanting to maintain the status quo were: their beliefs about: 1) the medication not causing problems, 2) the importance of continuing to take long-term medication 3) health could worsen if the medication were stopped, 4) uncertainty/concern about the unknown or what will happen if the medication were stopped. For participants who were unsure about deprescribing, the main themes were about needing: 1) more information about the rationale for deprescribing, 2) further tests or a second opinion, 3) ongoing support or a plan from the doctor.

Discussion
We identified older adults' potential reasons for being hesitant to deprescribing. This will inform clinicians on how to navigate discussions about deprescribing among individuals who express concerns about stopping medications in clinical practice.

Conclusion
Older adults who are reluctant or resistant to deprescribing may prefer to receive additional information about the potential benefits and risks of continuing or stopping an existing medication.

70: Older adults and decision-making about medicines: the quantitative development of a patient typology about deprescribing (the TYDE Study) (Oral presentation)

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Introduction
The importance of patient involvement in decisions about deprescribing, the tapering or discontinuation of medication, is widely acknowledged, but difficult to do in clinical practice. Therefore, understanding the factors that influence older adults as they engage in the deprescribing process is key. Previous in-depth qualitative work has led to the development of the Patient Typology, which identified three 'types' of patients that differ in terms of their attitudes towards medicines, willingness to deprescribe, and involvement preferences in decision-making (Table 1). This study explored the clinical and sociodemographic characteristics associated with the three types using quantitative methods.

Methods
We conducted an online, hypothetical scenario-based, randomized study in Australia, United States, United Kingdom and the Netherlands with participants 65+ years. This is part of a larger study. We measured demographic, psychosocial, and medication-related variables. We used multinomial logistic regression analyses to investigate associations between the three types and variables. Type 1 was the base outcome.

Results
A total of 5,311 participants (93.3% completion rate) completed the survey. See Table 1 for preliminary results which shows the relative probability of a participant selecting Type 2 or 3 over Type 1.

Discussion
Quantitatively exploring the Patient Typology has provided greater understanding of each patient type. It appears the Patient Typology is a useful categorisation, and the qualitative findings have been verified in a large sample of participants across 4 countries.

Conclusion
This study revealed factors that predict selection of the patient 'types', which supports a tailored and individualised approach to clinician-patient deprescribing communication.

Table 1. Multinomial logistic regression of the multivariate associations between sociodemographic, clinical variables, attitudes towards deprescribing, and the 3 typologies, adjusted for the cluster effect by country.

The base outcome in this model is: Type 1	*Type 2*				*Type 3*			
***Type 1**[1] Attached to medicines:* *Positive attitudes towards medicines, left decisions to their doctor, resistant to deprescribing. Rated their quality of life as good or above.*	***Type 2**[1] Would consider deprescribing:* *Ambivalent attitudes towards medicines, preferred a proactive role in decision-making, were open to deprescribing. Reported higher self-rated health than other groups.*				***Type 3**[1] Defers to others:* *Gave medicines little thought, deferred decisions to their doctor or companion, unaware deprescribing is an option. Were frail and reported their self-rated health as fair or poor.*			
			95% Confidence Interval for Exp(B)				*95% Confidence Interval for Exp(B)*	
	Exp(B)	*P-value*	*Lower Bound*	*Upper Bound*	*Exp(B)*	*P-value*	*Lower Bound*	*Upper Bound*
Variable name								
Female sex (reference: male sex)	1.29	**<0.001**	1.14	1.46	0.61	**<0.001**	0.51	0.74
Age (in years) (per 10-unit increase)	0.80	**0.001**	0.69	0.91	1.17	**0.005**	1.05	1.31
Education status (reference: high school diploma or less)								
Trade school/some college/ associate's degree	1.28	**0.028**	1.03	1.59	0.75	**0.002**	.63	0.90
Bachelor's degree	1.73	**<0.001**	1.42	2.11	0.70	**0.027**	0.51	0.96
Master's degree or higher	1.32	0.078	0.97	1.78	0.57	**0.004**	0.39	0.84
Marital status (reference: partnered/married)								
Not partnered/married	1.11	0.398	0.87	1.40	1.25	**0.049**	1.00	1.55
Living situation (reference: alone)								
With spouse/partner/friend/ companion/adult children	1.14	0.435	0.82	1.61	1.28	**<0.001**	1.17	1.40
Nursing home or retirement village	1.28	0.465	0.66	2.48	1.24	0.675	0.46	3.35
Confidence filling out medical forms (reference: none)								
Little bit	1.93	**0.001**	1.30	2.86	1.75	0.120	0.87	3.52
Somewhat	2.02	**0.001**	1.32	3.09	1.12	0.711	0.62	2.03
Quite a bit	2.55	**<0.001**	1.70	3.84	1.04	0.887	0.61	1.76
Extremely	2.88	**<0.001**	2.02	4.10	0.80	0.427	0.46	1.39
Number of prescription medications taken (per 1-unit increase)	1.00	0.313	0.10	1.01	0.99	0.128	0.99	1.00
Number of over-the-counter medications/supplements taken (per 1-unit increase)	1.01	0.162	0.10	1.02	0.96	0.070	0.92	1.00
Level of support for managing their medications (reference: none)								
Occasional support	1.01	0.875	0.90	1.13	1.07	0.744	0.71	1.62

Complete assistance	0.69	0.200	0.39	1.22	0.91	0.576	0.67	1.25
Self-reported health (reference: poor)								
Fair	0.80	**<0.001**	0.78	0.82	0.83	0.792	0.22	3.22
Good	0.93	0.169	.84	1.03	1.27	0.668	0.42	3.86
Very good	0.89	**<0.001**	0.84	0.95	1.50	0.487	0.48	4.75
Excellent	0.88	0.546	0.59	1.32	2.68	0.052	0.99	7.26
Medical Maximizing-Minimizing Preferences[2] (Interpretation: 1 = I strongly lean towards waiting and seeing, 6 = I strongly lean towards taking action) (per 1-unit increase)	0.95	**0.016**	0.91	0.99	0.84	**<0.001**	0.81	0.87
BMQ General[3] (Interpretation: 1 = strongly disagree, 5 = strongly agree) (per 1-unit increase)	2.13	**<0.001**	1.77	2.57	2.42	**<0.001**	2.07	2.83
Agreement with deprescribing (Interpretation: 1 = strongly disagree, 6 = strongly agree) (per 1-unit increase)	0.95	0.255	0.86	1.04	1.04	0.402	0.95	1.13
Attitude towards polypharmacy (Interpretation: 1 = very negative, 10 = very positive) (per 1-unit increase)	0.89	**<0.001**	0.85	0.93	0.85	**<0.001**	0.78	0.92
Need for certainty (Interpretation: 1 = strongly disagree, 5 = strongly agree) (per 1-unit increase)	0.90	**0.001**	0.85	0.96	0.87	0.057	0.75	1.00
Desire to engage in actions to promote good health (Interpretation: 1 = not at all, 7 = a great extent)[4] (per 1-unit increase)	0.97	0.333	0.90	1.04	0.77	**<0.001**	0.72	0.83
Previous experience with deprescribing (reference: no experience)	1.37	**0.013**	1.07	1.77	0.10	0.964	0.86	1.16
Perception of harmfulness of deprescribing (Interpretation: 1 = not harmful, 10 = very harmful) (per 1-unit increase)	0.96	**0.008**	0.94	0.99	0.97	**0.017**	0.94	0.99

[1] Previous qualitative study developing the Patient Typology (Weir et al. Decision-making preferences and deprescribing: perspectives of older adults and companions about their medicines. J of Geront. 2018)
[2] Scherer et al. Eliciting medical maximizing-minimizing preferences with a single question: Development and validation of the MM1. Med Decis Making. 2020
[3] Beliefs about medicines general (Horne et al. The beliefs about medicines questionnaire (BMQ): the development and evaluation of a new method for assessing the cognitive representation of medication. Psychol Health. 1999)
[4] HRFS scale - health promotion (Ferrer et al. Developing a scale to assess health regulatory focus. Soc Sci Med. 2017)

71: Why can 25% also be 0.1%? Development and piloting of a web-based tool to teach relative and absolute risk reduction (Poster)

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Introduction
Interpreting study results is an essential component of decision making. Both, laypeople and professionals often misinterpret treatment effects that are presented as relative risk. The aim was to develop and pilot a web-based tool to teach professionals and laypeople about the relative and absolute risk reduction.

Methods
We developed the tool according to the UKMRC guidance for complex interventions. The tool is based on theories of adult learning, instructional and multimedia design. Learning objectives are to raise awareness for possible misinterpretation of risk reductions and to understand the calculation of risk reductions. Examples of increasing complexity and interactive calculations are used. Learners can control the scope and complexity of the activity on their own.

In an iterative process of analysis and revision, the piloting was conducted with healthcare professionals and laypeople utilizing a qualitative feasibility study focused on acceptance, applicability, and comprehensibility. Data collection was done through think-aloud and guided interviews, which were analysed using qualitative content analysis. In addition, socio-demographic information, self-assessed computer and mathematical skills and knowledge were assessed and analysed descriptively.

Results
Between 01/2020 and 04/2021, we conducted 22 interviews with 8 laypeople and 14 professionals from different health care settings. Overall, the tool proved to be feasible and relevant. Identified barriers regarding usability and understandability were revised. Participants reported an increase in awareness of the presentation format and improvement in the interpretation of risk reductions. Participants encountered difficulties in the calculation linked to mathematical knowledge.

Discussion
Raising awareness of possible misinterpretations of efficacy measures is a first step towards improving evidence-based decision-making. Further attention should be paid to practical application, especially for professionals.

Conclusion
The tool can be used to improve the interpretation of risk reductions in various target groups and to supplement existing educational programs. Next, the tool will be evaluated in an RCT.

72: Development and evaluation of a patient decision aid for shared decision making in Covid-19 vaccination of pregnant women (Oral presentation)

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Introduction

Pregnant women are at increased risk of severe Covid-19 infection, which may result in severe obstetric complications, including pre-term labor, acute caesarian section and fetal death. Hence, vaccination against Covid-19 is recommended during the 2nd and 3rd trimester of pregnancy. Even so, many women express concerns about the vaccination itself and face a dilemma when deciding for or against vaccination.

In the present study we aimed to develop a patient decision aid regarding Covid-19 vaccination during pregnancy and to evaluate the impact of the decision aid on the women's level of decisional conflict.

Methods

The decision aid was developed according to the International Patient Decision Aid Standards. It was pilot tested among pregnant and lactating women, midwifes and doctors and was revised during the study period when new knowledge on Covid-19 emerged.

The effect of the decision aid on the level of decisional conflict was tested in a cohort study. Women with a live pregnancy at their first trimester scan and with a need to discuss the vaccination were invited to participate in the study. The study intervention consisted of a consultation with a doctor trained in shared decision making. The newly developed decision aid was used in the consultations. The effect of the intervention was evaluated using the validated decisional conflict scale, which was sent to the women before and after the intervention.

The intervention was expected to decrease the level of decisional conflict.

Results, discussion and conclusion

Inclusion for the study is ongoing, at present 17 women have completed follow-up. Based on the power calculation, 50 women will be included. We expect to present complete data at the time of the conference.

73: Experiences of end-of-life care planning for people with advanced kidney disease and their families (Oral presentation)

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Introduction

Renal guidelines recommend timely preparation of people with advanced kidney disease for the end-of-life. Discussions about end-of-life care are not part of routine kidney care management. Providing good quality, accurate information about dialysis withdrawal, choosing not to commence dialysis and palliative care, is a fundamental step in ensuring reasoned decisions are made between patients and professionals about the type of care people wish to receive at the end-of-life.

Methods

Survey using qualitative interview methods to explore older adults with advanced kidney disease (n=14), family/carers (n=2) and bereaved family/carer (n=2) perspectives of important end-of-life care issues. Interviews took place on the telephone or via Zoom and lasted no longer than 1 hour. Audio recordings were transcribed verbatim, NVivo software managed the data, which was analysed using thematic analysis.

Results

Most people had not discussed their future care with a kidney clinician. Preferences varied for how, when and with whom conversations about end-of-life should take place. People were uncertain about how death occurred as a result of kidney disease. Most learnt that stopping dialysis led to death, only after commencing treatment. People made their own end-of-life plans e.g., made a Will and/or nominated a Power of Attorney, often in discussion with their spouse.

Discussion

Identifying how people with advanced kidney disease and their families experience end-of-life improves clinicians understanding, and gives permission, to have discussions about end-of-life care options. For patients, these discussions improve knowledge and realistic expectations, reduce anxiety, and support decision-making in line with their preferences. For services, future care planning can mitigate against ‘crisis’ management in acute situations, improves allocation and co-ordination of services.

Conclusion

Patient quotations from this study are included in the ‘Difficult Conversations Booklet’, a guide to help kidney health professionals have conversations with their patients to ensure their end-of-life care needs are met.

74: The experience of developing a suite of decision aids for national implementation; what have we learnt? (Oral presentation)

Author(s): *Samuel Finnikin*

Affiliation(s): Personalised Care Group, NHS England and NHS Improvement

Introduction

There is a clear mandate in NHS England to make shared decision making 'business as usual' . As part of this ambition a new programme was establilshed in 2021 to develop decision aids in key clinical areas. The Personalised Care Group partnered with the Winton Centre (University of Cambridge) to develop 15 tools over the course of the year. This presentation will outline the production process and the key lessons learnt along the way to act as an example of the practical implementation of decision support tools at a national level.

Methods

As this is not a typical academic project, the content doesn't fit neatly into the abstract structure. However, the decision aids were co-produced by specialists in risk communication involving clinicians and patients and utilizing professional design services. The process will be described in detail so that delegates can learn from the experience gained over the course of this project. An example decision aid will be shared to allow delegates to discuss and critique the product. We will also discuss the experience of implementation and evaluating this process.

Discussion

They key points that will be discussed are the importance of clearly defining the decision to be made; identifying the right partners and ensuring that they are clear in their role; recognizing the opportunities to support implementation; and adapting to the needs of a broad audience. Learning will be illustrated by examples.

Conclusion

Whilst there is academic rigor in the production of decision aids; a tool that is not integrated into the health service will not fulfil its purpose. We hope the learning from our project will help researchers and healthcare leaders implement decision aids in their fields.

76: Are the measures of shared decision making and patient involvement aligned? (Oral presentation)

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Introduction
Shared decision making (SDM) is implemented in hospitals across Denmark as a method to increase patient involvement and person-centred care. The effectiveness of SDM can be evaluated using multiple outcomes and measurement tools. However, it is unclear how these measures align with stakeholders' understanding of patient involvement.

Aim
To describe, categorize and synthesize measures used to assess patient involvement interventions carried out in Danish healthcare settings.

Methods
Rapid review guided by PRISMA methods to search, identify and analyse empirical studies evaluating patient involvement interventions in Denmark. Data were extracted using a coding frame, and analysed using narrative synthesis.

Results
43/3767 studies met the inclusion criteria, identifying 22 disease-specific and 52 generic measurement tools within 5 categories: patient engagement; supporting self-management; supporting SDM; patient satisfaction and experience; patient-reported outcomes. "Supporting SDM" consisted of 10 different tools; few including explicitly items capturing patient involvement concepts.

Discussion
There needs to be a shared understanding between researchers, patients and health providers about the purpose of outcomes employed to evaluate SDM and other patient involvement interventions to synthesise findings across studies. This review helps researchers and clinicians reflect on the need for different measures to capture outcomes reflecting the priorities of different stakeholders when evaluating complex interventions to enhance patient involvement and engagement in healthcare.

Conclusion
SDM is one type of patient involvement intervention carried out in Denmark. The large number of measures used to measure SDM and patient involvement reflects the different goals of these complex interventions. Findings indicate a disconnect between measures used to assess the different components within these complex interventions. This review illustrates a lack of conceptual synthesis between SDM and patient involvement measurement tools.

78: Healthcare professionals' intention to engage in serious illness conversations after team-based versus individual-based training in advanced care planning: secondary analysis of a cluster randomized clinical trial (Poster)

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Introduction
In advance care planning (ACP), healthcare professionals (HCPs) discuss end-of-life decisions with patients and their families in respect for their wishes and autonomy. Very few studies have evaluated the impact of ACP in primary care, and none evaluated the involvement of primary care HCPs in ACP.

Objective
To compare the impact of interprofessional team-based training versus individual clinician-based training on healthcare professionals' intention to engage in ACP discussions.

Methods
This study is a secondary analysis of a cluster randomized trial. HCPs from 41 primary care clinics in the United States and Canada were recruited. Primary care clinics were randomly assigned to either interprofessional team-based training (intervention) or individual clinician-based training (control). Both trainings were adapted from the Serious Illness Care Program developed by Ariadne Labs and lasted 3 hours (1.5h online tutorial and 1.5h in-person role-play session). After training, participants were asked to complete CPD-Reaction, a self-administered validated questionnaire to rate effectiveness of continuing professional education activities, to measure their intention to have ACP discussions with their patients. Sociodemographic data were collected. A descriptive analysis is being performed and a linear mixed model will compare HCP intentions between study arms.

Results
534 participants were recruited. 326 completed the interprofessional team-based training and 208 completed the individual clinician-based training. Preliminary analyses are ongoing and results will be available in May 2022.

Discussion
Considering that an interprofessional approach facilitates the discussion of a complex subject using the knowledge of professionals from different disciplines, the main hypothesis of the study is that an interprofessional training approach will increase HCPs' intention to have end-of-life care conversations with their patients, thus increasing the use of ACP in primary care. Taking into account that ACP reinforces shared decision making, there would be an increase in patient autonomy and satisfaction and improved quality of care.

79: "I arrived with very heavy bleeding, and the doctor just took it all out. I guess he used suction, but I was not told": Women's experiences in decision making concerning miscarriages

(Oral presentation)

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Introduction

A miscarriage occurs in 15 to 20% of pregnancies. For some cases of miscarriage, such as incomplete or missed, different treatment options exist, e.g., expectant, medical, or surgical management. Each treatment option is associated with various risks and health consequences. Women in these situations may benefit from a shared decision-making process for choosing the most suitable treatment. In this study, we examined women's experiences with decision-making regarding miscarriage treatment.

Methods

One thousand two hundred women filled a survey that included quantitative and open-ended qualitative questions. The survey assessed women's experience and satisfaction with the decision-making process. An Immersion/Crystallization qualitative analysis method enabled exploring their experiences.

Results

After hearing the news about the pregnancy loss and before allowing time to digest the news, women were rushed into making treatment decisions. Only 30% of women said they were informed about their treatment, even though 80% believed they should have been informed. Women felt they didn't receive enough information about short- and long-term effects or the risks and benefits of the different options. As a result, some women were unaware of the procedure they went through, and some were surprised by difficulties, complications, and other implications on them, that they felt traumatized by. Half of the women indicated that they were not offered any psychological support despite their needs.

Discussion

According to this study's results, women felt the need for more patient-centered care, including getting adequate information, being involved in the decision-making process, receiving time to deliberate, and addressing their emotional needs.

Conclusions

To avoid further traumatization due to the challenging experience of pregnancy loss, there is a need to enhance health professionals' training in compassionate patient-centered care in general and shared decision-making specifically. This process should include empathically addressing emotional needs, followed by informational needs.

80: From „Share My Decision“ to “Shared Decision Making”: Are surgeons adept at reassessing paternalistic decision making while upholding efficacy? (Oral presentation)

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Introduction

Physicians of surgical specialties are faced daily with advising their patients about nuanced anatomical procedures in short-lived medical environments. Hence, surgeons are said to be inclined towards paternalistic communication models during patient consultation. In this study, we applied the SHARE TO CARE (S2C) program to the Department of General Surgery at the University Hospital in Kiel in order to evaluate whether SDM can be implemented, how consultation time is affected as a consequence thereof and what surgeons think about SDM.

Methods

26 surgeons (age 25-56y, 7 female, 19 male) of distinct clinical experience, yet unfamiliar with SDM, completed the S2C training for physicians comprising online training and personal coachings referring physicians’ video-taped consultations. 10 Decision Aids (e.g. Kidney Transplantation; Rectum Carcinoma; Bariatric Surgery) were devised with leading clinicians. Nurses were trained as “Decision Coaches“ and patients were activated using the Ask-Share-Know method via films, posters and flyers.

Before (t0), during (t1) and after implementation (t2), the SDM level in video-taped consultations was measured using MAPPIN’SDM and consultation time was assessed.

A survey amongst staff captured the perception of SDM relevancy in clinical routines.

Results

SDM-level in surgeons‘ consultations improved significantly after completion of the S2C-Program (effect size=.5 SD, $p<0.03$). Mean consultation length decreased by 2min (effect size=.18; n.s.). Surgeons reported in the survey that SDM deemed favourable and feasible. Decision Aids and Decision Coaches were successfully implemented. All patients were systematically activated.

Discussion

The S2C program has proven effective in implementing SDM into well-established clinical routines. Remarkably, the surgeons reached higher SDM levels within the same or lower consultation time. In line with feedback from physicians, this may be due to better structured encounters.

Conclusion

Our study shows viability of SDM when applied to a Department of General Surgery with the S2C-Program.

81: Implementation of SDM in two departments of internal medicine using the SHARE TO CARE program (Oral presentation)

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Introduction

Internal medicine is a fulcrum of every hospital. Given the complexity of the medical conditions, the department size and thus the large number of patients, implementing SDM in internal medicine is both crucial and challenging.
This study illustrates the SDM implementation process with the SHARE TO CARE program (S2C) and evaluates its efficacy.

Methods

Intervention
S2C is a comprehensive implementation program for SDM combining four intervention modules: 1) training of every physician (online tutorial & 2 individual feedbacks), 2) web-based decision aids, 3) empowerment of every patient using the Ask-Share-Know approach and 4) qualification of medical staff.

Measurement
Implementation success was evaluated by the SDM level in video-taped physician-patient-conversations measured with MAPPIN'SDM before (t0), during (t1) and after the implementation (t2).

Statistical analysis
The increase in mean SDM performance was compared with a priori contrast tests.

Results

87% (n=90) of all physicians could be fully trained in SDM. A total of 20 evidence-based online decision aids were developed and embedded into the clinical pathways (topics e.g. Crohn's disease, myelodysplastic syndrome). Decision aids were also anchored in neighbored disciplines in cases of cooperative patient care (e.g. ulcerative colitis in cooperation with the Department of Surgery). All patients could be systematically covered by the patient empowerment module. Medical staff was instructed how to support SDM.

The SDM level increased significantly along the implementation process (p=<.001; effect size=.64).

Discussion

SDM was successfully implemented in two of the largest departments at the hospital. Their size and the multiple entwinements of patient pathways with other departments like surgery, radiotherapy, neurology etc. were challenging. Therefore, the concurrent SDM implementation within the entire hospital was obviously a precondition for implementation success. All implementation processes could be continuously accelerated over time.

Conclusion

The S2C program successfully implemented SDM in internal medicine and profited from its hospital-wide approach.

82: Challenges in the development of a patient decision aid for microtia reconstruction to promote shared decision-making (PADAMIR project) (Oral presentation)

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Background
Microtia is a congenital disorder characterized by underdevelopment of the ear, leading to physical and psychosocial complaints among patients. Ear reconstruction is generally performed using different autologous or alloplastic surgical techniques, each with their advantages and disadvantages. However, it is not evident when and how ear reconstruction should be performed, and patients may also prefer to not undergo ear reconstruction. Hence, this condition seems ideal for implementing shared decision-making (SDM).

Objectives
To develop an online PtDA for microtia reconstruction.

Methods
A PtDA was developed along international guidelines. An online survey was sent to members of the International Society for Auricular Reconstruction in December 2021. Clinicians who treat microtia patients were asked which information on microtia and the reconstructive options should be included in a PtDA. Patients (and their parents) with microtia will be interviewed in February 2022 to identify their needs and preferences regarding SDM.

Preliminary results
Twenty-six experts from four continents responded to the first survey invitation. Most respondents (n=19) were plastic surgeons, with ample experience (median years of experience 16 years, IQR: 6.5-23 years). Most (>50%) respondents believed the PtDA should include information on the types of microtia, associated syndromes, psychosocial effects and hearing. Respondents disagreed on which reconstructive options ought to be described in the PtDA. The majority indicated that they would include general information about the techniques, the required patient age for surgery, the type of materials used, the number of surgeries, the length of surgery and hospital stay, adverse events and expected aesthetic results, though there was no definitive consensus.

Discussion/Conclusion
Although SDM seems suitable for children with microtia, diverging opinions exist as to the information to be included in the PtDA. The patients' (and parents') opinions will be decisive when developing the prototype, which will be presented at the congress.

83: Scalable training of Shared Decision Making: Development, application and evaluation of an online tutorial (Oral presentation)

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Introduction

Integrating Shared Decision Making (SDM) into clinical routine has become a legal requirement in many countries. Therefore, effective and efficient trainings are needed to help physicians involve their patients in therapy decisions. Especially in times of covid-19, online trainings (OT) are a contactless and efficient way to enhance SDM skills.

As part of the multi-component SHARE TO CARE (S2C) program, we developed an OT based on SDM literature, insights from SDM measurement (i.e. MAPPIN'SDM) and approved didactic strategies. The OT proved effective in terms of increased abilities to differentiate levels of SDM behavior in medical students.

This study aims to evaluate the applicability of the OT in clinical practice and its effect on SDM performance.

Methods

The OT was passed by >500 physicians in 17 departments as part of a hospital-wide implementation of SDM.

In two departments, gynecology and radiotherapy, physicians videotaped their consultations pre and post OT. Two blinded and independent raters assessed the SDM performance using the MAPPIN'SDM observer scales with focus on physician and the physician-patient dyad.

The effect of the OT was determined using one-tailed t-tests for independent (dyad focus) and dependent samples (physician focus).

Results

The OT was easy to pass in daily clinical practice. Based on feedback from physicians from all departments, modifications were made to the OT during the running study.

In gynecology and radiotherapy, over 80% of physicians completed the OT including videotaping their consultations (nGyn=24; nradio=11). The SDM level increased significantly for physicians (effect size=.57 (Hedges g); p<.001) and the dyad focus (effect size=.40; p=.05).

Discussion

S2C OT proved to be applicable to a large-scale hospital setting and increased physicians' SDM performance significantly. Given the duration of approximately 1h, the OT can be judged as highly efficient.

Conclusion

The easily scalable S2C online training increased physicians' SDM performance efficiently.

84: Department-wide implementation of SDM in Gynecology and Obstetrics using the SHARE TO CARE program (Oral presentation)

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Introduction

Effective programs for department-wide implementation of shared decision making (SDM) are rare. This study evaluated the effect of the SHARE TO CARE program (S2C) on the SDM level in the Department of Obstetrics and Gynecology in a German University Hospital.

Methods

Intervention

The S2C program includes 4 modules: 1) coaching of each physician (online + 2 individual face to face coachings referring to video-taped consultations), 2) shared development and implementation of tailored online decision aids, 3) qualification of medical staff to support SDM 4) patient empowerment including the Ask-Share-Know method.

Measurement

Each physician video-taped 4 regular consultations: 1) baseline, 2) after online training 3) after first coaching 4) after second coaching. Two blinded observers independently determined the SDM level within each consultation using MAPPIN'SDM (observer scale focusing on the doctor-patient dyad); in case of disagreement between raters, they agreed on a consensus score.

Statistical analysis

In a pre-post design, the increase in SDM level was analysed using *a priori* contrast tests.

Results

24 physicians (83% within the department) completed the SDM training. 8 new decision aids were developed and implemented in cooperation with the clinicians addressing 5 surgical topics (breast cancer, hysterectomy), delivery in case of breech position, endometriosis therapy, prenatal testing. All nurses were qualified to support SDM, and all patients were systematically addressed by the empowerment module.

The SDM level increased continuously along the implementation (M_1=1.12; M_2=1.31; M_3=1.50; M_4=1.61; effect size=.949 (Hedges g); p<.001). Interrater reliability was high (Cohen's kappa=.87).

Discussion

The S2C program proved to be practical and highly effective to implement SDM in obstetrics and gynecology. It requires considerable resources. However, the scalability of the approach justifies this investment, e.g. by national use of decision aids and other material.

Conclusion

The SHARE TO CARE program is successful in large-scale implementation of SDM.

85: Experimental test of a conjoint analysis-based versus rating-based values clarification method on values clarity in cancer patients (Oral presentation)

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Introduction

Little is known about the best way to aid patients in clarifying preferences through values clarification methods (VCMs), especially for patients differing in information processing skills/styles. This experiment tested the effect of a conjoint analysis-based VCM, compared to a ranking-based VCM and no VCM at all, on decision-related outcomes. Patient Decision Aid (PDA) for treatment of early stage lung cancer was used as a case example.

Methods

We conducted an online experiment with adults aged 18 years or older who had (a history of) cancer other than lung cancer (N=282). Participants were exposed to a PDA prototype about two treatment options: surgery and stereotactic ablative radiotherapy (SABR). The prototype either contained no VCM, a ranking-based VCM or a conjoint analysis-based VCM. Primary dependent variables: decisional conflict and values clarity. Secondary outcomes: perceived cognitive load, anticipated regret, ambivalence, preparedness for decision making, and hypothetical treatment preference. ANOVAs were performed.

Results

Type of VCM did not affect patients' decisional conflict, values clarity, cognitive load, anticipated regret, ambivalence, or preparedness for decision making. Type of VCM affected hypothetical treatment preference, with conjoint analysis-based VCM associated with a relatively higher preference towards surgery. In older patients, no VCM (compared to ranking-based VCM) was associated with higher values clarity. In highly deliberating patients, no VCM (compared to conjoint-based VCM) was associated with a greater preference towards SABR.

Discussion

Our findings imply that conjoint analysis-based VCMs may not aid patients better to determining their preferred treatment compared to no VCM or a ranking-based VCM. For older and highly deliberating patients, no VCM seems to be more helpful than the ranking-based or conjoint-based VCM. Mechanisms explaining diverging decision outcomes in light of similar decision processes need to be unraveled.

Conclusion

This study does not provide evidence for the effectiveness of conjoint analysis in supporting preference clarification.

86: Increasing the chances of successful large-scale implementation of SDM: The systemic approach of SHARE TO CARE (Poster)

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Introduction

Practicable and effective interventions are a prerequisite to successfully implement SDM into entire organizations like hospitals or healthcare regions. However, the interventions will only be applied, if these organizations see SDM as something beneficial and desirable. In addition, they principally have to have the opportunity to adopt SDM with regard to structural or financial constraints within the organization or in the healthcare system in general.

Methods

Following these systemic considerations, we defined a fivefold multi-level strategy in 2017:

1. Develop a program for large-scale implementation of SDM.
2. Prove its practicability and effectiveness using validated SDM measures.
3. Establish a certificate documenting sustainable SDM implementation in organizations.
4. Enlist health insurance companies (HICs) for additional reimbursement for SDM implementation, proven by the certificate.
5. Illustrate the competitive advantage of SDM for healthcare organizations and HICs.

Results

1. The multifaceted SHARE TO CARE (S2C) program was developed. It addresses the essential stakeholders of healthcare, with intervention modules focusing on all physicians (online+face to face-trainings), all nurses (integration as SDM supporters or decision coaches), all patients (by systematic patient empowerment) and information quality (by embedding evidence-based online decision aids).
2. S2C was applied to the University Hospital Schleswig-Holstein, Kiel, Germany. Today, 17 of its departments (covering >90% of patients) have fully implemented SDM (i.e. >80 decision aids, training of >400 physicians and >1000 nurses, systematic empowerment of all patients).
   The mean SDM level increased significantly according to video-based analyses of consultations using MAPPIN'SDM (N=545; effect size=.675; p<.001).
3. The S2C certificate was operationalized as proof of full SDM implementation.
4. The certificate got approval by Germany's largest HIC (Techniker Krankenkasse) triggering additional reimbursement for every case.
5. Certified clinics cite SDM as proof of their patient-centeredness on websites, presentations, job postings etc. New employees systematically pass SDM trainings to continuously comply with the S2C criteria.

Discussion

The hospital-wide implementation of SDM in Kiel proved practicable and effective. While implementation still demanded considerable resources, the financial and marketing benefits gathered by the systemic approach provided essential 'pull effects' for initial implementation and its intrinsically motivated continuation. Highlighting positive effects of S2C on patient safety were decisive for reimbursement.

Conclusion

SDM must be perceived as achievable, feasible and desirable by hospitals to spark sustainable implementation processes. Considering and utilizing the particular driving forces within the healthcare system is crucial for success.

87: More time enables better SDM, and better SDM saves time. How both can be true, and why this matters (Oral presentation)

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Introduction

Lack of time is a major problem in modern healthcare. Implementation of SDM is often rejected because it supposedly prolongates consultations. However, solid evidence on this fear is scarce. Therefore, we investigate two questions: 1) Is SDM associated with longer consultations? 2) Do physicians need more consultation time if they adopt SDM?

Methods

The SHARE TO CARE (S2C) program was used to implement SDM at the University Hospital of Schleswig-Holstein, Kiel, Germany. The SDM level was assessed before (t0), during (t1) and after the implementation (t2) using the observer instrument MAPPIN'SDM with focus on the physician. The duration of each consultation was measured.

Over 80% of physicians from seven departments were included.

1. The Pearson correlation coefficient between SDM level and consultation length was calculated over all available videos (N=546).
2. To determine the influence of an increased SDM level on each physician's consultation length, paired t-tests were used to compare the mean duration and the mean SDM level at t0, t1 and t2 (N=123 each). For a combined analysis, the 'SDM efficacy' was calculated as the ratio of both measures.

Results

The correlation between SDM level and consultation length was r=.42 (p<.001).

Physicians' SDM level increased significantly at t1 and t2 was significantly higher (effect size=.85 and .61 (Hedges'g); p<.001). Consultation length at t1 was slightly higher (effect size=.14, n.s.) and slightly lower at t2 (effect size=-.09; n.s.) compared to t0. 'SDM efficacy' significantly increased at t1 and t2 (effect size=.58 and .60; p<.001).

Discussion

These results suggest a simple and plausible interpretation: Longer consultations leave more room for more SDM, as the correlation indicates. While beginning to adopt SDM, a physician might need more time. After internalization of SDM, physicians might even save time.

Conclusion

Doing it right, more SDM does not require more time.

88: Motherhood choice in multiple sclerosis (MoMS) – Feasibility testing and piloting of a web-based Decision Support Tool and a Decision Coaching Programme (Oral presentation)

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Introduction

Motherhood is often an important issue for women with MS (WwMS). This multiphase mixed-methods study addresses the feasibility of a web-based Decision Support Tool (DST) and a Decision Coaching Programme (DCP) for WwMS considering pregnancy.

Methods

The study follows the MRC framework for tdhe development and evaluation of complex interventions. Both programmes consist of a web-based decision aid (DA) and a decision guide on motherhood choice following six shared decision-making steps. For the DCP, we developed a training course for MS nurses and moderation cards. For the feasibility testing, experts and WwMS assessed the DA and the decision guide for comprehensibility, completeness and usability. The participants received questionnaires and were interviewed. The questionnaires were analysed descriptively. Interviews were recorded, transcribed and analysed using qualitative thematic analysis. The DCP was tested within the research team and with an MS nurse. The DST and the DCP are currently being evaluated in a randomised pilot study (targeted sample size n=64).

Results

We conducted two focus groups (n=7) and personal interviews with WwMS (n=1) and experts (n=5). The WwMS and experts found the DA to be comprehensible, informative and easy to use. Some participants thought the DA was too comprehensive. Therefore, some parts were shortened. The decision guide was evaluated as useful for undecided WwMS and instructions were added to increase the usability based on the expert feedback. The results of the ongoing pilot study will be presented at the conference. Two nurses were trained and so far 28 WwMS are included in the study.

Discussion

The feasibility study will provide important information on the potential of the DCP and whether this approach should be pursued further.

Conclusion

The results of the feasibility testing and piloting will provide preliminary data on the potential of the two decision support programmes.

89: Can shared decision making be used in a communication bundle for optimizing communication with mechanically ventilated patient in the intensive care unit? (Oral presentation)

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Introduction
Mechanically ventilated patients admitted to the intensive care unit become voiceless due to the intubation, causing challenges in communication and patient involvement. A new light/no-sedation paradigm means that more patients are conscious and able to interact with the healthcare personnel and relatives. A communication bundle is suggested as a way of optimizing communication, but the content of such bundle needs to be explored.

Methods
As several research syntheses existed, the umbrella review method guided by the Joanna Briggs Institute was applied. This included a systematic search, a quality appraisal, data extraction, and synthesis. Literature from 2009-2019 was included.

Results
Seven research syntheses were included. Four key interventions were identified that form the basis for developing communication bundles in intensive care units. These were: 1) Communication assessment and documentation; 2) Implementation of communication methods and approaches; 3) Education and training of healthcare personnel; 4) Use of Augmentative and alternative communication.

Discussion
Besides the use of augmentative and alternative communication strategies and tools, the literature gives little guidance on what the bundle components should contain or how it should be designed. However, with the increased use of light or no-sedation protocols, shared decision making is relevant to include in the bundle as a method to optimise patient involvement. Previously, shared decision making has mostly been used between the healthcare personnel and relatives. Furthermore, previous research has primarily focused on shared decision making in relation to withdrawal of treatment. With the increased number of conscious patients, it is now time to consider how and when shared decision making can support the communication process between patients, relatives and healthcare professionals in the intensive care unit.

Conclusion
Shared decision making should be considered as a method in the development of communication bundles in the intensive care unit setting.

90: Shared decision making for tobacco cessation counseling in primary care: the patient perspective (Oral presentation)

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Introduction
Smoking cessation provides substantial health benefits. Medications for smoking cessation can double quit rates. The majority of Swiss patients expect a discussion about smoking cessation with their general practitioner (GP), but only a small number receive a prescription. The FIRST study aims to increase smoking cessation using a decision aid and a half-day GP training course on shared decision making (SDM). This qualitative study nested in FIRST explored the reactions of a purposive sample of patients to their GP's advice.

Methods
As part of the FIRST randomized controlled trial, we conducted qualitative semi-directed interviews over the phone 5-16 weeks after a routine visit with their GP. Data were analyzed using thematic data analysis assisted by the MAXQDA software with 20% dual independent coding. We followed COREQ standards.

Results
Preliminary results are available for 3 patients from the intervention and 3 from the control group.

Two intervention patients recalled seeing the smoking cessation intervention, appreciated its content and learned about all treatment options. Most patients in both groups felt their GP provided strong moral support. Some of them wanted education about smoking cessation. Only a few were expecting help, such as a medication, to stop smoking. All patients felt that the most important factor influencing smoking cessation was their own motivation.

At the time of conducting the interviews, 1 patient in the intervention group tried to decrease tobacco consumption by using electronic cigarette. None of the 6 interviewed participants reported having stopped smoking.

Discussion
These results provide trends from a small purposive sample of patients. We are expecting to have analyzed data from 20 patients by June 2022.

Conclusion
Patients in this sample expected their GP to provide moral support but not a choice of treatments to quit smoking. This presupposition could make SDM about smoking cessation treatments more challenging.

92: Implementation of an integrated care pathway in primary care clinics to improve patient-centered preventative care for older adults: a realist evaluation (Poster)

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Introduction

The health concerns of older adults are often missed in the too-short consultations in primary care. We have therefore implemented a care pathway that integrates frailty screening, shared decision-making to choose preventive strategies using decision aids, and facilitated access to community resources using a digital platform. We sought to describe how, for whom and under what circumstances this pathway was correctly implemented.

Methods

We used a realist evaluation, based on mixed-methods. Older adults (aged 70+), healthcare providers (HCPs), and clinic managers, completed surveys before and after implementation (CIHI providers and organizational surveys, PACIC, EQ-5D-5L). Interviews were conducted to understand the factors influencing implementation fidelity. We used mixed statistical models; inductive/deductive thematic analyses guided by the Consolidated Framework for Implementation Research. Findings were integrated into Context-Mechanism-Outcome configurations.

Results

We recruited 113 HCPs (73%women), 310 older adults (58%women, mean age 79.06 ±5.6SD) in four primary care clinics in Quebec. We conducted 34 interviews with a sample of older adults and eight focus groups (40participants) with HCPs and managers. Only one of the four participating clinics fully implemented the pathway, due to logistical administrative and human resources challenges. The sole clinic that fully implemented the pathway demonstrated better care coordination. It showed high fidelity in using screening (91% older adults), low fidelity in using decision aids (35%) and the referral platform (2%). HCPs explained that they did not use the decision aids as directed because they treat health issues more often than they recommend lifestyle changes, and so the decision aids were not always compatible with their role.

Discussion

Implementation in primary care clinics of this frailty prevention pathway that comprised decision aids about lifestyle change requires resources and supports.

Conclusion

Implementation of this pathway might require its promotion through a provincial program to allow the securing of the necessary resources.

93: Decisions and decision making needs of Canadians during the COVID-19 pandemic: A national survey (Oral presentation)

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Introduction

During the COVID-19 pandemic, there is limited, changing evidence. We aimed to determine the decisions Canadians were confronted with and their decisional needs (05/2020-05/2021).

Methods

Our study was co-designed by researchers and knowledge users (patients, clinicians). Two cross-sectional surveys were conducted with Leger's web-panel of 400,000 Canadians. Surveys for two eligible participant groups targeted: a) 1500 adults making decisions for themselves; b) 500 parents, or caregivers making decisions for an older adult. The survey included healthcare decision examples and questions from validated instruments. We analyzed findings descriptively.

Results

Of 14,459 adult panelists and 6542 parents/caregivers panelists randomly invited to participate, 1507 and 505 completed the survey. There were 1454 adults and 438 parents/caregivers from across Canada who faced a decision. The typical participant was urban living (88%), completed post-secondary education (80%), white (77%), English (69%), married (61%), female (53%), and self-identified as members of a marginalized group (29%).

Common decisions were (adults; parents/caregivers): vaccination (34%;20%), masking/social contacts (11%;19%), managing a health condition (17%;11%), mental healthcare (9%;7%), and medical decisions (8%;5%). Caregivers also reported decisions about moving a family member to or from a retirement/nursing home (10%).

Adults (22%) and parents/caregivers (22%) had clinically significant decisional conflict (>37.5/100). Factors making decisions difficult were worry about choosing the wrong option (38%;42%), worry about getting COVID-19 (35%;40%), public health restrictions (29%;36%), information overload (21%;18%), difficulty separating fake news from real scientific evidence (20%;18%), and difficulty discussing decisions with healthcare providers (15%;12%). For 1318 adults and 366 parents/caregivers who made a decision, 27% and 34% felt decision regret (>25/100).

Discussion

Canadians are facing new COVID-19 related decisions and experiencing difficulty making them. Many Canadians experienced decisional conflict and decision regret.

Conclusion

There is an urgent need to better support Canadians to address their decisional needs.

94: Training clinicians from five organizational settings to use Option Grid conversation aids (Oral presentation)

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Affiliation(s): The Dartmouth Institute for Health Policy and Clinical Practice, The Geisel School of Medicine at Dartmouth

Introduction

Conversation aids are known to help inform patients and elicit patient- preferences, yet most physicians do not receive formal training on how to operationalize these tools. We created tailored shared decision-making training sessions for clinicians to become familiar with how to use uterine fibroid conversation aids in practice as part of an ongoing multi-site implementation study.

Methods

We used principles of adult learning theory and simulation-based learning to iteratively develop a shared decision-making training curriculum. We mapped training content to the Consolidated Framework for Implementation Research. We tailored the content of each module to optimize operational fit for each of the five participating US gynecology departments and transitioned to an online format as necessitated by COVID-19. A member of the research team took field notes during trainings and subsequent study team debriefing sessions. A research team member conducted semi-structured interviews with participating clinicians post-training. Two analysts independently coded and conducted thematic analysis on field notes and interview transcripts.

Results

We conducted 9 training sessions with about 70 clinicians. Training sessions consisted of 30 minutes of didactic learning and 30 minutes of interactive role playing and discussions. A large-group in-person training session at the first site was adapted to online, smaller group trainings at subsequent sites. Small virtual groups enabled increased clinician interaction with the study team. However, the virtual format introduced more barriers to role-play simulations.

Discussion

Concurrent virtual small-group training sessions created more interactive and relational training environments than larger in-person or virtual sessions. The increased interactivity facilitated a shift of focus away from simulations rooted in adult learning theory. However, relationship building can be useful for facilitating implementation.

Conclusion

While we developed and adapted tailored training sessions to meet the needs of diverse clinical environments, what routine shared decision- making training will look like in clinical environments remains unclear.

Disclosure: *Research reported in this presentation was funded through a Patient-Centered Outcomes Research Institute (PCORI) Award (SDM- 2017C2-8507). The statements in this work are solely the responsibility of the authors and do not necessarily represent the views of the Patient- Centered Outcomes Research Institute (PCORI), its Board of Governors or Methodology Committee.*

95: Factors Affecting Implementation and Sustainability of two Patient Conversation Aids in Gynecology Practice (Oral presentation)

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Introduction

The use of conversation aids has been shown to increase patient knowledge and engagement, yet implementation remains challenging. Normalization Process Theory (NPT), which explores the processes by which organizations integrate interventions into routine work, can be used to guide sustainable conversation aid implementation. As part of a multi- site implementation study, we aimed to assess clinicians' perspectives on use and implementation of the uterine fibroid Option GridTM and Picture Option Grid in gynecological practice using NPT.

Methods

We conducted semi-structured interviews with clinicians. We used NPT to guide the development of the interview guide. We completed interviews with clinical staff from each of the five study sites as they began implementing the conversation aids. Two independent coders conducted framework analysis of the interview transcripts using the NOrmalization MeAsure Development through NPT. Another set of interviews will be completed post-implementation to explore sustainability at each site.

Results

We conducted 23 semi-structured interviews with clinicians as they began implementing the conversation aids into practice. Conversation aids were viewed as valuable tools clinicians could use to organize their thoughts, reduce bias, and empower and educate patients. A clinical champion supporting a shared decision-making culture could facilitate successful implementation. Available treatments varied across sites, and clinicians were hesitant to implement the tool if it did not accurately reflect the treatments they provide – highlighting key aspects of the cognitive participation and coherence required for normalization. Post-implementation data collection will be completed by May 2022.

Discussion

Across the five US sites, use of conversation aids was viewed favorably as a way to empower patients, but actual use requires local actions to change workflows.

Conclusion

Normalization is contingent on the constructs proposed by NPT, yet movement to alignment with coherence and cognitive participation is strongly influenced by clinical champions generating a climate conducive to adoption and sustainability.

Disclosure: *Research reported in this presentation was funded through a Patient-Centered Outcomes Research Institute (PCORI) Award (SDM- 2017C2-8507). The statements in this work are solely the responsibility of the authors and do not necessarily represent the views of the Patient- Centered Outcomes Research Institute (PCORI), its Board of Governors, or Methodology Committee.*

97: Shared decision making on radiation dose for stereotactic body radiotherapy of malignancies located < 1 cm from the thoracic wall – A randomized trial (Oral presentation)

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Introduction

Lung cancer is prevalent with more than 4,600 new cases in Denmark each year. Limited stage disease is often treated with curative intent with stereotactic body radiation therapy, where the tumor is irradiated with a high dose during a few treatment days. The physician sometimes reduce the dose to lower the risk of side effects, which results in less tumor control, often without asking the patient for their preference. In this case, the use of shared decision making (SDM) would ensure both inclusion of the newest medical evidence as well as the patients' preferences.

In this study we will involve the patients in the decision of high (66 Gray) or lower (45 Gray) radiation dose or no radiation treatment at all and test our newly developed Patient Decision Aid (PtDA), which is based on a generic template from Center for Shared Decision Making.

Methods

A randomized, controlled, unblinded study with 40 patients. The patients will be randomized to having the consultation with the physician with or without the PtDA. The primary outcome is extent of SDM behavior of this audiotaped consultation by means of OPTION 12 scoring by two independent reviewers. We also study differences of patient reported SDM with a range of SDM measurement tools, quality of life questionnaires and physician assessed side effects after the treatment.

Results

Inclusion began in November 2021 and will last for 16 months. We have enrolled one patient so far.

Discussion

We expect to see an increased extent of shared decision making in the consultations with the PtDA. This study might pave the way for a broader utilization of SDM in radiation therapy.

Conclusion

None yet, but possible preliminary results can be presented at the conference.

98: Teaching SDM to medical students in the context of virtual learning (Oral presentation)

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Introduction
In 2020 the Universidad Nacional de La Matanza (Argentina) conducted an emergency curricular reform, virtualising the educational activities due to the COVID-19 pandemic. A transversal content of the subject General Medicine 2, in the 5th year of medical school, is Shared Decision Making (SDM). We aimed to describe the educational approach for teaching SDM in this context.

Methods
We held a synchronous virtual seminar with real and simulated video consultations, and we provided additional bibliographic material was provided. We asked the students to work in pairs filming a simulated consultation through role-play, previously writing a script according to our clinical vignettes.

Results
The activity was carried out in two weeks, a first stage for writing the script and a second for filming the consultation. Different virtual platforms were used to film, edit, and deliver the assignment. The teachers interacted asynchronously through the online forum, guiding and answering questions about the clinical vignettes. The productions obtained were videos shared on the virtual campus of the University and socialized with other students. The tutors used an adapted version of the CollaboRATE tool to assess compliance with the SDM process and provided written feedback. This activity was repeated in 2021 due to the ongoing restrictions to in-person classes.

Discussion
It was a challenge to design an educational proposal for teaching and evaluating SDM in virtual learning for content usually taught in face-to-face workshops with high interaction with the students. In this way, original materials that could be shared and evaluated from virtuality had to be generated for this new approach. Students had variable
performance in the adherence to the SDM approach, and some perceived that some vignettes were easier than others.

Conclusion
Using a virtual platform was feasible to deliver the basic concepts of SDM.

99: Accepting “lack of control” on diabetes care as a precursor to the true implementation of Shared Decision Making (SDM) (Oral presentation)

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Introduction

Patients with diabetes play a major role in controlling their blood glucose levels and preventing complications through lifestyle modifications and treatment adherence. Shared Decision Making (SDM) is a recommended model for involving patients in their care. However, true SDM implementation is still limited. This study focused on healthcare professionals' practices, perceptions, and challenges regarding SDM implementation in Diabetes care.

Methods

A qualitative study using an Immersion/Crystallization approach that includes a thematic analysis of 23 semi-structured interviews with healthcare professionals, specializing in diabetes. The interviews focused on their decision-making processes with patients. Data analysis included horizontal and vertical analysis to learn how different professionals perceive working with diabetes patients and patients' involvement.

Results

Most healthcare professionals stated they believe in patient involvement. They emphasized the challenge of diabetes care, due to their limited “control” over patients’ day-to-day diabetes management and treatment success. Some have come to terms with this limited “control” and therefore focus on involving patients in their care. These tend to implement most SDM components. Others, who are concerned with their responsibility and feel frustrated and intimidated by the “limited/lack of control”, tended to focus on tactics to increase adherence. They usually presented only one treatment option and tried to tailor it to the patient, focused on persuasion. They also tended to use intimidation focused on possible complications.

Discussion

Health professionals' perception and approach to dealing with the limited “control” can be a precursor or barrier to their engagement in SDM.

Conclusion

Encouraging professionals to reflect on and deal with their sense of limited “control,” can help them accept their limited control and understand the importance of involving patients, communicating in a patient-centered manner, and truly implementing SDM. This in turn can help patients “control” their diabetes.

100: Shared decision making in recurrent ovarian cancer: From development to implementation of patient decision aids across three departments of oncology in Denmark (Oral presentation)

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Introduction
Patients with recurrent ovarian cancer (ROC) have multiple treatment options that should be discussed. In order to support that treatment and care match the patient's life values and preferences, shared decision making (SDM) and the use of patient decision aids (PtDAs) should be integrated as a natural part of the consultation.

This study aimed to develop as well as implement and evaluate the effects of PtDAs in patients with ROC.

Methods
Two PtDAs were developed by patients and clinicians in cooperation.

Acceptability and usability were tested using items from the “Preparation for Decision Making Scale” questionnaire.

Before and after implementation of the PtDAs, consultations were scored for observed SDM using the OPTION instrument.

Results
Ten patients and 15 clinicians tested acceptability and usability of the PtDAs. Most patients indicated that PtDAs would be helpful during the consultation with the clinician. Ten (75%) of the clinicians responded that the PtDAs helped the patients to understand the benefits and disadvantages of each treatment option. Generally, the clinicians indicated that they would use a PtDA, if they had one available for the specific clinical situation.

Twenty-two consultations before and 33 consultations after implementation of the PtDAs were observed. Mean overall OPTION score improved statistically significantly (17.8 to 23.4: p=0.03). When stratification according to extent of doctor training was done, significant improvement was observed only when the doctor had received SDM training (15.0 to 26.6: p=0.0002).

Discussion
Two PtDAs were systematically developed and implemented at the departments of oncology of three Danish hospitals in order to support SDM in consultations and to fulfil a request from patients and clinicians.

Observed SDM improved, and the PtDAs are still in use at the participating departments.

Conclusion
Training of doctors in SDM and the use of PtDAs appeared to be a necessity for improved evaluations of SDM in clinical practice.

102: Women's use of a decision aid containing a decision analysis model to support the shared decision-making process regarding thromboprophylaxis during pregnancy: DASH-TOP pilot study (Oral presentation)

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Introduction
The DASH-TOP pilot study aimed to assess the application of a decision analysis shared-decision making (SDM) tool to help women at risk of VTE during pregnancy decide whether to take prophylactic low molecular weight heparin (LMWH) during pregnancy.

Methods
The tool was developed by a multidisciplinary international group and includes 3 components: I) evidence-based information on the risks of VTE and efficacy of LMWH during pregnancy; II) value elicitation exercises (ranking, visual analogue scale, standard gamble) to determine patient preferences for each health state relevant to the treatment decision; III) a decision analytical model that examines the treatment options under consideration: prophylactic LMWH versus expectant management without LMWH. A personalized Markov model, according to women's age, risk of VTE and preferences, estimates the expected quality-adjusted life years (QALYs) for each treatment strategy. The option with the greatest expected QALYs represents the recommended strategy. We interviewed women in Spain (n = 8) and Canada (n = 7) to assess their perceptions on the use of the tool to support their decision-making process.

Results
DASH-TOP was well-received and most women engaged in the decision-making process. Women reported that information on health states and LMWH increased their knowledge and helped them make informed decisions. The value elicitation exercises helped women clarify and communicate their preferences. The decision analysis model recommendation helped women reaffirm their decision. However, women didn't respond to the concept of quality adjusted life years, and suggested more informative ways of presenting the decision analysis results.

Discussion/Conclusion
An evidence-based tool that explicitly incorporates patients' preferences can help support SDM for LMWH during pregnancy. The use of decision analysis is helpful to reduce uncertainty in the decision-making process and future testing is needed to evaluate its applicability to support shared decision-making in clinical encounters.

104: Implementation of a decision aid for shared decision making on breast cancer screening: a step forward to informed decisions (Oral presentation)

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Introduction

We developed a web-based decision aid (DA) to support shared decision making (SDM) during the clinical encounter between physicians and women with average breast cancer risk when deciding whether to participate in breast cancer screening (available on http://decidirmamografia.com.ar/). We aimed to assess its effect on informed decisions, SDM, knowledge of the benefits and risks of screening, decisional conflict and intentions to undergo screening mammography.

Methods

We conducted a pragmatic “before-after” trial, with 27 women aged 40 to 69 years old, with average breast cancer risk. Participants had an appointment with their primary care physicians using the DA and completed a pre and post-survey.

Results

The median age was 56. After the use of the DA, 12 out of 27 patients (44%) made an informed choice compared to only one patient (3%) before the use of the DA, an absolute difference (AD) of 41% (95% CI: 19 to 63, p=0.0010); 55% had adequate knowledge compared to 7% before (AD: 48%; 95% CI: 26 to 71; p=0.0002); fewer women expressed positive attitudes towards screening (37 vs 88% before DA, AD: 51%; 95% CI: 74 to 29; p=0.0001); and fewer women intended to do a mammogram (48 vs 74% before DA, AD: 26%; 95% CI: 0 to 52 p=0.0654). Only one patient reported a high decisional conflict, and 80% of the patients considered that they made a shared decision with their physician.

Discussion

This is the first DA for breast cancer screening developed and tested in Argentina. These results agree with similar trials that evaluated informed decisions.

Conclusion

The implementation of this DA demonstrated that women made more informed choices based on adequate knowledge of the benefits and harms of breast cancer screening and their own values and preferences.

105: Effectiveness of a web-based decision aid for patients with generalised anxiety disorder: a protocol for a randomised controlled trial (Oral presentation)

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Introduction

Patients with generalized anxiety disorder (GAD) have concerns and needs about their health and the healthcare they receive. Patient decision aids (PtDAs) are tools that assist patients in making health decisions, when there is uncertainty about treatment choice, incorporating their personal preferences and values about the available treatment options. PtDAs can improve shared decision-making and lead to better treatment outcomes. The aim of this study is to evaluate the effectiveness of a web-based PtDA for patients with GAD in primary care (PC).

Methods

The general study design is composed of two stages: (1) development of a web-based PtDA for patients with GAD, derived from an evidence-based Clinical Practice Guideline and (2) assessment of the effectiveness of the PtDA in a randomised controlled trial (RCT) design, in PC centres in Tenerife (Spain). This RCT (NCT04364958) will be carried out with 156 patients with GAD, comparing the PtDA to a fact sheet with general information on mental health. Patients will review the PtDA in one session accompanied by a researcher. Post-intervention measures will be administered immediately after the intervention and at 3-month follow-up. The primary outcome will be decisional conflict. Secondary outcomes will include knowledge about GAD and its treatment, treatment preference, concordance between treatment preference and choice, and decision quality (knowledge ≥60% and concordant decision).

Results

Seventy-three participants have been included from May 2021 (50% of the sample size needed), 34 in the intervention and 39 in the control group. Twenty-nine participants fulfilled the 3-month questionnaires. Preliminary results will be available at the congress.

Discussion/Conclusion

The use of PtDA for patients with GAD could improve knowledge and decrease decisional conflict when patients are faced with making decisions about their health.

106: Guideline Alignment with Needs for Decision Making and action (Poster)

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Background
Guidelines provide best evidence standards for practice, but are only useful to patients, providers, and systems to the extent that they provide the needed information for decision making and action.

Methods
To test the usefulness of current guidelines for decision making and action, a single reviewer performed a content analysis of the most recent primary cardiovascular prevention guidelines from the U.S. Preventive Services Task Force (USPSTF). She dually reviewed all documents for each guideline on two occasions a month apart for information that would facilitate decision making and action. Such information includes the magnitude and certainty of net benefit (e.g. strength of evidence, applicability) of tests, treatments, and implementation supports, and information to facilitate implementation (e.g. content, delivery routine, and any key mediating and moderating factors).

Results
Guidelines addressed various aspects of screening, early treatment, and implementation support. None systematically reviewed and meta-analyzed the combination of all of these. All five provided data that facilitates decision making. Five reported absolute benefits and harms (or provided information for calculation of these). Further, five reported the overall certainty of evidence (or provided information for assessment of this), providing transparency for recommendation statements. Interestingly, only two reported direct comparative benefits and harms and only one reported absolute net benefit in a nationally representative population, providing optimized assessments about what works. To facilitate implementation, all five additionally reported at least some key features of content and delivery routines and identified at least some key moderating factors. None indicated whether data was from ideal or real-world settings, reported on population and setting representativeness, or reported on mediators of effect.

Discussion/Conclusion
Reviewed guidelines provide most of the information needed for decision making and action. However, improvements would likely help decision makers and implementers agree with guidelines and find them more useful for implementation.

107: Impact of shared decision making on healthcare – a scoping review using a novel taxonomy (Oral presentation)

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Introduction

It is often claimed that shared decision making (SDM) interventions increase costs, consultation time or patient´s anxiety without improving health care processes or other patient-relevant outcomes. Meanwhile, SDM has been evaluated in numerous single trials and reviews with a wide variety of indications, interventions, outcome measures and effects. The aim of this scoping review was to classify these effects using a novel taxonomy.

Methods

We conducted a scoping review in PubMed from 2015 to 2021 of RCTs and systematic reviews comparing SDM interventions to control groups.

We grouped outcomes on five different effect levels – individual, interactional, organizational, system and treatment quality level. We excluded all outcomes related to the individual decision making and consultation process.

Results

Of 1.219 publications, 130 met inclusion criteria (110 single trials and 20 systematic reviews of RCTs). 328 healthcare outcomes revealed either no, a positive, or a trend for a positive effect of shared decision making. Most outcomes (288) belonged to the individual, healthcare system or treatment quality level while a minority (40) examined the interactional and organizational level.

Discussion

Strengths of our study are the novel taxonomy including a systematic approach to diverse interventions and outcomes and the number of included articles.

Weaknesses are the limited number of databases searched and missing appraisal of risk of bias and effect size. Furthermore, the search is limited to studies published after 2015.

Conclusion

Recent literature contradicts the idea that shared decision making leads to restraints in healthcare.

Future research should appraise outcomes on clinician, interactional and organizational level.

108: Physician and patient perspectives on the treatment decision process of unruptured brain aneurysms – a decisional needs assessment (Oral presentation)

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Introduction

Decision making on treatment of unruptured brain aneurysms is challenging because the dramatic consequences of potential rupture over time have to be balanced against the immediate treatment risk and patient preferences need to be weighed in. We aimed to explore if there is a need for decision support.

Methods

For this prospective descriptive study, we asked patients with unruptured brain aneurysms and physicians involved in aneurysm care to complete a needs-assessment questionnaire that was developed based on the Ottawa Decision Support Framework. Participants were asked to rate the importance of several factors that are considered during the decision-making process.

Results

54 patients and 33 physicians participated. For physicians, the rupture risk was of highest importance for decision making ($p<0.05$), followed by technical feasibility, patient preferences, comorbidity, and age. Most physicians (73%) report that they discuss all management options with their patients; however, most patients (82%) reported that only one management option was discussed in clinic. Furthermore, most physicians expect that patients experience negative emotions and difficulty throughout the decision-making process, which is the opposite from what patients reported ($p<0.0001$). However, similar proportions of physicians and patients believed it would be beneficial for patients to receive general information (42%) on brain aneurysms, and decision support (42%) on the management of brain aneurysms.

Discussion

Patients indicated that one treatment option was discussed masking an existing decision conflict, which may explain the overall low rate of negative emotions and decision difficulty. Recall bias could play a role. Interestingly, both patients and physicians see value in additional patient information and decision support.

Conclusion

These results seem to sufficiently underline the need for education and decision support for patients with unruptured brain aneurysms. A decision aid may facilitate shared decision-making for this patient population.

110: Effectiveness of individual feedback and coaching on shared decision-making consultations in oncology care: an ongoing randomized clinical trial (Oral presentation)

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Introduction

Implementation of Shared decision-making (SDM) in oncology care is challenging and clinicians state that it is difficult to apply SDM in their actual workplace. Training clinicians is an effective means of improving SDM, but is considered time-consuming. This study addresses the effectiveness of an individual SDM training program, using the concept of deliberate practice.

Methods

This multicenter single-blinded randomized clinical trial is performed in 12 Dutch hospitals. Patients are involved in the design and implementation of the study. Clinicians involved in decisions with oncology patients record 3 decision-making processes, with 3 different oncology patients. Clinicians in the intervention group receive the SDM-intervention after the first recording: completing E-learnings, reflecting on feedback reports, doing a self-assessment and defining 1-3 personal learning questions, and participating in face-to-face digital coaching. Clinicians in the control group do not receive the SDM-intervention until the end of the study. The primary outcome is the extent in which clinicians involve their patients in SDM, as scored using the OPTION-5 instrument. As secondary outcome patients rate their perceived involvement in the decision-making and the duration of the consultations is registered.

Results

We hypothesize that clinicians exposed to this intervention are more likely to adopt SDM behaviors than clinicians who do not and that patients perceive more involvement in the decision-making process. At this moment 12 hospitals have been recruited. Of the 100 clinicians whom we include for participation, 20 have started. We intend to finish the study in April 2022 and will present the (preliminary) results in June.

Conclusion

This theory-based and blended approach will increase our knowledge about effective and feasible training methods for clinicians in the field of SDM. The intervention is promising as it is tailored to the context of individual clinicians and targets their knowledge, attitude and skills.

111: Applying shared decision-making does not prolong the duration of medical consultations. A systematic review and meta-analysis (Oral presentation)

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Introduction

We summarized literature on the relation between the level of SDM and consultation duration, as a prolongation is one of the greatest perceived barriers to SDM.

Methods

We included studies with adult patients that assessed the level of SDM and the correlation with consultation duration, and that reported a significant improvement in at least one of the SDM-outcomes. Study selection and data extraction were conducted independently by two reviewers.

Results

47 studies, selected from 4,027 publications, met the inclusion criteria: 21 randomized, 4 quasi-experimental, and 22 cross-sectional studies. A reduction in consultation duration was found as often as an increase (7 studies each; range between 11.30 minutes shorter to 13.36 minutes longer. In 4 studies no difference was reported).

Meta-analysis was possible for 4 out of 9 types of intervention characteristics.

1. Interventions targeting both patients and clinicians (MD 0.37 min, 95%CI -1.70 to 2.44 min, I^2= 0%), and
2. Studies using telecom as intervention mode (MD -0.46 min, 95%CI -2.59 to 1.67 min, I^2=0%), did not significantly change consultation duration.
3. Interventions targeting clinicians only (MD 2.49 min, 95%CI 0.76 to 4.21 min, I^2=0%) and
4. Studies performed in primary care settings (MD 2.12 min, 95%CI 0.09 to 4.15 min, I^2=27%), significantly decreased consultation duration.

Discussion

SDM-promoting interventions do not necessarily lead to prolonged consultation durations. Consultation time may increase initially until the clinician has acquired the skills to apply a structured consultation gearing towards SDM.

Conclusion

SDM-promoting interventions, particularly in the primary care setting and those targeting only clinicians, do not increase consultation duration. Training clinicians' SDM skills, and adapting the context of clinicians seem crucial to integrate SDM in routine practice.

112: Older Adults with Advanced Cancer: A Mixed Method Study on Treatment Decision Conversations, Symptoms and Functional Status (Oral presentation)

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Introduction
In the United States 70% of cancer deaths occur in older adults (≥65 years). Few, if any studies have used direct observation methods to assess patient-clinician communication with older adults receiving palliative cancer treatments; and whether these patient-clinician conversations include treatment decision-making discussion, elicit patient values, preferences, and goals or address treatment symptom burden.

Methods
We longitudinally recorded, transcribed, and analyzed patient-clinician conversations involving 15 patients diagnosed with incurable cancer over 6 months. We assessed symptom severity using the MD Anderson Symptom Inventory (MDASI), and functional status with Katz Index of Independence in Activities of Daily Living (IADL) prior to oncology clinic visits. Using double-coding (inductive and deductive) with consensus resolution, we assessed how frequently the conversations a) included treatment decision-making b) elicited patient values, preferences or gals of care, and c) addressed treatment related symptom burden.

Results
Patient characteristics included: 6 female (40%); mean (SD) age 71 (6.57); diagnosis duration 3.6 years (4.45), 53% had severe symptoms on MDASI. Of 67 recorded and analyzed conversations, 7 (10.4%) contained treatment decision-making discussions with 5 (33%) of the patients. We observed no discussions in which patient values and preferences were explicitly elicited or discussed. We observed no discussions in which treatment symptom burden was explicitly discussed. Communication was mainly clinician-directed. Clinicians commonly addressed technical aspects of treatment including reviewing and planning scans or biological markers.

Discussion
Our findings suggest that treatment decision conversations among older patients with incurable cancer receiving palliative cancer treatment occur infrequently during oncology clinic visits. Patient preferences, values, and goals are not routinely elicited, and symptom burden (even when severe) is not frequently addressed.

Conclusion
There is an opportunity to improve shared treatment decision making through routine systematic assessment of goals of care and treatment preferences for older adults with advanced cancer receiving palliative treatment.

113: Measuring shared decision making in individuals invited to bowel cancer screening in a Swedish context – an attempt (Oral presentation)

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Introduction

Prior to the implementation of a nation bowel cancer screening program, the Screening of Swedish Colons (SCREESCO) study, with the aim of investigating how CRC screening impact incidence and mortality in CRC, was introduced. Alongside high participation in cancer screening it is desired that individuals make informed decisions based on knowledge rather than ignorance. Therefore, as a part of the SCREESCO study, we wanted to investigate shared decision making in relation to be invited to bowel cancer screening.

Methods

The CRC module of the DECISIONS survey from the original North American version was translated and culturally adapted into a Swedish context, resulting in the SCREESCO questionnaire. A number of 2748 individuals invited to screening were offered to respond to the web-based questionnaire. The psychometric properties of the questionnaire were then investigated with a Rasch approach.

Results

Twenty-two of originally 54 included items remained and two items were added. Cultural differences between Sweden and the US were found in health care communications. The Rash analysis showed that although the questionnaire was valid in response processes the separation index was less satisfactory. A total of 1320 screening participants and 161 non-participants responded to the SCREESCO questionnaire. The analyses on item level, measured aspects of SDM including knowledge, values and preferences, and involvement. Significant differences between groups were seen in values and preferences.

Discussion

The SCREESCO questionnaire did not measure SDM satisfactory. When using the questionnaire to measure aspects of SDM we found no differences between screening participants and non-participants in knowledge and involvement, but in values and preferences. Therefore, further attention to prominent values and preferences of non-participants may help in reducing screening barriers.

Conclusion

It may, be difficult to measure aspects of SDM in a cross-sectional manner since SDM can be seen more as a process than a static phenomenon.

114: Patient Reported Outcomes (PROs) in the Treatment of Children and Adolescents with Type 1 Diabetes – A Qualitative Study of PROs and Involvement (Oral presentation)

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Introduction
The use of Patient Reported Outcomes (PROs) to gather information about treatment effects, the patient's health status, and health-related quality of life are growing in today's health care system. PROs have the potential to involve patients' perspectives in their treatment, thereby supporting patient-centered care. Within pediatric health services PROs are mainly used in the treatment of children and adolescents with chronic conditions. The investigation of how PROs are used in the treatment of children and adolescents and in addition, which patient involving potential PROs can meet in the patient group, is still limited. The aim of this study was to investigate how children and adolescents with type 1 diabetes experience the use of PROs in their treatment with focus on the experienced involvement.

Methods
Employing Interpretive Description, 15 semi-structured interviews with children and adolescents with type 1 diabetes were conducted. The interviews dealt with a questionnaire about well-being, food, body, weight, and involvement. Moreover, the interviews concerned the use of PROs and the children and adolescents' experienced involvement.

Results
The analysis revealed three themes regarding the use of PROs. The first theme presents the value that PROs contribute with in the treatment of children and adolescents, including new topics of conversation. The second theme shows that the use of PROs make sense to the children and adolescents when the questionnaire structure is thought through, the questions are understandable, and the aim of the questionnaire is clear. The third theme illustrates that when using PROs, children and adolescents experience patient-centered communication and ownership of care among other things.

Discussion/Conclusion
The results clarify that to some extent PROs implement the possibilities that they offer. If the potential of PROs should be fully met in the treatment of children and adolescents, they need a number of adjustments and improvements.

115: Development and pilot testing of a patient decision aid to improve shared decision-making in general practice regarding a timely dementia diagnosis (Oral presentation)

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Introduction

As a consequence of increased public awareness around dementia and an increasingly aging population, more older people initiate a cognitive assessment. At the same time, underdiagnosis of dementia is common and help-seeking often still occurs in a late stage of the disease. This paradox reflects the difficulty of the decision to start a diagnostic process for dementia. The objective of this study was to develop and conduct pilot testing of a patient decision aid (PtDA) that supports patients, significant others (SO), and general practitioners (GP) in deciding on diagnostic testing for dementia.

Methods

In line with the International Patient Decision Aid Standards framework, the PtDa was developed together with end-users. This study has three parts. In part one we developed the PtDA, based on (1) a systematic literature review on patient and SOs' preferences on dementia testing, (2) semi-structured interviews with 11 people with memory complaints (PwMC) and their SOs and 17 GPs, and (3) two group sessions with caregivers of people with dementia and GPs. In part two, the PtDa will be user-tested with end-users using think-aloud interviews. In part three, PtDA users will complete a feasibility questionnaire after using the PtDA online.

Results

Part one: PwMCs' and SOs' needs were among others directed towards information on treatment possibilities and the hope to find the cause of their memory complaints. GPs mainly expected a PtDA to manage expectations regarding treatment possibilities and referral to memory clinics.

Part two: Results are expected by May 2022.

Part three: Data collection is ongoing (preliminary results by May 2022). PtDa will be adjusted as a result of the findings.

Discussion + Conclusion

Through involving end-users in the development of the PtDA, we expect that this PtDA has the potential to help PwMCs, their SOs, and GPs in deciding on whether to pursue diagnostic testing for dementia.

116: Bringing personal perspective elicitation to the heart of shared decision-making: a scoping review (Oral presentation)

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Introduction

Proponents of shared decision-making advocate the elicitation of patients' perspective. In this scoping review we explore if, and to what extent, the personal perspectives of patients are elicited during clinical encounters.

Methods

A search was conducted in 5 databases from inception to July 2020. We defined personal perspective elicitation (PPE) as: the disclosure (either elicited by the clinician or spontaneously expressed by the patient) of information related to personal preferences, values and/or context that are relevant to decision-making.

Results

We identified 4562 unique abstracts; 263 full text articles, and included 99 studies. 52 used an SDM instrument (quantitative approach), 45 were qualitative studies and 2 had mixed approaches. The 54 studies with PPE-related items reported scores that indicated low levels of personal perspective elicitation. Of the 47 qualitative studies, 24 were categorized as low personal perspective elicitation, 8 as medium and 6 as high, while 9 studies could not be categorized.

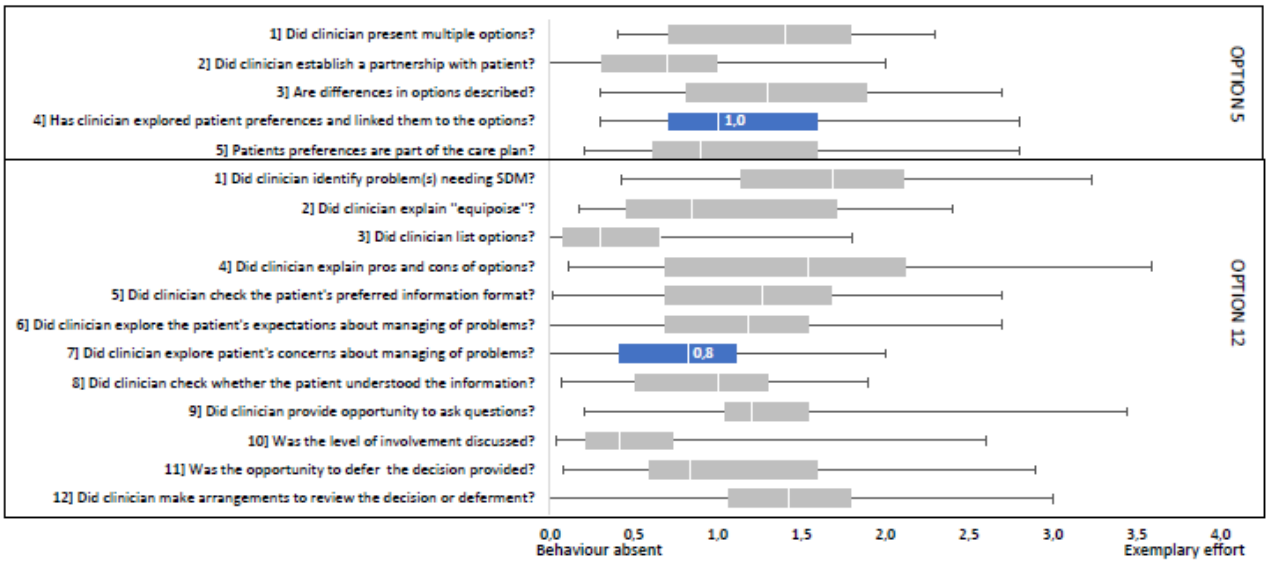
Discussion

Personal perspective elicitation, being recognized as an essential element of shared decision-making, occurs on a low level in efforts to achieve shared decision-making. To bridge this gap, possible causes should be identified followed by designing interventions and implementation strategies to improve this aspect of shared decision-making.

Conclusion

Personal perspective elicitation is advocated but rarely achieved in shared decision-making evaluation studies.

Figure 1: Box and whisker plot with median scores per item calculated from the mean scores of Observer OPTION 5 (n = 10 studies) and Observer OPTION 12 scores (n = 22 studies) highlighting personal perspective elicitation (PPE) scores.



117: The Tell me tool: the development and feasibility of a tool for person-centered fertility care (Oral presentation)

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Objectives

An important element of person-centered care is the elicitation and inclusion of individual patients' values and preferences. This is challenging but especially important for high-burden fertility treatments. We describe the development of a clinical tool that aims to facilitate the delivery of person-centered fertility care by giving insight into the patients' values and preferences.

Methods

We developed the Tell me Tool (TMT) following the three principles of user-centered design: 1) early and continual focus on users; 2) iterative design; 3) measurement of user behavior. Accordingly, our methods consisted of: 1) conducting semi-structured interviews with 18 couples undergoing fertility treatment, followed by a consensus meeting with stakeholders; 2) performing seven iterative improvement rounds; 3) testing the feasibility of the tool in ten couples.

Results

The TMT asks patients to rank important themes (part A – figure 1), explain why these themes are important to them (part B), and write down what matters most to them (part C). The field test showed that the tool is easy to complete, highlights what is important to the individual patient, and could give insight into patients' personal circumstances.

Discussion

The TMT was developed together with patients and appeared helpful for both partners of a couple. Our results need to be confirmed in a larger study, and after adaptation the TMT might be valuable for other conditions as well.

Conclusion

We developed a tool that gives insight into the values and preferences of the individual patient. The tool seems feasible for facilitating person-centered fertility care.

Figure 1: Tell me Tool

1: How important is every theme to you? Rate all themes. Themes you miss can be filled in at Other.
2: Mark the four themes that you feel require extra attention in your counselling and treatment (your top four).
3: Distribute 10 points over your top four. Themes may receive 0 points, as long as it adds up to 10.

	Not important 1 2 3 4 5 6 Very important (1)	(2) Top four	(3) 10 points
Becoming pregnant	☐ ☐ ☐ ☐ ☐ ☐	___	___
The relationship with your partner	☐ ☐ ☐ ☐ ☐ ☐	___	___
Physical health	☐ ☐ ☐ ☐ ☐ ☐	___	___
Mental health	☐ ☐ ☐ ☐ ☐ ☐	___	___
The medical expertise of the care team	☐ ☐ ☐ ☐ ☐ ☐	___	___
The information provision	☐ ☐ ☐ ☐ ☐ ☐	___	___
Seeing the same caregivers	☐ ☐ ☐ ☐ ☐ ☐	___	___
The caregivers' attitude	☐ ☐ ☐ ☐ ☐ ☐	___	___
Flexible scheduling of appointments	☐ ☐ ☐ ☐ ☐ ☐	___	___
Accessibility for questions	☐ ☐ ☐ ☐ ☐ ☐	___	___
That caregivers take the time	☐ ☐ ☐ ☐ ☐ ☐	___	___
Being involved in decision making	☐ ☐ ☐ ☐ ☐ ☐	___	___
The pain control and side effects	☐ ☐ ☐ ☐ ☐ ☐	___	___
Other: _____	☐ ☐ ☐ ☐ ☐ ☐	___	___
		Total:	10

Part A

Explain why those four subjects are important to you and what we can do for you personally.

Part B

Write down what you want your care team to know about you as a person (your experiences, beliefs, personality). Everything that may help us take good care of you.

Part C

Thank you for completing the Tell Me tool!

119: Tailoring an international collaborative platform to develop decision aids and support their broad implementation (Oral presentation)

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Introduction

We are creating a web-based platform to support the collaborative development of high-quality decision aids (DAs) by a diversity of stakeholders. In this project, we sought to describe the factors influencing sustainability of this platform.

Methods

In this ongoing qualitative descriptive study, a user-centered design approach serves to tailor a mockup of the platform to users' needs. Using the team members' networks, we are recruiting 24 DA authors (e.g., researchers, clinicians, patient/citizen partners), from low-/middle-income, and high-income countries, who speak French, English or Spanish. Think-aloud sessions help assess the usability of the platform, and open-ended questions based on the Normalization Process Theory, its potential for sustainability. Thematic analyzes sorting out the strengths/weaknesses of the platform support its adaptation. Evaluation/modification processes are replicated over several iterative cycles, to ensure delivery of the desired functionalities.

Results

Of the five participants recruited so far, three were clinical researchers, one a researcher and one a patient. They had developed 2 to 10 DAs each. They appreciated that the platform could support collaborative DAs development with partners less familiar with shared decision making, and welcomed its editing/commenting functionalities. During think-aloud, navigation appeared intuitive. Adding an introduction was suggested to clarify the overall process. Participants proposed some strategies to inform authors of the IPDAS criteria and support them in their application. They also mentioned that the platform should support authors in considering patients' needs.

Discussion

Several functionalities are needed to support sustainability of the platform, e.g. to ensure a significant engagement of partners in the development process, to support compliance with IPDAS criteria, to allow creation of web-based and printable versions. We will therefore use an incremental development and validation process.

Conclusion

This project will allow creating a collaborative platform that meet the needs of diverse stakeholders internationally.

120: Patient-centered cancer care through the provision of audio recordings of their clinical encounters for patients – study protocol and first results of a feasibility study (Oral presentation)

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Introduction
Patient-centered care and shared decision-making are highly relevant in oncology. Providing patients with audio recordings of their own patient-physician consultation improves their recall and understanding of medical information. The intervention thus contributes to patient-centeredness and shared-decision making. While this intervention has already been investigated internationally, there is barely any research on this topic in Germany, except for some preliminary qualitative work. Thus, the study aims 1) to assess attitudes of cancer patients and oncologists towards the provision of audio recordings of their own doctor-patient encounter, 2) to test the feasibility of this intervention, and 3) to investigate factors influencing feasibility.

Methods
A mixed-methods study is planned. In phase 1, cancer patients (n=300) and physicians (n=100) will receive a survey to examine attitudes and qualitative interviews will be conducted. In Phase 2, the intervention will be piloted to examine feasibility in routine care. A follow-up survey will assess implementation outcomes as well as perceived changes in patient outcomes and patient-physician-relationship. Finally, results will be discussed in an expert workshop.

Results
This study will give insights into attitudes towards as well as the feasibility of the intervention. We expect to find facilitators as well as barriers that influence patients' and physicians' openness towards the intervention and its feasibility in routine care. Preliminary results of phase 1 will be presented at the conference.

Discussion
This feasibility study can form the basis for further research (e.g. effectiveness studies, randomized controlled trials) and potentially for implementation in routine care. Also, the results can support the derivation of recommendations for action by interested health care facilities.

Conclusion
The provision of audio recordings of their own clinical encounters for patients is under-researched in Germany. The results of this study will allow a very good assessment of the potential of the intervention for cancer care in Germany.

122: Implementing SDM in interprofessional home care teams to engage caregivers in health-related housing decisions for engage caregivers in health-related housing decisions for cognitively Impaired Older Adults: A Stepped-Wedge Cluster. Randomized trial (Oral presentation)

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Introduction

Caregivers need help to make difficult decisions about health-related housing for cognitively impaired older adults. This study aims to evaluate the impact of adding a training program in interprofessional shared decision making (IP-SDM) to passive dissemination of a decision guide to increase the proportion of caregivers reporting an active role in the decision-making process.

Methods

A stepped wedge cluster randomized trial was conducted from in nine health centers in Quebec, Canada. Participants were caregivers of cognitively impaired older adults who were facing health-related housing decisions and receiving care from home care teams working in the health centers. The intervention included a 1.5-hour online tutorial for home care teams plus a 3.5-hour interactive workshop in IP-SDM. The control was the passive dissemination of a decision guide. The primary outcome was caregivers' active role in the health-related housing decision-making process. Secondary outcomes were preferred health-related housing option, actual decision made, decisional conflict, decision regret, caregivers' involvement in decision-making, exposure to the decision guide and burden of care.

Results

The 339 caregivers were on average 66.4 (11.7) years old, female (70.5%) and 87.3% had a secondary school level or higher. After adjusting for clustering and time effects, there was no statistically significant change in the proportion of caregivers reporting an active role in the decision-making process between the intervention and control periods (absolute increase 6.1%, 95% CI −11.2% to 23.4%; *P =.49*). The intervention had no significant effect on any secondary outcomes. However, we observed an absolute decrease in decisional conflict -7.5% (95% CI − 16.5% to 1.6%; P = .10).

Conclusion

In home care setting, the addition of a training program in IP-SDM to the passive dissemination of a decision guide was not sufficient to increase the proportion of caregivers reporting an active role in the decision-making process.

123: Evaluation of a program for routine implementation of shared decision-making in oncology: results of a stepped wedge cluster randomized trial (Oral presentation)

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Introduction
Despite high relevance, shared decision-making (SDM) is rarely implemented in oncology. This study evaluated an empirically and theoretically grounded SDM implementation program in oncology.

Methods
We used a stepped wedge design. Three departments of one comprehensive cancer center sequentially received the implementation program in randomized order. The program had six components: training for clinicians, individual coaching for physicians, patient activation intervention, patient information material/decision aids, revision of quality management documents, and reflection on tumorboards. The primary outcome was patient-reported SDM uptake using the 9-item Shared Decision Making Questionnaire. We assessed several secondary implementation outcomes. To evaluate reach and fidelity of the program, we conducted a process evaluation using mixed methods. We analyzed data using mixed linear models, content analysis, and descriptive statistics.

Results
We evaluated a total of 2,128 patient surveys, 559 surveys from 408 clinicians, 132 audio recordings of medical encounters, and 842 case discussions from 66 tumorboards. There was no statistically significant improvement in the primary outcome. Shared or patient-lead decision-making was more likely experienced by patients in the intervention condition than in the control. The quality of psycho-social information in tumorboards was lower in the intervention than in the control condition (d = − 0.48). Other secondary outcomes did not show statistically significant differences between conditions. We implemented all components in all departments. However, reach was limited (e.g. training of 44% of eligible clinicians) and a range of adaptations occurred (e.g. reduced dose of coaching).

Discussion/Conclusion
Possible explanations for the lack of effects in most outcomes are provided by the process evaluation. The results may be explained by low reach and adaptations, especially in dose. We need different or more intensive approaches to successfully implement SDM on departmental levels in routine oncology. We need further research to better understand factors that influence SDM implementation.

124: The role of time in the participation of patients in cancer treatment decision-making: A scoping review (Oral presentation)

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Introduction

Patients and clinicians often mention time as a barrier for patient participation in cancer treatment decision-making. Yet, little is known about how patients, their decision partners, and clinicians perceive the role of time in effective patient participation in cancer treatment decision-making, and which strategies can be applied to overcome time-related barriers to patient participation. Our aims are to 1) understand the role of time in patient participation in making decisions about their cancer treatment, and 2) identify strategies to overcome time-related barriers.

Methods

We carry out a scoping review and conducted a literature search in seven biomedical databases: PubMed, EMBASE.com, Emcare (via Ovid), The Cochrane Library (via Wiley), CINAHL and APA Psycinfo (both via EBSCO) and Web of Science, from their inception until October 5th 2021. Publications are eligible if they report on the role of time in the participation of adult patients (18+) with cancer, and/or on strategies to overcome time-related barriers to patient participation. Reviewers work independently and in pairs to select publications and extract data. We will analyze the data thematically.

Results

Our literature search identified 3657 publications. After deduplication, 2064 publications were left for title/abstract screening. We selected 789 publications for full-text screening, which is currently ongoing.

Discussion/Conclusion

Based on our scoping review findings, we aim to develop: 1) a conceptual model of the role of time in the participation of patients in cancer treatment decision-making, and 2) an inventory of strategies to overcome time-related barriers to patient participation. Both outcomes will help to understand how and when time can be used most effectively for patients with cancer to participate in treatment decision-making.

125: The role of time in the participation of patients in cancer treatment decision-making: A qualitative study (Oral presentation)

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Introduction

Patients and clinicians often mention time as a barrier for patient participation in decision-making. Yet, little is known about how patients, decision partners, and clinicians perceive the role of time in promoting effective patient participation in cancer treatment decision-making, or which strategies can be applied to overcome time-related barriers to patient participation in decision-making. Our aims are to 1) understand how time (how much and when) may promote and/or hinder patient participation in making decisions about their cancer treatment, and 2) identify strategies to overcome time-related barriers.

Methods

We are in the process of conducting individual interviews with individuals diagnosed with cancer, decision partners, and physicians. To be eligible, patients and decision partners should have faced one of the following decisions at most six months before: whether or not to undergo intensive treatment in patients with acute myeloid leukemia (aged ≥60 years), or adjuvant chemotherapy in patients with stage II/III colon cancer (aged ≥18 years). Physicians are eligible if they carry medical responsibility over one of the two decisions.

We ask participants about their experiences with and opinions about (the time for) the decision-making process, and ways to improve (the time use in) this process. We will continue conducting interviews until we reach data saturation. We expect to include 10-12 patients, 4-6 decision partners, and 12-15 physicians. We will record and transcribe the interviews, and apply open, axial, and selective coding on the transcripts.

Results

At this point, we have conducted four physician interviews. We expect to complete data collection and analysis by May 2022.

Discussion/Conclusion

Based on the results, we aim to develop: 1) a conceptual model of the role of time in effective patient participation in cancer treatment decision-making, and 2) a list of strategies to overcome time-related barriers to patient participation.

126: Costs Associated with Implementation of a Patient Decision Aid for Uterine Fibroids (Oral presentation)

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Introduction
Decisions to implement clinical innovations are often cost-dependent, so information about necessary resources, purchases, and workflow adjustments is critical. Unfortunately, the costs of implementing patient decision aids have not been rigorously evaluated.

Methods
Within a larger multisite study, we estimated the cost of implementing a patient decision aid at five gynaecology clinics. We followed a time-driven activity-based costing approach, which requires information on who does what, when, and how often. We gathered data on site-based (e.g., EHR integration, workflow modification) and non-site-based (e.g., subscription to the decision aid) costs primarily through qualitative interviews with key stakeholders. Costs were categorized as one-time or recurring to distinguish between initial implementation and sustainability periods.

Results
Planning, EHR integration, training, and workflow modification were the most common sources of site-based costs. These costs were largely personnel expenses (staff activities to accomplish these tasks), and were absorbed by existing staff. The primary non-site expense was the subscription fee paid to the decision aid developer. Costs varied across sites based on several factors, such as the clinic's capacity for EHR integration, whether they already used other decision aids, and how they typically shared information with patients (e.g., electronic vs. paper; pre, during, or after visit).

Discussion
There are predictable costs incurred with implementing patient decision aids. Some health systems likely have many of the necessary resources to absorb these costs. However, costs will vary depending on numerous factors. For instance, intangible costs associated with cultural and workflow issues are harder to predict.

Conclusion
Institutions will need to consider many factors when adopting a patient decision aid. Many of the costs will be predictable and our findings help elucidate those. Costs associated with changing culture, practice patterns, and workflow will be more elusive, and these factors will impact implementation success.

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128: Determinants of the adoption of frailty prevention strategies by older adults exposed to the Healthy Aging decision aids: a qualitative study (Poster)

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Introduction

Implementing shared decision-making in primary care to support older adults in selecting frailty prevention strategies has proven challenging. We therefore created seven decision aids (DAs), to directly inform older adults of their options, without the mediation of healthcare providers. We sought to describe the factors influencing the adoption of frailty prevention strategies by older adults who read these DAs.

Methods

In this ongoing qualitative study, we will recruit 77 participants—older adults, caregivers, healthcare providers, representatives of community organizations. Each participant is required to read one of seven DAs, available in web and printable format: Memory, Mood, Social life, Mobility/vigor, Self-care, Sleep and Nutrition. Semi-structured interviews and thematic content analyzes, guided by the Theoretical Domains Framework, allow identifying the characteristics of DAs, individuals and living environments that influence the adoption of frailty prevention strategies by older adults.

Results

So far, we interviewed 3 older adults (mean age: 80±1 years), 3 caregivers, 9 healthcare providers (social workers, nurses, physiotherapist, occupational therapist) and 4 representatives of community organizations. Older adults appreciated the directory of local and online resources included in the DAs to implement the selected strategies. They also liked that the DAs confirmed that some of their current lifestyles were conducive to preventing frailty, and suggested adding a section to describe their good habits. The healthcare providers valued that the DAs offered synthesis of evidence and identified several contexts where they could use them, such as with isolated older adults.

Discussion

DAs about lifestyle changes may require information beyond DAs' usual scope, to increase people's sense of self-efficacy. Community organizations could facilitate the implementation of these DAs.

Conclusion

Results of this study will help tailor the DAs and leverage community and health resources to support the adoption of preventive strategies to limit the risk of functional decline in older adults.

130: Evaluation of a national programme to enhance shared decision-making skills among junior medical doctors in Denmark: A mixed methods study of satisfaction, usefulness, and dissemination of learning outcomes in clinical practice (Oral presentation)

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Introduction

Shared Decision-Making (SDM) is a cornerstone in patient-centred care and there is an increase in programmes aiming to enhance clinicians' abilities to engage in SDM. However, the evidence of such programmes' effectiveness on clinicians' use of SDM in clinical practice is sparse. The SDM Ambassador course, developed and facilitated by the Danish Association of Junior Doctors is a SDM training programme for junior medical doctors (JMDs). This study aims to evaluate the SDM Ambassador course, with a focus on satisfaction, usefulness, and dissemination of learning outcomes in clinical practice.

Methods

We conducted a mixed methods study consisting of an online survey followed by semi-structured interviews. The participants were JMDs who had trained to be SDM ambassadors between May 2016 and September 2020 (n=185). In total, 112 ambassadors completed the survey, corresponding to a response rate of 61%. Descriptive statistics and $\chi 2$-tests were conducted. Subsequently, purposive sampling was used to identify 10 ambassadors for interviews. The interviews were transcribed, encoded and subsequently analysed thematically. Finally, the quantitative and qualitative results were integrated.

Results

Overall, the ambassadors were satisfied with their learning outcomes and experienced a greater capacity to unfold the perspectives of their patients. A majority (79%) reported that they had used SDM in encounters with patients, and 59% had disseminated SDM to their colleagues. The usefulness and dissemination of learning outcomes in the clinic were shaped by the ambassadors' perceptions of their moderate professional experience, and constrained by structural and cultural conditions in the context of clinical practice.

Discussion

Despite overall satisfaction with their learning outcomes, ambassadors experienced conditions constraining the translation of their learning outcomes into clinical practice.

Conclusion

To improve, continuous refresher courses should be added, and enhanced support at organisational and political levels is necessary for SDM to become an integral feature of the clinical encounter.

132: Assessing incomplete harms reporting when summarizing evidence for PDAs (Poster)

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3. Cochrane Adverse Effects Methods Group (Dr. Loke is Senior Co-Convenor and Dr. Vohra is Co-Convenor)

Introduction

Summarization of evidence on harms for PDAs is challenging because harms are typically selectively and incompletely reported, usually with insufficient detail to be included in a review meta-analysis. An absence of reporting does not mean an absence of events.

Methods

We identified and summarized methods for handling and evaluating incomplete reporting of harms for systematic reviews. We were a priori aware of the ORBIT II method. A snowball search identified no other relevant methods besides ORBIT II.

Results

The ORBIT II method groups studies with no reporting or partial reporting of an outcome according to a 13-point classification system designed to make a judgment about the reason for missing data on harm outcomes. A classification of "high risk" of outcome reporting bias is assigned when the specific harm had been measured but the data were presented or suppressed in a manner that would mask the harm profile of the intervention in question. These classifications can be presented in an outcome matrix, which shows an assessment of the overall risk of outcome reporting bias across studies. The ORBIT website (http://www.outcome-reporting-bias.org/) includes an "ORBIT Toolkit" with the ORBIT classifications worksheets (for harms [ORBIT II] and separately for benefits [ORBIT I] outcomes) and ORBIT matrix generators.

The poster will include illustrative examples of the ORBIT II classification system and outcome matrix.

Discussion

The ORBIT II classification system is a method that allows for an assessment of risk of selective outcome reporting in summarizing evidence for a PDA.

Conclusion

Standard use of the ORBIT II classification system for the evidence summarization process of harms for PDAs would promote the quality, reproducibility, and standardization of harms assessments.

133: Adolescents' self-efficacy in meeting with their provider alone to discuss their care (Oral presentation)

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Background

Adolescents with special healthcare needs (ASHCN) preparing to transition to adult-based care must be able to independently discuss their care and make decisions with providers. Fewer than 50% of ASHCN meet with their paediatricians alone, limiting opportunities to develop/practice independence and self-management skills. We used Self-Determination Theory (SDT), a model of behavior change, to identify factors associated with self-efficacy to meet with a provider alone among 18-year-old ASHCN.

Methods

With IRB approval, 83 ASHCN completed assessments of their self-efficacy to meet with a healthcare provider without a parent/guardian. Questions assessed perceived self-efficacy; perceived importance of being interviewed alone; whether they had met with their provider alone; perceived competence in healthcare self-management (Patient Activation Measure); healthcare autonomy (HCA); and perceived support for HCA from parents and providers. Analyses included t-tests, Chi-square, correlations, and linear regression.

Results

Participants were 54% female, and 53% publicly insured. Fifty-two percent (n=46) reported meeting with their provider alone in the last 12 months. Self-efficacy was correlated ($p<.05$) with perceived competence in healthcare self-management ($r=.481$); autonomous ($r=.368$) but not controlled ($r=-.050$) HCA; and provider ($r=.449$) and parent ($r=.413$) support for HCA. In the multivariate model, female gender ($p=0.013$), competence ($p<0.001$), and provider support for autonomy ($p=0.005$) were associated with self-efficacy in meeting with provider alone (R-square=.365, F-change=15.150, $p<0.001$).

Discussion

48% of 18-year-old AYSHCN are not meeting with their provider alone to discuss their care and make decisions. This is a missed opportunity to promote autonomy and to practice decision-making. Factors that independently contribute to ASHCN self-efficacy to meet with their provider alone provide a framework for the development of interventions to promote self-efficacy while still in paediatric care.

Conclusion

Opportunities for ASHCN to meet with their providers alone and methods wherein providers can show support for HCA should be promoted.

136: Some current developments to promote SDM-implementation in the Netherlands (Oral presentation)

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Introduction

Since the beginning of this century, the implementation of SDM is advocated by a growing number of proponents, but is still lagging behind in clinical practice. We present a bird's eye view of the current initiatives in the Netherlands to promote SDM on national, healthcare institution (HCI), and healthcare professional (HCP)/patient levels.

Methods

National level:
SDM is part of value-based and outcome-based healthcare projects, supported by the ministry of Health, the Dutch Organisation for Health Research and Innovation, healthcare insurance companies, and professional and patient advocacy societies.

HCI level:
Collaborating academic centres and teaching hospitals take ongoing initiatives and trials to implement SDM for various disorders and specialties.

HCP/patient level:
Various tools, e.g., consultation trainings and decision-making support tools, are being developed and employed.

Results

National level:

- SDM was incorporated in legislation. Since October 2021, an 18-month, public SDM-campaign is running to improve awareness and attitude among citizens, HCPs and patients. Healthcare insurers contemplate how to reward SDM.
- A 5-year programme "Outcome-based healthcare" will wrap-up this year, promoting SDM through better access to outcome information, and a national database of patient decision aids.
- SDM-competency definitions were developed for both nurses and doctors to be embedded in professional curricula.

HCI level:

- A set of 16 projects in various specialties has just been completed and provide organisational and practical examples to promote SDM.

HCP/patient level:

- Clinical trials have shown what helps to implement SDM, such as practice al SDM-training, feedback, and decision support
- Presently, 170 Dutch decision aids are available.

Discussion

Awareness about the need for, and importance of, SDM needs continuous attention at macro and micro levels for SDM to become common practice.

Conclusion

The Netherlands may rejoice in the growing interest and efforts to further SDM. However, these initiatives constantly have to compete with other priorities.

137: Defining and measuring knowledge in cancer screening – is there a need for new information materials? (Oral presentation)

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Aim
The aim of this PhD project is to examine the concept and measurement of knowledge in cancer screening, as a key element of making informed choices about (non)participation.

Methods
A workshop with national and international scientific experts and focus group interviews with 50 Danish citizens eligible for breast, colorectal and/or cervical cancer screening will be used to determine what constitutes relevant knowledge of cancer screening. The results from the workshop and the focus group interviews will be used to develop a validated scale for the measurement of knowledge about cancer screening, and the psychometric properties of the scale will be evaluated. The scale will be used in a cross-sectional study to investigate the level of knowledge of cancer screening among Danish citizens eligible for population-based cancer screening.

Results
It is expected that the project will contribute to international consensus on what constitutes relevant knowledge of cancer screening and how it is measured. The validated scale will contribute to an evaluation of Danish citizens' level of knowledge of cancer screening based on the current information materials. Further, it is expected that the project will provide insight into the level of knowledge across screening programs, sexes, age groups and socioeconomic status and further international validation of the scale will be planned.

Discussion/Conclusion
This project is innovative and with the involvement of both national and international scientific experts, it is expected to progress the research area, contributing to the measurement of informed choices. Consensus on what constitutes relevant knowledge in cancer screening and the development of a validated scale for measurement of knowledge will enable comparison of citizens´ knowledge of cancer screening across countries and between studies. Further, it will contribute with insight of whether current information materials sufficiently support citizens in making an informed choice about (non)participation in population-based cancer screening.

138: Effectiveness of training and support tools in improving shared decision-making in vascular surgery: A randomised trial (Oral presentation)

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Introduction

Vascular surgery is an ideal area for shared decision-making (SDM), as different treatment options are possible for various diseases. However, SDM is not yet common in vascular surgical outpatient clinics. We studied the effectiveness of a set of tools (decision cards, consultation cards, online patient decision aids) and a SDM-training to improve SDM-levels among vascular surgeons and their patients.

Methods

We conducted a Stepped-wedge cluster-randomised trial in 13 Dutch vascular clinics. Each centre chose their preferred set of tools. Data were obtained via questionnaires and audio-recordings of the consultations. Primary outcome was the level of patient involvement using the OPTION-5 instrument. Main secondary outcomes were: patients' disease-specific knowledge, consultation duration, and treatment choice. Factors influencing OPTION-5 scores were studied using regression analysis.

Results

We included 342 patients with an abdominal aortic aneurysm (AAA; n=87), intermittent claudication (IC; n=143), or varicose veins (VV; n=112). Overall mean OPTION-5 score significantly improved from 28.7% to 37.8% (mean difference 9.1%, 95%CI: 6.5-11.8%) after implementation of the tool, especially the preference eliciting phase. Also patient knowledge increased significantly (median increase: 13%, p=0.025). The fraction of patients choosing non-surgical treatment choices increased from 21.4% to 28.8% for AAA-patients and from 16.0% to 32.0% for IC-patients. For surgeons, the SDM-training, and for patients the decision aid significantly increased OPTION-5 scores (p<0.001 and p=0.047, respectively).

Discussion

Implementing the SDM-tools and a SDM-training better involved patients in the decision-making process, particularly regarding the elicitation of patient preferences. However, it remains a challenge to make SDM and these tools part of routine clinical practice.

Conclusion

The combination of SDM-tools and a SDM-training improves the level of SDM in vascular surgery, improves patient knowledge, and shifts their preference towards more non-surgical treatments. Implementation of SDM-training for clinicians and the decision aid for patients is an effective combination to improve SDM.

139: Development and evaluation of a decision aid for breast cancer screening in the Chilean primary healthcare (Oral presentation)

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Introduction

Breast cancer (BC) is one of the most common cancers in Chile. National efforts focus on early detection, offering universal access to screening. However, 30% of women do not undertake the exam due to a lack of knowledge and anxiety. Aim: to develop and evaluate the effectiveness of a decision aid (DA) for women facing BC screening.

Methods

following the Medical Research Council guidelines for the development and implementation of a complex intervention in public health, we: 1) adapted the German DA for mammography; 2) conducted focus groups with experts to further develop the DA; 3) pilot-tested the DA with 40 women; 4) We are currently conducting an online two-arm randomised controlled trial nationwide. A total of 1375 women aged 50 to 69 years old are invited to join the study. Both groups complete a set of baseline questionnaires (Informed Choice, decisional conflict, anxiety). The intervention group access the DA. The Control group receives standardised information. Both groups complete the follow-up questionnaires two weeks later. Multiple lineal regression analysis will be conducted.

Results

independent researchers adapted the German DA. Two focus groups were conducted with an expert group compounded by ten professional, three patients, and one professional designer. The group iterated three versions of the DA and agreed on the content and the design. This is an ongoing project, and the results of the trial phase will be updated by the time of the conference.

Implications

This is the first DA for the Chilean population. During the process, it has been identified key elements for implementing the DA and, in the context of the pandemic, the need to offer accessible and virtual information for BC early detection.

140: How is patient centered care being taught in the undergraduate programs? A review of the Faculty of Medicine at a Chilean University (Poster)

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Introduction
Patient-centered care (PCC) has been defined as one of the pillars of the Chilean health system. Consequently, health providers are expected to deliver care that puts patients at the center. However, little is known about how PCC is being taught at health undergraduate programs. The aim is to identify teaching practices at the undergraduate programs of a Chilean Faculty of Medicine.

Methods
A qualitative study was conducted using documentary analysis. The graduate profile of all the undergraduate careers of the Faculty of Medicine were reviewed. An extraction matrix was used to record this information. Content analysis was performed.

Results
Seven undergraduate programs were included (Medicine, Nursing, Dentistry, Nutrition and Dietetics, Physiotherapy, Speech therapy, and Occupational Therapy.). The results showed that although PCC is mentioned as a desirable competence of the students, very little is done to help them to understand about PCC and master it as a professional skill. A proposed strategy to strengthen PCC in the curricula is presented.

Discussion/Conclusion
As PCC is a desirable skill of health professionals, special attention must be given to the way undergraduate students are receiving training to master PCC.

141: Promoting Patient Participation in Care: Transferring knowledge on patient centered research, education, and clinical practice (PRO-PACT) (Poster)

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Introduction

In Chile, research on and promotion of PCC have taken place over the past decade. However, PCC has not extensively been implemented in clinical practice, yet. In Germany, an integrative model of PCC and patient-reported experience measures of PCC have been developed. However, a structured program for the implementation of PCC in clinical practice is still missing. The overall aim of this international project, funded by the Federal Ministry of Education and Research, is to facilitate international collaboration, exchange, and research on the implementation of PCC in Chile, Germany and beyond. The specific objectives of the project are: 1) to establish an international network on PCC to foster exchange in research, education, and clinical practice, 2) to understand the needs for PCC implementation and factors influencing implementation in both countries and adapt the integrative model of PCC for the Latin American context, 3) to develop and implement a workshop program on PCC, 4) to facilitate the international exchange of young researchers between Chile, Germany and beyond.

Methods

The “International Network for PCC” is currently being initiated. A virtual network platform on PCC will be launched. A systematic review and a Delphi study will be conducted in Chile and other Latin American countries with the objective to adapt the integrative model of PCC to the Latin American context. To understand the needs for PCC in both countries a mixed-methods study will be conducted. Based on the results of the previous steps, PCC training programs for health care professionals (HCPs) will be developed and implemented. Finally, an international conference on the implementation of PCC will be held.

Results

Four online events were organised as an opportunity for learning, networking, and discussion about PCC. Thirty two members of the research groups of the team in Chile and Germany were invited.

142: Co-creation of a Massive Open Online Course on Shared Decision Making and Digital Health Literacy for women with Breast Cancer (Poster)

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Introduction

Diagnosis of breast cancer (BC) is usually experienced as a traumatic event and the patient becomes more vulnerable to the negative consequences of the use of biased or low-quality online health information. Sometimes patients do not often discuss their findings online with their healthcare professionals. Due to the complexity of health information, it is recommended that digital health literacy (DHL) interventions be based on a co-creation design with women with BC.

Objective

To develop a Massive Open Online Course (MOOC) with educational materials on Shared Decision Making, Person-Cantered Care and DHL for women with BC and different sociodemographic and clinical profiles.

Methods

19 women (48.07±5.85 years) participated in an online co-creation process during July-November 2020 aimed at developing jointly with healthcare professionals the design, structure and content of a MOOC about BC. An evaluation of the experience of the participants in the co-creation process was carried out and a pilot was conducted to evaluate the navigability and usability of the MOOC.

Results

All participants considered that involving women with BC in the development of health resources increases its relevance and usefulness. All reported that participating in the online co-creation process increased their DHL and this helped increase their ability to take control of their health by participating in decision-making processes. They all fully agreed to recommend the MOOC to other people.

Discussion

Promoting the development of competencies that allow PLW to assess the quality and accuracy of online health information to make informed decisions about their health is essential. The use of MOOCs with interactive tools, can be a possibility of shared empowerment between healthcare professionals and share similar experiences with other women with BC in the same situation.

Conclusion

A co-created MOOC can be a viable strategy to address the literacy and empowerment challenges of women with BC.

143: Co-creation of decision-relevant information with patients to support shared decision-making about adjuvant treatment in breast cancer care (Oral presentation)

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Introduction

Patient Decision Aids (PDAs) usually provide benefit/harm information about treatment options and value clarification methods (VCMs). Personalized risk information from prediction models is also increasingly integrated. We aimed to design this total package of decision-relevant information about adjuvant breast cancer treatment in co-creation with patients, and to present it in an understandable way.

Methods

Three co-creation sessions with breast cancer patients (N=7-10; of whom N=5 low health literate). Participants completed creative assignments and evaluated prototypes of benefit/harm information and VCMs. Prototypes were further tested in a new group of patients (N=10) and professionals (N=10). Notes, homework assignments, photos and audio-recordings were summarized and main themes were identified. User test sessions were transcribed literally and analyzed using ATLAS.ti to assess key themes related to comprehension.

Results

Important information needs identified were: (a) need for overview/structure of information directly after diagnosis; (b) need for transparent benefit/harm information for all adjuvant treatment options, including detailed side-effects/late effects information. As for VCMs, patients stressed the importance of a summary or conclusion. A classical bar graph seemed the most appropriate way of displaying personalized survival rates; the impact of most other formats was experienced as too distressful. The concept of 'personalized information' was not understood by multiple patients.

Discussion

Patients' need for numerical information about side-effects/late effects is in line with previous literature. This numerical information is not always easily available, complicating SDM. The need for conclusions in VCMs also corresponds to previous studies, but is still not included in many PDAs. Although we experimented with alternative visualizations of survival rates, patients seemed to be supported better with a classical bar graph.

Conclusion

This co-creation study provided concrete perspectives to meet patient information needs through a PDA. Further quantitative studies are needed to establish comprehension of generated prototypes and the concept of 'personalized information'.

145: Shared DECision-making in patients with capilLARy malformATIONs (the DECLARATION-project): preliminary results of a multinational prospective study (Oral presentation)

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Introduction
Shared decision-making (SDM) is considered a vital communicative process, in which clinicians and patients make a joint decision about the therapeutic strategy that best fits the patient's preference, based on best available evidence and the patients' personal values and preferences.

A capillary malformation (CM) is a preference-sensitive condition for which multiple treatment options are available, and therefore particularly suitable for SDM. The aim of this study was to evaluate preferences regarding decision-making and assess current SDM-behavior in CM care.

Methods
Adults and children with CMs facing a treatment-related decision were recruited from three Dutch, one British, and one Australian university hospital. Consultations were audio-recorded. The participant's preferences regarding decision-making were measured prior to the consultation using the Control Preferences Scale.

After the consultation, participants completed the SDM-Q-9 and CollaboRATE questionnaires, while physicians completed the SDM-Q-Doc questionnaire. Two researchers independently and objectively rated SDM-behavior from the audiotapes, using the Observing Patient Involvement (OPTION-5) instrument. Results were presented as percentages of the maximum score (i.e. optimal SDM).

Results
So far, 24 participants (6 CM-patients and 18 parents of CM-patients) have been included. Most participants preferred active participation in treatment decision-making, of whom 36% wanted to share the decision with the physician and 56% preferred to make the final decision after seriously considering the physician's opinion. Objective OPTION-5 scores were low (median 30.0; IQR 15.0-37.5), whereas subjective patient- and physician SDM-Q scores were high (medians of 71.1 (IQR 60.0-80.0) and 75.6 (IQR 68.3-82.2), respectively). The median CollaboRATE score was 85.2 (IQR 77.8-92.6).

Discussion
Currently, objectively measured SDM behavior is still far from optimal in CM care, although patients and parents express a strong desire to be actively involved in treatment decision-making.

Conclusion
SDM in this disorder should be improved by enhancing awareness about the concept and knowledge about the conduct of SDM.

146: Evaluation and improvement of shared decision-making within plastic surgery in the Netherlands (Oral presentation)

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Introduction

Shared decision-making (SDM) seems particularly valuable within the field of plastic, reconstructive and hand surgery, as often more than one elective (surgical) treatment option is available, and patients' preferences consequently play a crucial role in treatment-related decision-making. Current practice, however, is still below expectations.

Several national initiatives have been instigated with the aim to evaluate and improve SDM within this field.

Methods

We initiated:

1. Baseline measurements of the objective and subjective levels of SDM in patients with vascular malformations (VM), using the OPTION-5 and SDM-Q-9 questionnaires, respectively.
2. Focus groups with patients with VM and microtia, both particularly suited for SDM, to determine patient-relevant information to be included in patient decision aids.
3. A national survey to evaluate knowledge and perceived barriers regarding SDM within the realm of plastic surgery.

Results

1. A total of 55 VM-patients or their parents were included in the baseline measurement. SDM-Q-9 scores were high (mean 68, SD 18), whereas OPTION-5 scores were low (mean 31, SD 15).
2. A total of 19 VM patients and parents were included in the focus groups. The following items were considered relevant: information about the condition, the available treatment options, treatment effectiveness, possible side effects, what to do when treatment is no longer effective, and use of visual aids. The focus group sessions for microtia are being carried out.
3. The national survey is ongoing. Results will be presented at the congress.

Discussion

The outcomes greatly help improve the level of SDM in the specified disorders, but will likely also serve as an example for other medical conditions treated within the field of plastic surgery.

Conclusion

Objective SDM behaviour is still suboptimal within plastic surgery. The described initiatives will improve the implementation of SDM in plastic surgery in the Netherlands.

147: Application of Artificial Intelligence in Shared Decision Making: a Scoping Review (Oral presentation)

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Introduction

The application of Artificial intelligence (AI) has shown promising results in various fields of medicine. It has the potential to facilitate shared decision making (SDM). Therefore, we identified and evaluated studies that tested and/or implemented AI to facilitate SDM.

Methods

We used the Levac et al. modifications to the original scoping review methodology and the Joanna Briggs Institute scoping review framework to conduct our scoping review**.** Inclusion criteria. *Population:* All populations who provided or received care. *Intervention:* All AI interventions used to facilitate SDM. Studies without an AI intervention in SDM decision-making were excluded. *Comparators:* none. *Outcome:* Any patient, healthcare provider (HCP), or healthcare system outcome. *Setting and study design:* Any healthcare setting. Studies of mixed, quantitative, or qualitative methods were included.

Results

We reviewed and included six peer-reviewed papers out of 894 screened publications. Three papers on primary and three papers on secondary care. All papers used machine learning methods. Three studies included HCPs in the AI intervention validating stage. Only one involved HCPs and patients in clinical validation, but none involved either of them in AI system design and development. To assist SDM, all papers used AI to make clinical recommendations or predictions.

Conclusion

There is limited evidence of AI in SDM. We found AI supported SDM similarly across the included papers. Results revealed AI interventions were underreported. Moreover, little effort was made to address AI interventions' explainability, and include end users in the design and development of AI interventions. Further efforts are required to improve and standardize AI use in different SDM phases as well as evaluate its impact on various decisions, populations, and settings.

148: Engaging Tobacco Quitlines to Help Persons Who Smoke Make Informed Decisions about Lung Cancer Screening (Oral presentation)

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Introduction
Quitlines are telephone-based cessation services that help tobacco users quit smoking. Previously we developed a patient decision aid (PDA) to prepare callers to quitlines to have a conversation with a health care provider about lung cancer screening (LCS). We are now conducting an implementation project in eight state quitlines to expand the reach of the LCS PDA nationally.

Methods
The project was implemented through the Consolidated Framework for Implementation Research (CFIR), and included planning meetings with quitline administrative staff, adaptations to intake databases, training of counselors, and ongoing technical support. Resources for callers included the PDA video, a discussion guide for use with providers, and eligibility and risk calculators. Service providers tracked the number of callers who met eligibility criteria. Engagement with website were monitored through analytics.

Results
351 quitline staff have been trained, and 7,610 quitline callers have been referred to the website. To expand the reach of the materials, quitlines adopted alternate referral strategies including text and email, links to the project website or embedded resources on the quitline website, emailing previous callers, mailed referrals, and social media campaigns. Adoption of one or more alternate strategies increased the number of website visits and views the PDA. To date, 315 callers have been referred via text, 837 via email, 34,173 through email to past callers, 292 fliers were mailed, and there were 6,339 social media views.

Discussion
Quitline intake platforms required augmentation to calculate pack-year smoking history and modifications to accommodate alternate referral strategies. In contrast, links and embedded resources on quitline websites and social media campaigns improved reach.

Conclusion
A PDA placed on quitline websites plus text and email contact with callers appear efficient strategies to reach large numbers of persons who are seeking cessation services and may benefit from LCS.

149: Policy, Politics, and Shared Decision Making for Lung Cancer Screening in the U.S. (Oral presentation)

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Introduction

In 2015, the Centers for Medicare & Medicaid Services (CMS), the federal program that pays for health care for individuals 65 years of age and older in the U.S., mandated that eligible beneficiaries undergo a counseling and shared decision making (SDM) visit in order for providers to be reimbursed for lung cancer screening (LCS). Uptake of LCS in the U.S. has remained low, and some professional groups have argued that the SDM requirement is the principal reason for the low screening rates. Late in 2021, CMS initiated an update of its coverage decision about LCS, which included two public comment periods.

Methods

We conducted a thematic analysis of public comments submitted to CMS during the two comment periods. We also grouped commenters based on their affiliation.

Results

170 comments were submitted during the initial comment period and 49 during the second, with the largest group being individuals affiliated with radiology and/or LCS programs. Recommendations about the SDM visit were varied and included complete removal, endorsing its importance without making it mandatory, and retaining the requirement with changes to reduce its administrative burden. Objections to the required SDM visit included: 1) SDM is a barrier to screening initiation, 2) SDM is a burden for providers; 3) SDM is not required of other cancer screening tests, and 4) the process is too complex. Relevant evidence supporting the objections was lacking. Arguments in support of SDM recognized its importance in the context of LCS while arguing for changes that allow non-clinical professionals to conduct the SDM visit and allowing for telehealth visits.

Conclusion

Criticisms of the SDM requirement for LCS appear largely related to it being a barrier to reimbursement for screening programs rather than a barrier for patients. Evidence-based arguments against SDM are lacking and most concerns appear anecdotal.

150: Can internationally accepted standards for reporting efficacy and harms for systematic reviews inform the evidence summarization process for PDAs? (Poster)

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3. PRISMA Harms (Dr. Zorzela is first author, Dr. Loke is second author, and Dr. Vohra is last/corresponding author of Statement paper)
4. Cochrane Adverse Effects Methods Group (Dr. Loke is Senior Co-Convenor and Dr. Vohra is Co-Convenor)

Introduction

A 2021 IPDAS review of all publicly available PDAs (n=471) found that 86% did not report any step in the evidence summarization process (i.e., how the evidence was found, appraised, *or* summarized). The EQUATOR Network, an international initiative that seeks to improve the value and transparency of health research by promoting transparent reporting using reporting guidelines, have recently updated the PRISMA statement (i.e., PRISMA 2020). This statement contains a set of evidence-based standards of the minimum items to be reported in SRs of interventions. However, PRISMA authors state that it may be used as a basis for reporting of SRs with other objectives (e.g., prevalence, diagnosis). This presents an opportunity to evaluate PRISMA for the reporting of SRs conducted for PDA development.

Methods

PRISMA 2020 was developed for SRs conducted with primary studies as the unit of analysis. Yet, SRs are often used as a data source in the evidence summarization process for PDAs, which may impact applicability. PRISMA offers a series of extensions, one of which is PRISMA Harms, covering items to report for SRs including harm outcomes. Both will be reviewed and evaluated for their applicability to the evidence summarization processes for PDAs.

Results

We will (1) identify and report the PRISMA 2020 items having face validity that would be challenged by use of SRs as data sources; and (2) summarize four *mandatory* items from PRISMA harms and discuss their face validity and applicability to summarizing harms for PDAs.

Discussion

Standards for the reporting of SRs may need to be adapted for use in reporting of the evidence summarization process for PDAs to ensure they are developed and reported using explicit, systematic methods.

Conclusion

Adapting reporting standards to the evidence summarization process for PDAs may support transparency around PDA development and promote harmonization of processes across developers.

151: Problem-based shared decision making as a novel approach to SDM in diabetes care (Oral presentation)

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Introduction

Decision-making about diabetes care requires patients and clinicians to find suitable approaches of collaboration. However, diabetes research and implementation have focused almost exclusively on weighing treatment options. The aim of this study is to understand the use of different collaborative and problem-focused forms of SDM to make diabetes care fit individually.

Methods

Using the Purposeful SDM model to distinguish different deliberative SDM methods, we analyzed a random sample of 100 video-recorded clinical encounters of patients with type 2 diabetes with their primary care clinician. We coded the form(s) of SDM used and described their prevalence using alluvial plots.

Results

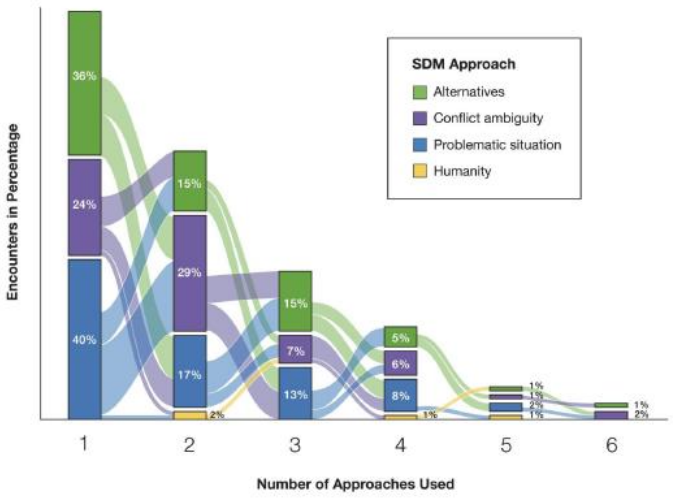
In 86% of the encounters a form of Purposeful SDM was observed. Three forms were equally present: weighing alternatives (33%), negotiating conflicting desires (30%) and solving problems (36%). Developing existential insights was observed in 1% of the encounters. In 31% of the encounters one form of Purposeful SDM was present, in 25% 2 forms and in 30% ≥3 forms.

Discussion

In this sample of videos, SDM was commonly present once we accounted for other forms of this practice. Only a third of the forms of SDM focused on weighing alternatives, the form of SDM usually emphasized in SDM research and implementation. Furthermore, we found that patients and clinicians often switch between different forms of SDM during their encounter.

Conclusion

The recognition of a diverse repertoire of SDM approaches opens new lines of research that may contribute to improving patient-centered care and outcomes.



152: Conceptualization of Patient-Centered Care in Latin America – A Scoping Review (Poster)

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Introduction

The integrative model of patient-centeredness by Scholl et al. (2014) could serve as a point of reference for international research on the implementation of patient-centered care (PCC). However, the model is predominantly based on research from Europe and North America. The present scoping review aims to accumulate research on PCC in Latin America (LA) of the past 15 years and analyze how PCC has been conceptualized.

Methods

Scientific databases (MEDLINE, EMBASE, PsycINFO, CINAHL, Scopus, Web of Science, Redalyc.) were searched, and reference and citation tracking was performed. Studies were included if they were carried out in LA, investigated PCC, family-centered care, or person-centered care in any clinical and community setting (public and private), provided a definition of the main concept (e.g., PCC), and were published in English, Spanish, French, or Portuguese since 2006. Furthermore, any theoretical framework or conceptual model to guide how PCC is conceptualized in LA was included. Three reviewers were responsible for the screening, full-text assessment, and data synthesis. The conceptual definitions of PCC, person-centered, or family-centered care were analyzed by use of deductive and inductive coding.

Results

The primary search yielded 2.105 citations, 185 of which fulfilled the inclusion criteria exactly. After examination of the full-texts, 34 articles were included in the data extraction. Preliminary analyses of included publications show that 17 (50%) articles were from Brazil, 5 (15%) from Chile, 4 (11%) from Mexico, and 8 (24%) either from another or from multiple countries in LA. Twenty-three of the included articles investigated PCC or person-centered care, while 10 articles investigated family-centered care. Final results will be presented at the conference.

Discussion/Conclusion

The resulting overview of PCC in LA will be a foundation for a subsequent study aiming at the adaptation of the integrative model of patient-centeredness to the LA health care context.

153: Factors associated with patient empowerment in adults with type 2 diabetes: a cross-sectional analysis (Oral presentation)

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Introduction

As Type 2 Diabetes Mellitus (T2DM) is a chronic condition, patients are required to incorporate multiple lifestyle changes in their everyday life. Current evidence suggest that empowered patients are more likely to adhere to treatment plans and lifestyle modification. While the positive effect of empowerment on clinical and psychosocial outcomes seems to be established, less it's known about its correlates.

Understanding personal and clinical factors related to patient empowerment might lead health-care professionals to identify high-risk groups, prioritize resources and target interventions to better support people with T2DM to be actively involved in their own care. The aim of the present study is to identify factors associated with patient empowerment in people living with T2DM.

Methods

Secondary cross-sectional analysis of data obtained in the INDICA study, a 24-months cluster randomized controlled trial evaluating the effectiveness of educational interventions supported by new technology decision tools for T2DM patients. Sociodemographic variables, clinical data, diabetes knowledge, affective outcomes and diabetes-related quality of life were assessed as potential correlates of patient empowerment, assessed with the Diabetes Empowerment Scale-Short Form (DES-SF). Multilevel mixed linear regression models on patient empowerment were carried out.

Results

The analysis included the baseline data of 2,334 patients. Results showed that age (β=-0.14; p<.001), diabetes knowledge (β=0.61; p<.001) and state-anxiety (β=-0.09; p<.001) are significantly associated with patient empowerment.

Discussion

Our study suggests that state-anxiety, older age and poor diabetes-specific knowledge are significant correlates of patient empowerment. Given the cross-sectional nature of the data, causal inferences cannot be made. The chance to address the direction of the observed association is limited.

Conclusion

If effective interventions are planned to improve patient empowerment of people with T2DM, older patients may need special attention and anxiety and diabetes-specific literacy should be addressed with evidence-based techniques such as psychological and educational programs.

154: Relationship between patient empowerment, affective symptoms and quality of life in patients with type 2 diabetes: a systematic review and meta-analysis (Poster)

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Introduction

Nearly one in four patients with type 2 diabetes mellitus suffer from comorbid depression and the incidence of anxiety disorders is high. Empowering patients could contribute to enhance mental health and quality of life. This systematic review and meta-analysis attempt to generate new attention on the association between both patient empowerment and affective symptoms and/or quality of life on patients with type 2 diabetes mellitus.

Methods

A systematic review of the literature was conducted according to the Preferred Reporting Items for Systematic reviews and Meta-Analysis (PRISMA) guidelines. Meta-analyses of correlation coefficients were performed using the transformation of r values into Fisher's z scores and then reconverting to r values. When heterogeneity was significant, subgroup analyses for categorical variables and meta-regression for continuous variables were performed. Registration number: CRD42020192429.

Results

Sixty-two studies met inclusion criteria. The total sample comprised 16,006 participants (mean age: 57.73 ± 6.5 years). There is a weak-to-moderate inverse association between the level of patient empowerment and anxiety (r = -0.24), depression (r = -0.29) and distress (r = -0.29) in patients with type 2 diabetes mellitus. Besides, a moderate positive association between patient empowerment and general quality of life was observed (r = 0.32), while small but significant association between empowerment and both mental (r = 0.23) and physical quality of life (r = 0.11) were reported.

Discussion

Patient empowerment is negatively correlated with affective symptoms and positively correlated with quality of life. This evidence mostly proceeds from cross-sectional studies and it is not possible to confirm the direction of the observed association.

Conclusion

Our results highlight patient empowerment as an important component of diabetes care linked to better mental health and increased QoL. High-quality prospective studies are needed not only to better understand the role of patient empowerment but to assess causal associations.

156: Development and piloting of a decision coaching intervention to support informed decision-making about vaccination against COVID-19 (Poster)

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Introduction
High vaccination rates against COVID-19 are needed to mitigate illness and mortality caused by the virus. To enable vulnerable groups to make informed decisions about vaccination, we aimed to develop and pilot a decision coaching intervention including a decision guide and an evidence-based option grid in Germany.

Methods
The intervention was developed and piloted following the Medical Research council's framework on complex interventions.

Phase 1: The development was based on preexisting decision coaching interventions. To assess the information needs of vulnerable groups, a focus group interview with community health workers (CHW) and a systematic literature search were conducted. A training course for CHW, a decision guide and an option grid were developed.

Phase 2: The intervention components were piloted with CHW focusing on feasibility and acceptance. Classroom observation was carried out and feedback from CHW on the training and materials was obtained. Field notes and interview transcripts were analyzed using qualitative content analysis.

Results
Phase 1: Information needs included general information about COVID-19 vaccines, their efficacy and side effects. A blended learning training for CHW was developed (180/360 minutes web-based/face-to-face training) comprising lectures about informed shared decision-making, evidence-based health information and practical exercises in (risk) communication and decision coaching.

Phase 2: Eight CHW participated in the training. Overall, the training was feasible. The option grid was highly appreciated due to its clear and concise presentation. CHW valued the intervention as useful and suggested an extension for further target groups such as children. Time constraints and the growing number of anti-vaccinationists were seen as an implementation barrier.

Discussion
The single components of the interventions are feasible and the intervention may facilitate informed decisions about COVID-19 vaccination.

Conclusion
A pilot test of the entire intervention with the vulnerable target groups is planned to ensure comprehensibility, acceptance and support of informed decisions.

157: Measuring patient readiness for shared decision making about cancer treatment: Development of a questionnaire (Oral presentation)

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Introduction

Shared decision making (SDM) about treatment can be difficult for cancer patients. We have identified what elements might lead patients to be ready (i.e., well-equipped and enabled) to participate in SDM[1,2]. We are now developing a patient self-report questionnaire to measure cancer patient readiness for SDM in research.

Methods

Step 1: Item development. We determined the elements and sub-elements of readiness based on previous studies[1,2], longitudinal interviews with cancer patients (n=7) and the results of an ongoing review of qualitative studies. The selection of (sub-)elements was discussed within the research team, and we consulted clinicians (n=3), researchers (n=2), and patients (n=2). We developed multiple items for each sub-element, and consulted experts on health literacy and SDM (n=2) for feedback.

Step 2: Item reduction and content validity testing. Given the formative nature of our construct, we will conduct an online field-study among cancer patients to select items.

Step 3: Comprehensibility testing. We will cognitively test the resulting items in low health literate individuals and make necessary changes.

Results

Step 1: We identified seven elements of readiness (understanding of and attitude towards SDM, information skills, self-awareness, emotions, skills in communicating and claiming space, consideration skills, self-efficacy), divided over 30 subdomains. We developed approximately 160 items and received feedback on them.

Step 2 and 3 will have been completed at the time of the conference.

Discussion

The questionnaire will enable to get a better insight in what cancer patients need to be ready to participate in SDM.

Conclusion

To finalize the questionnaire, next steps will be to conduct feasibility testing and test the validity of the final questionnaire.

158: Decisional needs of patients with recurrent high-grade glioma and their family members (Oral presentation)

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Introduction
High-grade gliomas are the most aggressive type of brain tumor with no curative treatment options, and the patients often experience cognitive challenges. When the tumor progresses, the patients and their families need to consider the harms and benefits of different treatment options, including the option of ending active treatment. The objective of this study was to explore the decisional needs of these patients and their families.

Methods
Adult patients diagnosed with recurrent high-grade glioma and their family members were interviewed about their experiences and decisional needs during the decision-making. We applied a phenomenological hermeneutical approach to the analysis and interpretation.

Results
Fifteen patients and 14 family members were included in the study. Both patients and family members expressed a preference for being involved in the decision making, and patients highlighted the importance of family support. We identified a trustful relationship with the clinician, sufficient time to discuss the options, and receiving balanced and tailored information as decisional needs shared by patients and families. Participants also highlighted a need to cling to hope no matter how poor the prognosis was. Family members emphasized a need to be recognized by the clinicians as part of the decision-making team.

Discussion
Family support is essential for patients with high-grade gliomas, especially when the patient experiences cognitive challenges. The family members likewise express preferences for being involved and supportive. Based on these findings, clinicians must acknowledge family members as part of the decision-making team when considering decision support to patients with a high-grade glioma recurrence.

Conclusion
Experiencing a trustful relationship with the clinician, having sufficient time, receiving tailored information, and clinging to hope were identified as decisional needs shared by patients and family members. Family support was found significant, and both patients and their families preferred to be involved in the decision making.

159: How do current digital patient decision aids in maternity care align with the health literacy skills and needs of clients in maternity care?: a think aloud study (Oral presentation)

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Introduction

Patient decision aids (PDAs) have been shown to be effective in facilitating shared decision-making (SDM) in maternity care. However, there is a need to establish the 'essential' elements and suitability of PDAs for clients with varying health literacy (HL) levels. This study aimed to explore how (elements of) current Dutch PDAs support HL skills and how they fit clients' needs for support in decision-making.

Methods

Think aloud interviews were held among clients in Dutch maternity care (N=21) with varying HL skills. Thematic analysis was performed to identify how clients used elements of the PDAs and which difficulties they experienced while using those elements. A further interpretation of themes was made on perceived needs for support.

Results

It remained often unclear for clients what the exact aim of the PDAs was. Clients neglected key benefit/harm information in case they were unfamiliar with the medical jargon used to describe the options. If the medical terms were understood correctly, clients actively processed and weighed information on benefits and harms of options, thereby often searching for balanced probability information about outcomes for mother and child (i.e. for all options and all benefits and harms). Value/preference clarification tools were used adequately by clients, but only if the specific value statements were considered relevant.

Discussion

The difficulties encountered by clients when using the maternity care PDAs largely correspond to previous studies into HL and PDAs, e.g. problems with understanding medical jargon and the PDAs' structure. Previous literature has also shown the importance of facilitating difficult trade-offs between benefits and harms for mother and child.

Conclusion

Several key parts of Dutch PDAs in maternity care do not optimally support HL skills of clients. Improvements are needed in describing the aim of the PDAs, and particularly to weigh benefit/harm information in light of existing values and priorities.

160: Women's participation in decision-making in maternity care: a qualitative exploration of clients' health literacy skills and needs for support (Oral presentation)

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Introduction

Shared decision-making (SDM) requires adequate functional health literacy (HL) skills from clients to understand information, as well as interactive and critical HL skills to obtain, appraise and apply information about available options. This study aimed to explore women's HL skills and needs for support regarding shared decision-making in maternity care.

Methods

In-depth interviews were held among women in Dutch maternity care who scored low (N = 10) and high (N = 13) on basic health literacy screening test(s). HL skills and perceived needs for support were identified through thematic analysis.

Results

Women appeared to be highly engaged in the decision-making process. They mentioned searching and selecting general information about pregnancy and labor, constructing their preferences based on their own pre-existing knowledge and experiences by discussions with partners and significant others. However, women with low basic skills and primigravida perceived difficulties in finding reliable information, understanding probabilistic information, constructing preferences based on benefit/harm information and preparing for consultations. Women also experienced difficulties dealing with uncertainties, changing circumstances of pregnancy and labor, and emotions.

Discussion

The HL skills specified corresponded to the existing literature about HL and SDM. Additional skills identified were: searching and selecting information, discussing initial preferences with health professionals as opposed to actual choices, since these are typically made with partners or postponed to the time of labor, and taking responsibility for mother's and child's health. In addition to HL skills, we also identified other decision making skills, including coping with emotions, uncertainty and changing (medical) circumstances.

Conclusion

The HL skills discussed by women largely corresponded with the skills described in previous studies about HL and SDM. Maternity care professionals could further support women to participate in important decisions during pregnancy and labor. Guiding them towards reliable and easy to understand information is an important first step.

161: Protocol: Implementing Shared Decision Making for Breast Cancer Using a Coproduction Learning Collaborative (Poster)

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Introduction

We tested two conversation aids (Option Grid and Picture Option Grid) for breast cancer surgery in a comparative effectiveness trial and found they increase shared decision making (SDM) and patient-reported outcomes. Our current goal is to broadly implement these aids through an SDM strategy across a wide range of clinical settings in North America by engaging breast cancer teams in a learning collaborative. We will 1) support clinical teams through adopting the Option Grids, 2) evaluate the SDM approach, and 3) create a sustained learning collaborative.

Methods

The SDM Adoption and Implementation Resource (SHAIR) Collaborative project will have two phases. The first phase will consist of developing the implementation materials and website to host the Collaborative online and integrate the Option Grids at 5 pilot sites. The second phase will include launching the online Collaborative and implementing the conversation aids more widely (up to 32 sites). The American Society of Breast Surgeons will sustain the Collaborative when the project period ends (2024).

Results

Our primary outcome, patient reach, will be the percentage of eligible women per site who use one of the aids. Our patient-level secondary outcomes include shared decision making (collaboRATE), decisional conflict (SURE), healthcare integration (integRATE), a self-report of the surgery chosen, and a one-item assessment of breast cancer surgery understanding. Our site-level secondary outcome will be the extent to which the intervention is normalized, assessed through Normalization MeAsure Development (NoMAD).

Discussion

A two-phase approach will allow for the successful development and implementation of a breast cancer learning collaborative in North America. We will ensure success through engagement with all levels of stakeholders and a wide range in clinical sites.

Conclusion

The SHAIR Collaborative will allow for national and international implementation of effective conversation aids for breast cancer surgery decision-making.

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162: Tracking adaptations to support implementation of Cost Talk, an intervention to promote cost conversations in shared decision-making about slow-growing prostate cancer (Oral presentation)

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Introduction

Cost Talk is a multi-component intervention for the US context comprising (1) a conversation aid with relative cost information for prostate cancer management options compared in a one-page table, delivered before or at the time of a prostate cancer consultation; and (2) brief urologic surgeon training. We aimed to track intervention and study procedure adaptations recommended before and during a stepped-wedge randomized controlled trial.

Methods

Study staff monitored routine meetings and communications with research team members, clinical and community stakeholders, and participating urologic surgeons to capture recommendations for adapting the intervention and study procedures to facilitate use in the trial and future implementation. We documented all suggestions using the Framework for Reporting Adaptations and Modifications – Extended (FRAME).

Results

To date, 15 types of adaptations have been recommended by surgeons, community stakeholders, other clinically-trained stakeholders, and study team members, all of which we considered consistent with intervention fidelity. Two primary recommendations were: (1) changing the timing of decision aid delivery from before the visit to before, during, or after the visit; and (2) using 2 formats depending on the patient and context: a single page version comparing all available options and a multi-page version with one option on each page.

Discussion

In this study, stakeholders recommended content, process, format, and procedural adaptations to facilitate delivery of the conversation aid about slow-growing prostate cancer management and support tailoring of the options presented on a case-by-case basis.

Conclusion

Context-sensitive delivery of conversation aids is an emerging area of implementation research, with some studies suggesting pre-visit delivery as optimal to allow patients to prepare for visits in advance. In this study, stakeholders recommended flexible decision aid delivery and flexible formats to maximize patient uptake. This reinforces the importance of tracking adaptations over the course of a trial to facilitate future routine use.

163: Shared decision-making requirements in United States healthcare policy: the case of left atrial appendage closure (Oral presentation)

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Introduction

The Centers for Medicare and Medicaid Services (CMS) are a US government agency constituting the country's largest healthcare payer organization. Left atrial appendage closure (LAAC) is a minimally-invasive procedure that places a device in the heart to prevent stroke in people with atrial fibrillation. In its 2016 national coverage determination about LAAC, CMS required documentation of shared decision-making (SDM) between patients and clinicians using an evidence-based decision tool as a prerequisite for LAAC eligibility. We aimed to examine whether and how clinicians document the SDM process for stroke prevention in patients with atrial fibrillation in order to evaluate the CMS requirement's impact.

Methods

We conducted semi-structured interviews with: (1) cardiologists; (2) patients with atrial fibrillation; (3) cardiology clinical coordinators; and (4) other stakeholders. We conducted thematic analysis guided by the Consolidated Framework for Implementation Research.

Results

We interviewed 10 clinicians and 2 other stakeholders. Interviews with patients and coordinators are underway; full results will be available in February 2022. Clinicians reported that the complexity of the CMS requirement contributes to substantial administrative burden. Several clinicians used standardized templates, identical across all patients, to meet CMS requirements for documenting shared decision-making (SDM) in the medical record. A few clinicians reported using evidence-based decision tools published by EBSCO or the UK's NICE; most either referred patients to the device manufacturer's website or reported not using a decision tool. No clinicians reported formal SDM training.

Discussion

In response to the CMS requirement, clinicians commonly used manufacturer-developed materials that present only one treatment option in place of formal evidence-based decision tools. Documentation requirements were challenging; as operationalized by this sample of clinicians, benefits were unclear.

Conclusion

Preliminary findings suggest that complex policy requirements alone do not promote optimal SDM. Widespread SDM training and availability of comprehensive evidence-based decision tools may help fill this gap.

164: Implementing shared decision making for uterine fibroids: a multi-site evaluation in 5 US gynaecology clinics (Oral presentation)

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Introduction

Uterine fibroids are highly prevalent and can cause disruptive symptoms including pain, pressure, and bleeding. Many treatment options are available to people with uterine fibroids and decisions are preference-sensitive. In a stepped-wedge study implementing text- and picture-based conversation aids for uterine fibroids treatment decisions at 5 US sites, we aimed to evaluate conversation aid implementation and its impact on patient-reported and observed shared decision-making (SDM).

Methods

To assess reach of the conversation aids, we counted how many were delivered to patients at each study site. During both baseline and active implementation phases at each site, we administered online patient surveys collecting the collaboRATE measure of SDM at two time points: immediately following a patient's clinic visit to discuss uterine fibroids treatment options and at three months' follow-up. We collected audio-recordings of clinic visits about uterine fibroids during baseline and active implementation phases at each site. Two raters applied the Observer OPTION-5 shared decision-making measure. We compared collaboRATE and OPTION-5 scores across baseline and intervention phases.

Results

Data collection is ongoing; full results will be available in May 2022. As of December 2021, 1134 conversation aids were delivered to patients with uterine fibroids across the 5 sites. In unadjusted interim analysis of 702 patient survey responses, 50% of patients who received the conversation aid reported collaboRATE top box scores compared to 45% of patients who did not receive the conversation aid.

Discussion

Interim findings suggest that patient-reported SDM may be more common in the intervention phase than at baseline. However, SDM remained limited in the intervention phase despite the use of conversation aids.

Conclusion

Conversation aids can improve SDM between clinicians and patients with uterine fibroids. However, making conversation aids available to patients is not enough to ensure high-quality SDM.

165: The fidelity of use of two conversation aids for early-stage breast cancer surgery: analysis of 184 audio-recorded surgical consultations (Oral presentation)

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Introduction

Using a conversation aid as intended (fidelity of use) is important in understanding its impact. We tested two conversation aids (Option Grid and Picture Option Grid) for breast cancer surgery in a comparative effectiveness trial with four sites. Our aims were to (1) assess the fidelity of conversation aid use among numerous variables and (2) explore the correlation between fidelity of use and observed shared decision making (OPTION-5).

Methods

A 12-item fidelity checklist was piloted on a subset of five recordings by two independent raters before starting data analysis. Two independent raters completed the checklist by listening to 184 surgical consultation audio-recordings between 16 surgeons and patient participants. They also conducted OPTION-5 assessment after training. We descriptively analyzed fidelity by site, intervention arm, surgeon, over time, and patient demographics. We also conducted univariable and multivariable mixed effects linear regression to explore the correlation between fidelity of use and OPTION-5 scores.

Results

There were no significant differences in fidelity of use of the conversation aids by site, surgeon, intervention arm, patient socioeconomic status (SES), or patient health literacy. Additional Aim 1 results and Aim 2 results will be available June 2022.

Discussion

There were no differences in fidelity of use, indicating that fidelity was not affected by external variables. Since the fidelity of use is not affected by external variables, particularly patient variables like SES and health literacy, there is promise that the conversation aids can be used equitably among diverse patient populations.

Conclusion

Our results will be important in understanding the fidelity of use of conversation aids used in a controlled trial context. Our additional results of fidelity's correlation with OPTION-5 will shed light on the implications for fidelity of use of the conversation aids in future practice.

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166: Patient Decision Aids Improve Patient Safety and Reduce Medical Liability Risk (Poster)

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- Albany Medical College

Introduction

Legal doctrines of medical malpractice and informed consent have failed to assure that patients understand the risks, benefits, and alternatives to the healthcare they receive. Most patients lack an adequate understanding of their treatment options.

Methods

The authors conducted systematic reviews both (1) research on the benefits of PDA use and (2) research on medical liability risk. They then correlated PDA benefits with types of legal risk.

Results

PDAs reduce liability risk from negligent nondisclosure (informed consent) in three ways. First, using PDAs sometimes earns clinicians a “shield” from liability. Second, failing to use PDAs will increasingly be used as a “sword” to find clinicians liable. Third, PDAs lower risk through better documentation.

While PDAs can most obviously mitigate liability from negligent nondisclosure, they also mitigate liability from other types of medical malpractice claims. They do this in three ways. First, PDAs result in better outcomes, and patients with better outcomes bring fewer claims. Second, PDAs result in more satisfied patients, and satisfied patients bring fewer claims. Third, even when patients have adverse outcomes, they are less likely to have the surprise and anger that motivates claims.

Discussion

PDAs benefit not only patients but also clinicians and healthcare entities, because PDAs materially reduce the risk of liability both from negligent non-disclosure and from other types of medical malpractice claims. This should help design incentives. For example, professional liability insurance carriers can nudge clinicians to use PDAs with their patient by offering the monetary incentive of insurance premium reductions.

Conclusion

Using PDAs improves patient safety and reduces medical liability risk.

167: Implementing SDM into Clinical Practice: Law and Policy Update (Oral presentation)

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- Albany Medical College

Introduction
Real-world use of SDM and PDAs remains sparse. While ISDM rightly explores the latest tools and strategies for improving patient oriented SDM, we must also explore ways to increase clinician uptake.

Methods
This is a comprehensive and up-to-date status report on legal and policy incentives for SDM implementation. Because more work has been done on SDM in the USA, the authors reviewed statutes and regulations at both the state and federal level in the United States.

Results
Three different types of new legal and policy incentives are pushing SDM implementation. (1) Payment incentives link PDA use to insurance/payor reimbursement. (2) Liability incentives link PDA use to enhanced legal protection from liability. (3) Mandate incentives require PDA use categorically.

In this highly graphic session, an attorney / bioethicist describes specific examples of each of these three types of legal incentives for clinicians to use PDAs and engage in SDM. He also assesses how effectively these incentives are working.

Discussion
Law cannot solve the implementation challenge by itself. Guidance documents identify multiple, overlapping strategies for implementing SDM and increasing clinician uptake. Still, law remains one important piece of the puzzle. This session offers a succinct, yet comprehensive, review of recent law and policy related to SDM and PDAs.

Conclusion
It is not enough to design communication materials and best practices. To ensure patient safety and protect patient rights, we must also ensure that they get adopted and assimilated into clinician-patient encounters.

168: Physicians' Clinical Intentions and Behaviors after Continuing Professional Development Activities: A Prospective Study with Pre and Post Measures (Poster)

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Introduction

Socio-cognitive theories of behavioral change provide a solid basis for developing continuing professional development (CPD) activities. As behavioral intention and its determining factors are important predictors of clinical behavior change. We aim to assess the impact of CPD activities on physicians' intention to engage in the targeted clinical behavior using the CPD-REACTION questionnaire.

Methods

This is a prospective study with pre and post measures. We used the integrated behavior change framework developed by Godin et al. to guide our study. Data are from the databases of the Federation of Medical Specialists of Quebec. Our sample consists of 219 physicians who participated in 9 CPD activities at an interdisciplinary training day organized in 2019, one of which is related to decision-making with patients during a safety-of-care incident. Physicians completed online 1) a socio-demographic questionnaire, 2) the CPD-REACTION questionnaire before and after each CPD activity, and 3) self-reported behavior change questionnaire 6 months later. Descriptive, bivariate, and multivariate analyses will be performed.

Preliminary results

We found an increase in behavioral intention scores after each of the 9 CPD activities ranging from 0.20 to 1.87. Further analyses are underway.

Discussion

Physicians' behavioral intention scores improved varying by CPD activities. The behavioral intention score could be affected by different confounders factors.

Conclusion

These results are intended to help CPD organizers develop more effective activities to continuously improve their CPD program. Future CDP activities could include shared decision making (SDM) on regular basis to assess progress in physicians' intention to engage in SDM.

169: Decisional needs of older adult receiving home care and their relatives in Canada (Oral presentation)

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Introduction

In Canada, older adults receiving home care face difficult decisions that may lead to decision conflict or decision regret. We assessed what was needed to make better-informed and better-supported decisions, i.e. decisional needs, among older adults, caregivers and home care teams providers supporting older adults in making difficult decisions.

Methods

From March 13 to 30, 2020, i.e. at the outbreak of the COVID-19, we conducted 3 online surveys with 1) older adults receiving home care; 2) caregivers of older adults receiving home care, both in the ten Canadian provinces; 3) with interprofessional home care providers from a Canadian home care company, SE Health (in Ontario, Quebec, Alberta). We identified the types of difficult health-related decision faced in the past year, and evaluated clinically significant decisional conflict (CSDC) using the 16-item Decisional Conflict Scale (score 0–100) with a >37.5 cut-off and regret using the Decision Regret Scale, scored from 0 to 100.

Results

Among 460 participants with an average age of 72.5 years, difficult decisions were about housing and safety (57.2%), managing health conditions (21.8%), and end-of-life care (8.3%). CSDC was experienced by 14.6% [95% CI: 11.5%, 18.1%] of older adults. Among 932 participants, difficult decisions most frequently reported were about housing and safety (75.1%). Caregivers mean DRS score was 28.8/100 (SD=18.6). According to interprofessional home care providers, the most difficult decision for older adults is "whether to stay at home or move." Overall, interprofessional home care providers reported high levels of shared decision-making. However, personal support workers reported lower levels than nurses or rehabilitation professionals.

Discussion

Decisions about housing and safety are the difficult decisions most frequently encountered by the three groups. Many Canadians experienced decisional conflict and regret.

Conclusion

There is a need to better support older adults receiving home care services about housing and safety decisions.

170: Validation of indicator measures for patient involvement among children and young persons with Type 1 diabetes (Oral presentation)

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Introduction

It is important to involve children and young people diabetes in their course of treatment. No validated measurement tools for assessing patient involvement among children and adolescents exist. We aimed to validate and develop indicator measures for patient involvement for children and adolescents with diabetes.

Methods

Indicator measures for patient involvement for adults are validated and tested (table 1). In the consultation, participants (11-18 years) with type 1 diabetes from the Steno Diabetes Centre Aarhus (DK) answered a diabetes-specific questionnaire containing the indicator measures. Beside the questionnaire data consists of cognitive interviews. Statistical analysis was made by looking at statistical tests of reliability and validity how validity and reliability is, and it varies by age.

Results

Primary results from 15 cognitive interviews show that participants found it challenging to distinguish the five involvement questions from each other and participants (<15 years) had difficulties in understanding words like “healthcare professional" and “involvement”. Statistical analysis from 281 questionnaires shows from participants <15 years the proportion of missing on the second indicator was over 30%, almost 50% higher than the <15 years. It may be considered a sign of difficulty in answering the question. For 4 of 5 indicators the correlation with the overall satisfaction was higher for the >15-year-olds.

Table 1: Indicator Measurement regarding patients' experience of involvement

These questions are about to what degree you have felt involved in your treatment? (select only one answer for each statement)

Response categories	Not applicable	Not at all	To a slight degree	To some degree	To a high degree	To a very high degree	Don't know
The health staff asked questions about my own experiences with my illness/condition							
I talked to the healthcare staff about the questions or concerns I had							
The health staff encouraged me to ask questions or talk about my concerns							
I was involved when decisions were made about what was to take place							
I have had an appropriate number of talks with the healthcare staff about how I can best handle my illness/condition							
All in all, I am satisfied with my last visit to the outpatient clinic							

Hoelück JT, Sevelsted J, Riiskjær E. Udvælgelse af inddragelsesspørgsmål til patienter Validitet, reliabilitet og accept. [Validity, realbilyt and acceptance on indicator for patient involvement]. Region Midtjylland: DEFACTUM; 2017.

Discussion

This knowledge can be applied to children and young people with diabetes and may be used in children and young people with other chronic diseases.

Conclusion

Final results are presented at the conference.

171: Towards culturally sensitive shared decision-making in oncology: A study protocol integrating bioethical qualitative research on shared decision-making among ethnic minorities with ethical reflection (Oral presentation)

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Background

Shared decision-making (SDM) is often considered the ideal for decision-making in oncology. Views of specific groups such as ethnic minorities have seldom been considered in its development.

Aim

In this study we seek to assess in oncology if there is a need for adaptation of the current SDM model to ethnic minorities and to formulate possible adjustments.

Methods

This study is embedded in empirical bioethics (EB), an interdisciplinary approach integrating empirical data with ethical reasoning to formulate normative conclusions regarding a practice. For the empirical social scientific part, a cross sectional qualitative study will be conducted; for the ethical reflection the Reflective Equilibrium (RE) will be used to develop a coherent view on the application of SDM among ethnic minorities in oncology.

Results

Semi-structured interviews combined with visual methods (timelines and relational maps) will be held with healthcare professionals (HCPs), ethnic minority patients, and their relatives to identify values steering the behavior of these actors in SDM. In addition, focus groups (FG) will be held with HCPs and ethnic minority community members to identify value structures at the group level. Respondents will be recruited through organizations with access to ethnic minorities and collaborating hospitals. Data will be analyzed using a reflexive thematic analysis through the lens of Schwartz's value theory. The results of the empirical phase will be included in the RE to formulate possible adjustments of the SDM model, if needed.

Discussion

The integration of empirical data with ethical reflection is an innovative method in shared decision-making. This method enables a systematic and profound assessment of the need for adaptation of SDM and the formulation of theoretically and empirically based suggestions for adaptations of the model.

Conclusion

Findings of this study may enrich the SDM model by the inclusion of the perspectives of ethnic minorities.

172: What values seemingly steer the behaviour of the actors involved in SDM? A thematic analysis of SDM models through the lens of Schwarts' value theory (Oral presentation)

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Background

During the past decades various SDM models have been developed to enable or study SDM in clinical practice. There can be a difference between how SDM is conceptualized in scientific literature and how it is understood and experienced by patients and healthcare professionals HCPs. Also, views of specific groups such as ethnic minorities have seldom been considered in the development of SDM.

Aim

The aim of this study is to investigate the values underlying SDM models that, according to the SDM models, seemingly steer the behaviour of the actors involved in SDM (healthcare professionals (HCPs), patients, relatives and important others).

Methods

Research papers in which SDM models have been conceptualized were included in this study. We used the SDM models recently analysed by Bomhof-Roordink et al (2019) (n=40). The research papers are currently analysed using the reflexive thematic analysis and coded through the lens of Schwartz value theory.

Results

We included 40 models in total, published in English between 1997-2019, Coding revealed that predominantly the values universalism (equality, respect), self-direction (of both patients and HCPs), achievement (expertise, knowledge and skills) and security were reflected in the explanation of the models. In more recent models benevolence (supporting, helping) appeared to be an additional predominant value.

Discussion

Identifying and analysing the underlying value structure of SDM models enhances our understanding of what values, according to the SDM models, seemingly steer the behaviour of different actors involved in SDM in clinical practice. Furthermore, a description of the value structures underlying SDM enables a comparison of the values of the models with those of the actors involved in SDM in a specific context (e.g. SDM among ethnic minorities).

Conclusion

A representation of the value structure underlying SDM can contribute to the alignment of the model with values of actors in SDM.

173: Patient and clinician perspectives of a new osteoporosis shared decision-making intervention tested in UK Fracture Liaison Services: findings from the iFraP study (Poster)

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Introduction
The Improving uptake of Fracture Prevention drug treatments (iFraP) study developed a prototype theoretically-informed, complex intervention underpinned by theory, empirical evidence, and stakeholder and patient advisory group (PAG) involvement. The iFraP intervention consists of a computerised decision aid (DA) and clinician training package to facilitate shared decision-making (SDM) about osteoporosis medicines in Fracture Liaison Services (FLSs). In-practice testing of iFraP aimed to explore perceived acceptability by those using iFraP, barriers to, and facilitators of, implementation in-practice, and necessary changes to the iFraP prototype.

Methods
Three in-practice testing cycles were completed at one FLS. Four clinicians delivered 10 iFraP consultations with patients with a recent fragility fracture (n=3 cycle 1; n=3 cycle 2; n=4 cycle 3). All 10 patients completed a post-consultation interview. Four clinicians completed 7 interviews across all cycles.

Theoretically-informed framework analysis is ongoing to understand iFraP acceptability and barriers to, and facilitators of, implementation.

Results
Early analysis shows that patients and clinicians reflected positively about the DA, with suggestions that iFraP should be used in usual care.

Patients and clinicians perceived iFraP to increase patient involvement in the consultation and provide accessible information to support SDM. Clinicians viewed the iFraP training package as an integral intervention component facilitating SDM. Barriers were also identified, with clinicians concerned that iFraP may extend consultation length and be less appropriate depending on patient factors (e.g. visual impairment) and consultation characteristics (e.g. telephone consultations).

Recommendations to improve iFraP included changes to DA presentation and structure and increased allocated time for clinicians to practice using the DA.

Discussion
iFraP was viewed as acceptable, with potential to facilitate SDM about osteoporosis medicines. Findings will be discussed with key stakeholders and PAG members to refine iFraP in-preparation for the iFraP trial.

Conclusion
These findings support notions that multicomponent interventions give most promise of SDM implementation.

174: We're still learning…: Setting-up a learning collaborative to implement shared decision making in breast cancer care (Oral presentation)

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Introduction

The What Matters Most (WMM) randomized controlled trial tested two conversation aids (Option Grid and Picture Option Grid) for breast cancer surgery in a comparative effectiveness trial and found they increase shared decision making (SDM) and patient-reported outcomes. Based on this success, we have begun an implementation project with 25+ sites to integrate the tools into routine care across North America. As we saw in the trial, implementation requires successful engagement with clinical teams at each site. Historically, however, clinician and clinical team engagement has been a challenge due to competing priorities and busy clinic schedules. Our goals were: 1) to engage breast cancer teams in the US in a learning collaborative where clinicians support each other to use conversation aids for early-stage breast cancer treatments and 2) document our learning curve.

Methods

Beginning in June 2021, we collected meeting notes, monitored meeting attendance, collected clinicians' feedback and noted interactions between clinician members of the collaborative. We tested several methods for increasing the engagement of clinicians in the learning collaborative, including 1:1 meetings, bi-weekly engagement meetings, individual emails, and engagement newsletter surveys.

Results

Promoting interactions between the learning collaborative, its members and the research team proved challenging from the start. Standard visioconference meetings yielded poor clinician attendance with limited feedback and interactions. New engagement modalities were developed to better engage clinicians and collect feedback to inform the set-up of the learning collaborative. Analyzed data will be available in June 2022.

Discussion

Engaging busy clinicians in SDM research is an established barrier to implementation. It has become particularly challenging over the past 2 years, largely influenced by the COVID-19 pandemic.

Conclusion

Testing new ways to engage key stakeholders, such as clinicians, in SDM research and implementation projects will be important to maximize their reach and impact.

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175: A scoping review mapping empirical evidence of patient involvement interventions for patients with end stage kidney disease having to consider end-of-life care (Poster)

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Introduction

Clinical guidance integrating end-of-life-care (EoLC) within end stage kidney disease (ESKD) management pathways is varied. This study synthesises evidence from published evaluations of EoLC interventions for patients with ESKD. It provides evidence to inform the development of a shared decision making intervention for Danish kidney services to involve patients with ESKD in EoLC plans.

Methods

A scoping review informed by JBI methods and PRISMA-ScR guidelines. MEDLINE, Scopus, Embase, and CINAHL were searched for full-text studies in English, Danish, German, Norwegian, and Swedish languages. Two independent reviewers assessed the literature against the inclusion criteria, and used a data extraction form to elicit data from included studies. Relational analysis managed within NVIVO was used to synthesise the data against shared decision making and patients' decision aid standards guidance (NICE, 2021).

Results

The search identified 1623 articles, 32 articles met the inclusion criteria, describing 22 interventions. Interventions targeted: patients (n=13); patients and relatives (n=9); relatives (n=1); health professionals (n=7); health professionals and patients (n=1); health professionals, patients, and relatives (n=1). Intervention components included: (e.g. consultations, information, education, advance care planning, shared decision making, and communication training)

Discussion

Most interventions targeted patients with ESKD; findings suggest targeting relatives and kidney professionals is appropriate for implementation within management pathways. Several patient involvement techniques were included within interventions, but few included resources to support patients' health literacy. Including a patient decision aid within the intervention will support greater engagement with this difficult decision.

Conclusion

The review identified several components to support patients with ESKD involvement in EoLC decisions. Future interventions should adopt a complex intervention framework to support multiple stakeholders in the research and design of an intervention to share decision making between patients with ESKD making decisions with their families and health professionals about integrating EoLC options into their kidney disease management pathway.

176: Growing a curriculum for shared decision making in nursing education (Poster)

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Introduction

Increased political focus on implementation of SDM in all public healthcare service emphasizes the need to educate nurses better – nurses being a large professional group with extensive patient contact. At a Danish nursing education institution an effort was made to build a didactically sound curriculum regarding SDM

Methods

Involving teachers from all parts of the 3½ year long education in the development of the curriculum should ensure best use of experience and a logical progression in student development of skills handling SDM. Supervised group discussions were conducted to organize the creative process into a joint product. Efforts were made to integrate research-based definitions of SDM into the discussions

Results

Group discussions showed a great diversity in the view of skills needed to engage in SDM as a nurse. Understanding of logical progression throughout the bachelor's program were also not uniform. Some teachers focused on ethical competence, some focused on organizational and hierarchical structures while others focused on communication skills training. Motivation was also an issue as all educators have experienced student discouragement when facing the ambitions of patient involvement and the resources available for patient-provider cooperation in clinical practice.

Discussion

National and international research has shown that SDM is a very distributed concept and this was reflected in the group of educators. Acknowledgement of this fact and discussion based on the newly published NICE guidelines gave way for creative curriculum development

Conclusion

It is important that nurses - students as well as teachers - can see themselves as a profession in the context of SDM to engage in developing skills needed to include active patient decision making in clinical practice. The provision of research in the field can enhance tolerance and alignment among colleagues regarding educational strategies to encourage development in student SDM competence

177: Patient involvement in the transition from care in an Emergency Department in Denmark (Oral presentation)

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Introduction

The decision on which care the patient is offered after an admission to the emergency department (ED) is not simple and requires dialogue between patient and health professionals. Feeling involved is related to better well-being and improved recovery of the patient. The context in the ED requires navigation in multifaceted situations. Patients are attending with very different needs of treatment and care. Many diagnostic tests are carried out. Often time available per patient is limited. These terms in the ED may challenge the ideal of patient-centred care. To provide input for a personalized care plan patient involvement is essential and the individual patient´s preferences, needs and values must be taken into consideration.

Purpose:

1. To explore the extent of self-reported patient experiences of involvement and related demographic characteristics of the patient
2. To describe how patient involvement in the planning of transition is carried out in the interaction between patient and health professionals in the ED.

Methods

The study uses a multi method design. Data includes the CollaboRATE questionnaire and demographic data from the patient records. Field observations in clinical practice will be performed using multi-sited ethnography, theoretical sampling and analysis.

Results

The data collection is expected to be completed in January 2022. Preliminary findings will be presented at the conference.

Discussion/Conclusion

Findings are expected to provide insight into patient involvement in the ED. This is important knowledge in the further work with developing and implementing a dialogue-tool to facilitate a more systematic patient involvement in the interaction between patient and health professionals.

178: Breast cancer patients' perspective on side effects communication (Oral presentation)

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Introduction

In preference-sensitive decisions such as breast cancer, shared decision-making (SDM) is an essential step to assess the trade-off between the risks and benefits. The purpose of this study was to determine from breast cancer patients' perspective which side effects are most important to include in the radiation therapy decision aid.

Methods

Together with the Breast Cancer Association Netherlands (BVN) in December 2020, an online survey was sent to former breast cancer patients who are part of the B-force panel. Several multiple-choice and open questions related to demographics, quality of life (QOL), use of decision aids, and risk communication were included in the survey.

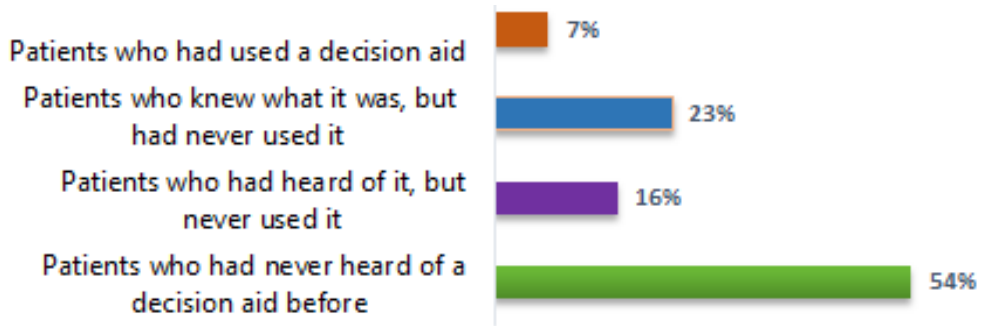
Results

744 women responded; 89% had invasive breast cancer, 3% in situ, and 8% stage four metastasizing breast cancer. 75% of these women received radiation therapy, whereas the 51% of them had not discussed the advantages and disadvantages of radiation therapy with their doctors. Surprisingly, 54% had never heard of a decision aid before (Figure 1). Having energy, being able to use the arm and pain are the top three QOL themes for former breast cancer. Being independent, being able to do hobbies and sports, and ability to work are major reasons for choosing these themes.

Conclusion

Having enough energy is the most important QOL theme for women with breast cancer, highlight the need for fatigue research. For patients, the impact of side effects on their QOL and their personal risk are both important.

Figure 1: Knowledge of participants about the decision aid



179: Towards shared decision-making in localized prostate cancer: data-driven approach to predict erectile dysfunction post treatment (Oral presentation)

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Introduction

For patients with localized prostate cancer choosing the optimal treatment is challenging due to the trade-off between harm and benefits of each, in particular when it comes to long term side effects such as erectile dysfunction (ED).In many of the decision aids currently available to these patients, information regarding side effects is limited to general population-based odds and risks. Therefore, the PROSPECT project developed a personalised treatment decision aid for prostate cancer that offers patients risks of side effects based on personalised predictions. Here we present one of the models offered in this decision aid, namely a data-driven model predicting ED one year and two years post-diagnosis.

Methods

We trained, and validated two logistic regression algorithms using data from 964 localized prostate cancer patients from 69 Dutch hospitals (IKNL ProZIB dataset). In this study, we applied the logistic regression algorithm with recursive feature elimination (RFE) at two time points: one-year and two years after diagnosis. Patients' demographics, clinical data, and patient-reported outcomes (PROMs) at diagnosis were used to develop these models.

Results

The proportion of patients who reported not having an erection 1-year and 2-year after diagnosis was 46% and 47% respectively. The prediction models performed equally well predicting ED in both training and validation datasets. The training set AUCs for 1 year and 2 years post-diagnosis were 0.86 and 0.84, respectively, while the validation set AUCs were 0.84 and 0.81. Treatment group, pretreatment quality, frequency of erections, and ISUP group were identified as the most important predictors of post-treatment ED.

Conclusion

To facilitate SDM, we successfully developed and validated two models that predict ED post-diagnosis for men with localized prostate cancer. The generated models have been integrated into a decision aid which is under assessment for its effectiveness.

180: Gender differences in the decision-making process about undergoing total knee replacement (Poster)

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Introduction

Women have higher prevalence of knee osteoarthritis (OA) and experience greater functional disability than men, but their uptake of total knee replacement (TKR) is lower. This study aims to assess gender differences in the decisional process for knee OA treatment.

Methods

A secondary analysis from a randomized trial was conducted (n = 193). Gender differences on knowledge of OA and TKR, decisional conflict, satisfaction with the decisional process, treatment preference and total knee replacement (TKR) were evaluated. Univariate and multivariate regression models were constructed for identifying significant predictors of these outcomes, separately by gender.

Results

Women showed less knowledge (MD = -7.68, 95% CI: -13.9, -1.46, p = 0.016), reported less satisfaction (MD = -6.95, 95% CI: -11.7, -2.23, p = 0.004) and gave more importance to avoiding surgery (U = 2.09, p = 0.019) than men. For women, a greater importance attributed to pain relief significantly related to lower satisfaction and higher decisional conflict, whereas concerns about the time needed for experiencing relief was associated to a lower likelihood of preferring and undergoing TKR. In men, but not in women, a poorer health-related quality of life significantly predicted TKR uptake.

Discussion

Provision of information and promotion of shared decision making could be hindered for women. Predictors of TKR preference and uptake seem to be influenced by traditional gender roles, which could make more difficult for women to face the recovery period.

Conclusions

A gender-sensitive approach is needed in order to reduce health inequalities.

181: Effectiveness and cost-effectiveness of a virtual community of practice to improve the empowerment of patients with ischaemic heart disease: a randomised controlled trial (Oral presentation)

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Introduction
Virtual Communities of Practice (VCoP) or knowledge-sharing virtual communities offer ubiquitous access to information and exchange possibilities for people in similar situations, which might be especially valuable for the self-management of patients with chronic diseases. In view of the scarce evidence on the clinical and economic impact of these interventions on chronic conditions, we aim to evaluate the effectiveness and cost-effectiveness of a VCoP in the improvement of the activation and other patient empowerment measures in patients with ischaemic heart disease (IHD).

Methods
A pragmatic randomised controlled trial is currently being performed in Catalonia, Madrid and Canary Islands, Spain. Three hundred patients with a recent diagnosis of IHD attending the participating centres should be selected and randomised to the intervention or control group. The intervention group is being offered participation in a VCoP for 12 months based on a gamified web 2.0 platform where there is interaction with other patients and a multidisciplinary professional team. Intervention and control groups receive usual care. The primary outcome is measured with the Patient Activation Measure questionnaire. Secondary outcomes include: clinical variables; knowledge, attitudes, adherence to the Mediterranean diet, level of physical activity, depression, anxiety, medication adherence, quality of life and health resources use. Data is collected from self-reported questionnaires and electronic medical records.

Results
One hundred and seventy-seven participants have been included from June 2021 (70% of the sample size needed), 96 in the intervention and 81 in the control group. Forty-one participants fulfilled the six-month questionnaires out of 112 that have already been involved in the trial for six months. Preliminary results will be available at the congress.

Discussion/Conclusion
Due to COVID-19 situation which is affecting primary and specialized care, recruitment is a major challenge. Participants will continue to be recruited continuously until the desired sample size is achieved in order to maintain the integrity and validity of the trial. The results of this study will provide evidence on the effectiveness and cost-effectiveness of an alternative way of managing patients with a recent diagnosis IHD by using a VCoP which could be extended to other chronic patients.

This study has been funded by Instituto de Salud Carlos III through the projects “PI18/01404, PI18/01397, PI18/01333”, Cofunded by European Regional Development Fund (ERDF), “A way of shaping Europe”.

Trial registration number: ClinicalTrials.gov Registry (NCT03959631). Pre-results.

182: Supporting Health Care Professionals to Improve the Processes of Person-Centered Care in a Web Based Intervention: Randomized Controlled Trial (Oral presentation)

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Introduction

Person-centred care (PCC) is considered "*gold standard*" for medical care. Patient Decision Aids (PtDA) are tools designed to facilitate Shared Decision Making (SDM) in patients, while continuous training in PCC, using tools to work on communication skills and empathy, improve professionals' knowledge and ability to communicate with patients towards more informed decision-making. However, there is a significant gap in the demand, perception and clinical application of the PCC model in clinical practice. The use of continuous training PCC model in primary care professionals could improve their attitudes and encourage a more active role in patients with Generalized Anxiety Disorder (GAD) and hip osteoarthritis.

Methods

Randomized primary care physicians and nurses participated between October and December 2021. The intervention group received one training session about principal contents of PCC to improve SDM skills and supported by videos that staged complex cases in consultation. During January and February 2022, the intervention group will receive a second session. Healthcare professionals in the control group received their regular continuing education programme offered at their health care centre. The Leed Attitudes Towards Concordance Scale was used to assess their attitudes towards the SDM and PCC model and the changes brought about by the intervention.

Results

Thirty-four professionals were invited to participate (70 % of the sample size needed), ten professionals in the first session (7 physicians and 3 nurses) and health professionals in the control group (12 physicians and 2 nurses). Preliminary results will be available at the congress.

Discussion/Conclusions

The development and use of SDM training programmes could improve the informed decision making process between professionals and patients. The conclusions of this trial will be oriented to improve the professionals' attitudes towards the PCC model offered to patients with GAD and hip osteoarthritis through a training programme based on this model.

183: The 'Kidney Failure Decision Aid'; development of a novel patient decision aid to support kidney failure treatment modality decisions with real-world outcome information (Oral presentation)

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5. Radboud University Medical Centre, IQ Healthcare, Nijmegen, the Netherlands;
6. Leiden University Medical Centre, Medical Decision-Making, Department of Biomedical data sciences, Leiden, the Netherlands;
7. St. Antonius Hospital, Department of Internal Medicine, Nieuwegein, the Netherlands.

Introduction
Real-world outcome information may improve patients' risk perception and help patients make decisions congruent with their expectations and values. We describe the development of the first patient decision aid (PtDA) that provides patients with real-world outcome information on all kidney failure treatment modalities.

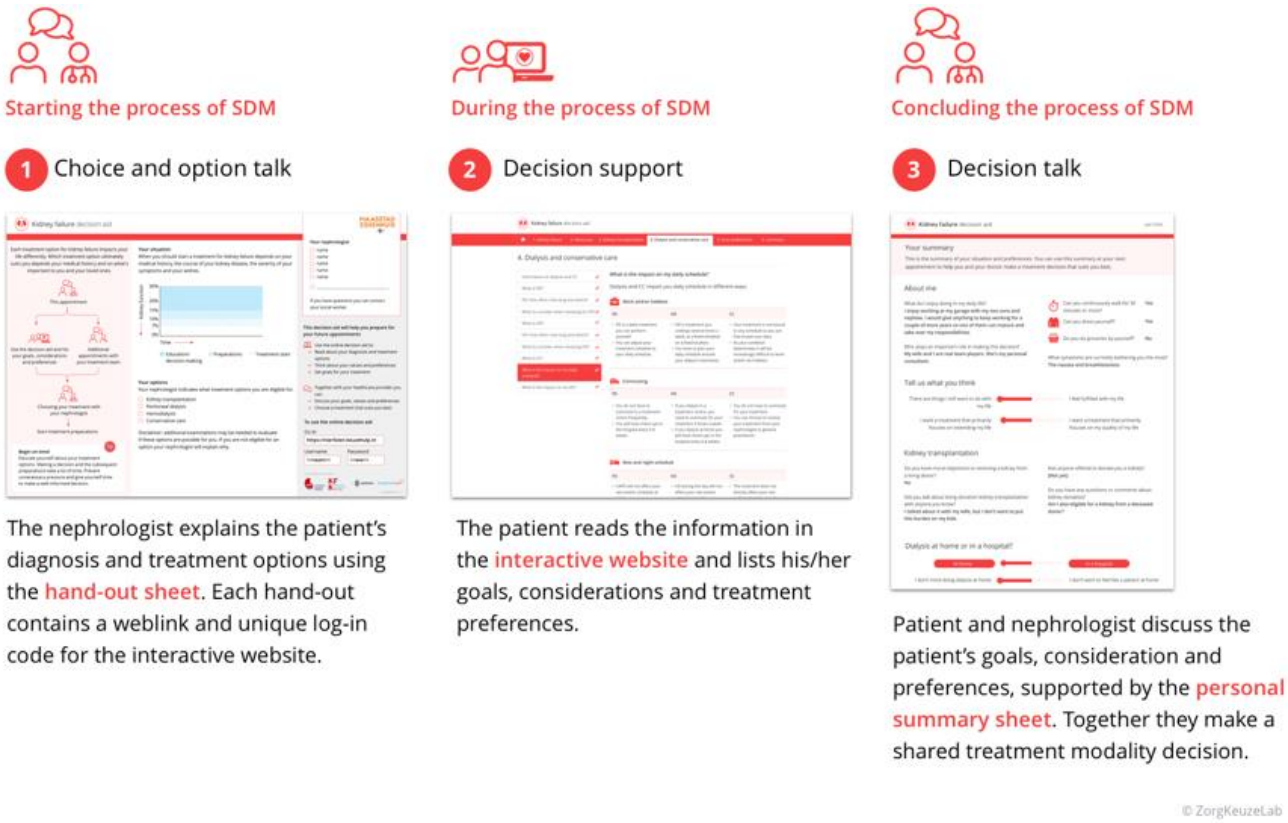
Methods
The International Patient Decision Aids Standards development process model was complemented with a user-centred and convergent mixed-methods approach. An exploratory evidence review and needs-assessment among end-users were conducted to guide a steering group in an iterative process of co-creation. Patients ranked outcomes derived from the International Consortium for Health Outcome Measurement and the Standardised Outcomes in Nephrology initiative on their usefulness for decision-making. Patients-like-me infographics were developed to visualize treatment-outcomes in the PtDA.

Results
The 'Kidney Failure Decision Aid' consists of three components designed to facilitate shared decision-making (SDM) in clinical practice (**figure 1**). Real-world outcome information considered useful by patients has been incorporated in the PtDA**.** Patients and clinicians were confident that the PtDA would help patients make values- and preferences-based decisions.

Discussion
Involving end-users in the developmental process was invaluable in gaining insight on their needs and preferences regarding the design and content of the PtDA. Moreover, it facilitated in the ongoing collaboration with educational platforms and registries that provided essential content for the development of the PtDA.

Conclusion
We developed a PtDA for kidney failure treatment modality decisions that meets the needs and preferences of end-users, contains real-world outcome information on all kidney failure treatment modalities, and facilitates SDM in clinical practice.

Figure 1: The three components of the 'Kidney Failure Decision Aid'. SDM = shared decision-making.
*Note: this is a translation from Dutch to English.



184: Presenting decision-relevant numerical information about survival rates and side-effects to patients with varying levels of Health Literacy: case example of adjuvant therapy in breast cancer (Oral presentation)

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b. Division of Psychosocial Research and Epidemiology and Division of Molecular Pathology, The Netherlands Cancer Institute-Antoni van Leeuwenhoek Hospital, 1066 CX Amsterdam, Netherlands
c. Amsterdam University Medical Center, Vrije Universiteit Amsterdam, Department of Medical Oncology, Cancer Center Amsterdam, 1081 HV Amsterdam, the Netherlands.

Introduction

Decision-relevant numerical information about treatment options presented in Patient Decision Aids/a consultation, is important for Shared Decision Making (SDM). In two experiments risk communication formats to present probabilistic information to patients with varying levels of Health Literacy (HL), numeracy, and Graph Literacy (GL) were investigated using adjuvant therapy for breast cancer as a case example.

Methods

Two between-subjects experiments were conducted with hypothetical scenarios, among women aged 50-70 years. The first experiment (n = 219) investigated the effect of survival rate format (i.e., textual, bar graph, and icon array) on gist and verbatim comprehension.

The second experiment (n = 282) investigated the effect of side-effect presentation format (i.e., text, numbers, visualization, description of the side-effects with numbers or a visualization) on gist comprehension and feeling informed.

Results

No significant differences in the primary outcomes were found for the different survival rate presentation formats. Although gist and verbatim comprehension were influenced by HL, numeracy, and GL, no interaction effects with format were found.

The effect of the presentation format of side-effects on participants' comprehension and feeling informed are currently being analyzed.

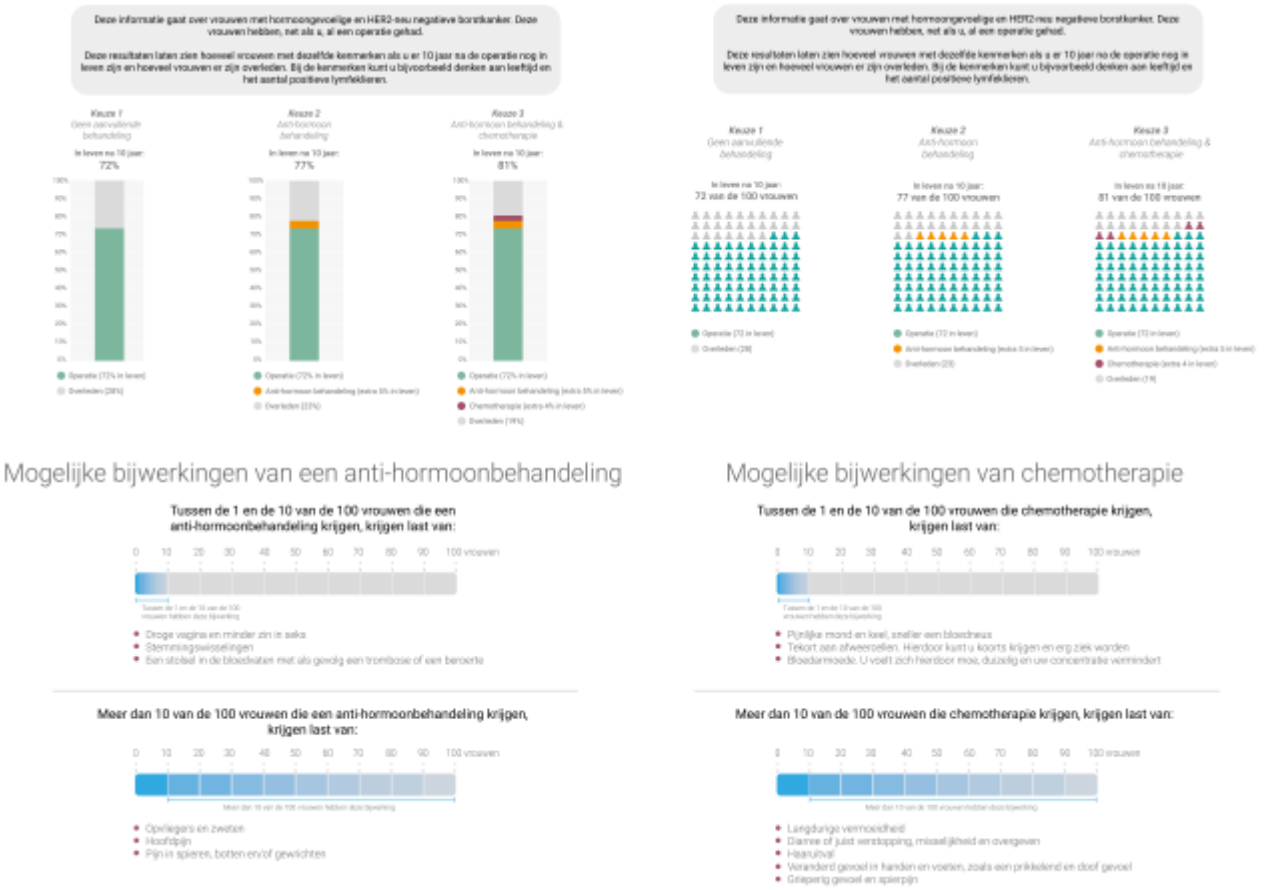
Discussion

Contrary to previous literature, the format in which survival rates were presented did not affect any of the outcomes assessed, irrespective of the patients' information processing skills. The number of treatment options, in this case, three, and the presented small difference in survival rates between these options might have influenced these results.

Conclusion

The survival rate presentation format did not affect patients' responses to the numerical information presented.

Figure 1: Examples of presentation formats of decision-relevant information used in experiments



186: Development and implementation of a web-based decision aid in Swedish cancer screening – the BESTa project (Oral presentation)

Author(s): *Kaisa Fritzell, Anna Jervaeus*

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Introduction

For population-based cancer screening to be effective, i.e., decreased incidence and mortality, a high participation rate is crucial. However, to ensure autonomy and equity in relation to screening participation, it is desired that individuals make an informed decision based on knowledge rather than ignorance, misconceptions or fear. A decision aid (DA) can help in the decision making process but in Sweden no such initiative is currently ongoing, why the project aims to develop and implement a web-based decision aid for individuals invited to cancer screening in Sweden.

Methods

The project is based on the theoretical framework of shared decision making (SDM) based on previous research from us. The DA development process follows The International Patient Decision Aid Standards (IPDAS), including: 1/defining scope and purpose; 2/assemble a steering group; 3/designing the decision aid; 4/alpha testing; 5/beta testing. In addition, behavior flow, and digital literacy, knowledge, values, and preferences will be studied.

Results

The DA scope are the three population-based cancer screening programs (breast, bowel, cervical) currently running in Sweden including individuals 23-75 years of age. A steering group has been formed encompassing relevant expert areas such as clinical, psychometry, IT, DA, SDM, and lay persons. The work on a template to design an interactive DA is currently ongoing.

Discussion

The developmental process of a web-based DA is a complex process involving several expertise areas. A further challenge is the inclusion of three different cancer screening programs, with some similarities but also differences, why we have decided to start with bowel cancer.

Conclusion

Our experience of developing a DA for population-based cancer screening, so far, is that it is a complex intervention including a lot of expertise. Using a framework such as IPDAS is a necessity to be able to do it in a structured and scientific way.

187: To what extent is Shared Decision Making applicable in different kinds of decisions – a systematic review (Oral presentation)

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Affiliation(s):

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Introduction

In the transition from advocating Shared Decision Making (SDM) towards implementation in daily clinical practice, questions arise whether there are limits to SDM's applicability. The aim of this review is to identify for which decision characteristics SDM authors deem SDM to be applicable or not, and based on what arguments.

Methods

In this systematic review we applied two methods. In Method 1 we included the SDM models collected in a 2019 review (42 included articles). In Method 2 we conducted an original search in nine databases (50 included articles): Pubmed, Embase, Medline, Web of Science, Cochrane, Emcare, PsychINFO, Academic Search Premier.

Results

We identified 24 decision characteristics where SDM authors deem SDM applicable and 14 where they deem it is not (figure). We identified five decision characteristics in which papers contradicted regarding the applicability of SDM.

Discussion

In addition to well-known decision characteristics related to SDM such as *equipoise*, other decision characteristics came forward such as *patient commitment needed in carrying out decision*. This highlights the broad range of decisions in which SDM is proposed to be applicable. The contradicting findings reveals the ambiguity of when to apply SDM in some cases.

Conclusion

Our review summarizes SDM authors statements about decision characteristics for which SDM is considered to be applicable or not. When advocating the implementation of SDM and making policies, this review can help to identify for which decisions there is agreement in the literature whether SDM should be practiced, and for which decisions this is less clear.

PROSPERO registration: CRD42021236297.

Figure 1: List of identified decision characteristics in order of most mentioned by authors of SDM models (Method 1) and the quantity in which they were mentioned per setting

Decision characteristics SDM is deemed applicable	Allergy care	Childbearing mother with disease	Elderly care	Emergency Department	End-of-life decisions	Enrolment research	Genital surgery children	Gynaecology	Intensive Care Unit	Mental healthcare	Neurology	Oncology	Paediatric care	Physiotherapy	Primary care / chronic care	Surgery / invasive treatment	Urology	Vaccinations
total decision characteristics per setting→	9	2	2	7	1	2	5	3	6	16	9	43	14	2	35	21	1	1
Preference sensitive (11)	2		1	1			1	1	2	3	2	11	3		7	1		
Multiple options (11)	1				1		1			1		7	3		4	3		
Equipoise (10)		1		3		1		1		2	2	3		1	8	3	1	
•Impact decision high (7)	1			1					1	3		7	2		1	3		
Patient commitment needed in carrying out decision (5)	3		1							1			1		5			
Uncertainty in evidence (4)							1					5	2		1	2		
Uncertainty in outcomes (4)												4	1		1			
•One best option (3)										1			1	1				
One best option but likely to disagree (2)										2		1						
Trade off options (3)							1			1		1			2	1		
• Decision known to often entail misalignment in views (1)	1					1			1	1								
Uncertainty (2)											1	2				1		
No best option (2)	1						1					1	1			1		
Every decision (1)		1		1						1	2				1	1		
Reversibility (1)															1			
Impact decision intermediate (1)															1			
Long window of opportunity to make decision (1)									1						1	1		
Short timeframe to make decision				1														
Weight of the decision (heavy)									1		2	1				3		
Weight of the decision (light)															1			
•Impact decision low															1			
Irreversibility																1		
Value sensitive								1										
•Trade off individual impact and public benefit																		1
Decision characteristics SDM is deemed NOT applicable																		
total decision characteristics per setting→				8				1	2	5	1	3	4		11	6		
•One best option (2)				3				1			1	2	1		3	2		
Short timeframe to make decision (2)				2														
No equipoise (1)				1											2			
Conflicting views patient-clinical judgment in decision				1					1	1			1		1			
•Impact decision low																3		
Life saving measures needed												1			2			
Physician implements decision (based on clinical expertise)									1				1			1		
Decision entails potential threat for public safety										2								
Options restricted by legal/institutional policies										1					1			
Behaviour change needed															1			
Certainty in outcomes																		
•Impact decision high										1								
•Decision known to often entail misalignment in views															1			
•Trade off individual impact and public benefit													1					

- **Bold**=decision characteristics identified in Method 1. Non-bold=Method 2.
- (*number*) = the number of papers from which the decision characteristic was extracted (only calculated in Method1)
- •=decision characteristic both mentioned as a decision characteristic where SDM is and is not applicable

188: General practitioner's attitudes and behaviours regarding cancer screening in older adults: A qualitative interview study (Oral presentation)

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Introduction
Older adults continue to be screened for cancer with limited knowledge of the potential hams. In Australia, general practitioners (GPs) may play an important role in communication and decision-making around cancer screening for older people. This study aimed to investigate GP's attitudes and behaviours regarding cancer screening (breast, cervical, prostate and bowel) in patients aged ≥70 years (as screening programs recently began targeting ages 70-74).

Methods
Semi-structured interviews were conducted with GPs practising in Australia (n=28), recruited through multiple avenues to ensure diverse perspectives (e.g., practice-based research networks, primary health networks, social media, cold emailing). Transcribed audio-recordings were analysed thematically.

Results
Some GPs initiated screening discussions only with patients younger than the upper targeted age of screening programs (i.e., some thought 69 or 74 years). Others initiated discussions beyond recommended ages. When providing information, some were uncomfortable discussing why screening reminders stop, some GPs believed patients would need to pay to access breast screening, and detailed benefit and harms discussions were more likely for prostate screening. When navigating patient preferences, GPs described patients who were open to recommendation, insistent on continuing/stopping, or offended they were not invited anymore, and tailored their responses accordingly. Ultimately the patient had the final say. Finally, GPs considered the patient's overall health/function, risk, and previous screening experience as factors in whether screening was worthwhile in older age.

Discussion
There is no uniform approach to cancer screening communication and decision-making for older adults in general practice. Our findings also suggest older adults and GPs have limited understanding around why screening has an upper targeted age.

Conclusion
Tools to support effective communication of the reduced benefit and increased chance of harm from cancer screening in older age are needed to support older people to make more informed screening choices.

189: Evaluating Shared Decision Making about Prostate Cancer Screening: An Analysis of Audio Recordings from Clinical Encounters (Oral presentation)

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Affiliation(s): University of North Carolina at Chapel Hill, USA

Introduction
Despite varying prostate cancer screening guidelines, there is consensus that clinicians should not order prostate-specific-antigen (PSA) screening tests without shared decision-making (SDM). Few studies have used audio-recorded encounters to assess SDM for PSA screening in practice.

Methods
Using key words, we electronically searched Verilogue™, a commercial database of transcribed U.S. clinician-patient encounters occurring June 2012-April 2018 to identify PSA screening dialogue with men ages 55-59 years. Two investigators independently reviewed transcripts and rated communication in two domains, SDM-equipoise and SDM-pros/cons, using items adapted from OPTION (Table). Discrepancies were resolved by consensus. We calculated the proportion of discussions meeting at least "minimum skill" (rating ≥2 on 0-4 scale) for each SDM domain and present excerpts.

Results
(Table 1) We identified and analysed 29 encounters. Two (7%) met minimum skill criteria for SDM-equipoise communication, where clinicians suggested there was more than one option for screening. Three (10%) met minimum skill for SDM-pros/cons communication, where clinicians provided information regarding pros (likelihood of preventing prostate cancer death) or cons (e.g., surgical complications).) In 12 (41%), PSA was ordered before the encounter without discussion beyond giving results to patients.

Discussion
We observed poor quality SDM in a community sample of clinician-patient discussion about PSA screening. Few clinicians provided even minimal communication regarding equipoise or specific pros/cons trade-offs. Many clinicians presented patients with results of PSA screening tests ordered before the encounter, without any apparent SDM.

Conclusion
Interventions are needed to improve SDM and deimplement the practice of pre-ordering PSA screening tests without SDM.

Table 1: Illustrative dialogue and Shared Decision Making (SDM) "equipoise" and "pros/cons" communication rating for prostate specific antigen (PSA) screening

Dialogue excerpt from transcript	SDM rating: 0-4 scale*
Clinician: "... Then we're checking a blood count, blood sugar, liver, kidney, electrolytes, um, cholesterol, thyroid, prostate cancer screening, vitamin D and vitamin B12. Um, why don't you have a seat up on the table ..." Patient: -- [no dialogue about PSA]	SDM- equipoise score: 0 SDM – pros/cons score: 0
Clinician: "Usually [with a] physical I always do a PSA" Patient: "Yeah"	SDM- equipoise score: 0 SDM – pros/cons score: 0
Clinician: "You know, there's some people that even say, you know, you shouldn't even do PSAs in people, and - " Patient: "Why? It's a preventive, isn't it?" Clinician: "Well we find cancers earlier, which is a good thing, but sometimes there's a jump in PSA without cancer, and then people have a biopsy or have tests and have complications from those, and they didn't have cancer anyway.... And it's, uh, it, it's one of those medical debate things" Patient: "Yeah"	SDM-equipoise score: 2 SDM-pros/cons score: 2
Clinician: "One thing that you'll see is missing on your blood test compared to last year is I did not do a prostate test and there's a reason I don't do it is because the United States Preventative Health Services Task Force ... now say that I should discourage patients from having a prostate blood test done.... Here's the issue, if I do 3000 prostate blood tests on the next 3000, 50 plus year old men who come through, and then I come back 10 years later and say show of hands, how did it turn out. What I can expect out of 3000 blood tests is that I will have ultimately prevented 3 prostate cancer deaths. That's a good thing, although it's a smaller number than I probably would have expected for 3000 blood tests. I will have caused one surgical death because of surgical complications, and I will have caused, by doing these blood tests, 150 serious surgical side effects, like incontinence and erectile dysfunction and infection and bleeding. And when they look at that, they say the benefit is modest, and the risk is larger than the benefit." Patient: "When are they going to do it like every other year or 3 years? How are we going to do it?" Clinician: "We recommend that you don't do it. It's a bad test and they're basically telling us do no test rather than a bad test." Patient: Okay, so...so you end up with prostate cancer or whatever and forget about it? Clinician: "Well, it's not exactly that. You're not going to get the early warning." Patient: "Right...."	SDM- equipoise score: 3 SDM- pros/cons score: 4

* Adapted from OPTION scale (Elwyn et al). **SDM-equipoise:** the clinician states that there is more than one way to deal with the identified problem ('equipoise'). **SDM-pros/cons:** the clinician explains the pros and cons of options to the patient (taking 'no action' is an option). Rating scale: 0= behavior not observed; 1=perfunctory attempt to perform; 2= performed at basic skill level; 3= performed to good standard; 4= performed to high standard.

191: Cultural adaption of the Danish SDM-Q-9 for team-consultations (T-SDM-Q-9-Pat) (Poster)

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Affiliation(s): Dep. of Gynecology and Obstetrics, Hospital Sønderjylland, University hospital of Southern Denmark

Introduction

Shared decision making is challenging for patients with complex pelvic floor disorders (PFD) because several clinicians can be involved in their treatment-decision.

A Danish unit at Hospital Sønderjylland offers a team-consultation with four clinicians (consultants and nurses) from urogynecology, urology, proctology, sexology and a physiotherapist to deliberate these patients' preferences regarding treatment-decision.

We needed a robust and adapted measure-instrument to ensure SDM in a context of team-consultations.
The objective was to cultural adapt an acceptable Danish version of SDM-Q-9 1,2for team-consultations.

Methods

We applied Who's Guidelines for a systematic approach[3].

An expert panel was assembled and adapted all nine questions from the SDM-Q-9 replacing the wording: 'the doctor' with 'one or several team members'. During cognitive interviews, patients answered the questionnaire after consultation (ranging 0-5; completely disagree (0) to completely agree (5)) and were probed, specifically about the context of decisions in team-consultations.

Additionally, we collected data from the clinical context after consultations using the adapted questionnaire to assess acceptance (completeness)[4].

Results

Data was collected March – December 2021. Eleven cognitive interviews with two male and nine female patients (mean age 63 years; the youngest 32 and the oldest 86) showed that patients found questions understandable and adaptable for the context of team-consultations.

A total of 50 questionnaires were collected and 96 % of the patients (n=48) had answered all questions (Table 1).

Table 1: T-SDM-Q-9 (pat) / Pelvic floor unit (Hospital Sønderjylland) after their team-consultations

Respondents (n=50)	Female	Male	Total
Gender (n)	44	6	50
Mean age (y)	57	65	61
Bowel disorder (n)	33	5	38
Urinary incontinence (n)	34	4	38
Pain (n)	5	0	5
Mean SDM (0-5)	4.5!^	4.0!*	4.5!"
Acceptance (%)	98	82	96
Missing 1 item (n)	1	1	2
Missing 2 items (n)	0	0	0
Missing > 2 < all (n)	0	0	0
Missing all items (n)	1	1	2

! without 2 outlayers
^ 4.4 with outlayer
*3.2 with outlayer
"4.3 with outlayer
-both patients commented 'very satisfied with consultation' but mean of the SDM =0

Discussion/Conclusion

The T-SDM-Q-Pat was well adapted to the context and showed high acceptance for patients with PFD and decision-making in team-consultations. Further, a psychometric evaluation is preferable.

192: Boosting shared decision making by integrating its steps into the electronic health record (Oral presentation)

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Affiliation(s):
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Aim
Multiple Myeloma (MM) patients and caregivers are not equally aware of all four shared decision-making (SDM) steps (choice, options & information, preferences, decision) in their care trajectory which may hinder SDM. We assessed the extent to which SDM takes place from multiple perspectives (observer, patient, healthcare professional (HCP)) and identified ways to improve this process as part of an improved electronic health record (EHR) for MM.

Methods
Mixed-methods study with data from audiotaped consultations (observer based: OPTION5, ACEPP), patient surveys (SDMQ9, CPS, prepDM) and HCP interviews (based on the theory of planned behaviour) to assess and explain SDM processes. Self-reported SDM scores, observed behaviours and HCP's statements were tied to the 4 SDM steps in order to identify *what SDM elements* to target in the electronic health record (EHR). In co-creation sessions with stakeholders it was determined *how* to incorporate these elements in the EHR.

Results
Data was collected from 31 consultations, 19 surveys, 10 HCP interviews. Patient reported SDM (SDMq9) scores were 67/100, Preparation for SDM 43/100. Observed SDM was 27/100, communication of outcomes median=3/5. Step 2 (options & outcome information) was most explicitly observed. Other SDM steps were merely implicit, and spread over time and persons. A prepared and active patient was seen as the most important facilitator for SDM.

Discussion
This solution is promising as it focusses on SDM steps 1 and 3 that are not often well-performed, enables SDM processes to take place over time and by different actors and empowers patients for their role in SDM.

Conclusion
Some important elements of SDM were *implicitly* present, leading to average SDM scores. To improve SDM, three adaptations were made to the EHR: 1) patient activation through questionnaires to prepare for SDM; 2) central visualisation of preferences; 3) monitoring of patient reported SDM for quality improvement.

193: Updated of Decision Aid Enabling Women to Choose between No Analgesia or Epidural Analgesia during Labor, and Confirmation of Validity (Poster)

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Introduction

In Shishido's study of 300 pregnant women(2020), it was reported that the use of a decision aid for anesthesia or no anesthesia during childbirth increased knowledge, and increased the proportion of women who made their own decisions compared to women who did not use a decision aid. In this study, we updated and evaluation of the second edition in the 2022 version. We aimed to evaluate the validity and content suitability of the development process of an updated decision aid (the second edition) enabling women to choose between no analgesia and epidural analgesia during labour.

Methods

This study was a descriptive study based on a literature review for updated and additional information on keywords in the first edition.We searched using PubMed, Cochran Library, and Japan Medical Abstracts Society (Ver. 5) from 2003 to May 2021. Next, obstetricians, anesthesiologists, and midwives were asked to respond to a questionnaire regarding validity and content suitability. It met the quality standards of the International Patient Decision Aid Standards instrument, version 4.0 (IPDASi). The Institutional Review Board of St. Luke's International University, Tokyo, Japan, approved the study protocol (21–A055).

Results

Two doctors and three midwives responded to the questionnaire. For the evaluation items of surface validity (i.e., style and clarity), the responses were generally positive. there were 38 specific comments regarding the suitability of the content. These were classified into the following eight categories: "addition or revision of text", "unification of expressions", "need for explanation/information", "lack of evidence", "potential to mislead", "questionable, "structure, and "utilization of a decision aid".

Discussion/Conclusion

We confirmed the validity and content suitability of the second edition. The next steps in the development are to have pregnant women who give birth evaluate the decision aid.

194: Effectiveness of technological interventions to improve healthcare communication with children with long-term conditions: A systematic review and meta-analysis of randomised controlled trials (Oral presentation)

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Introduction
Effective communication and shared decision-making between healthcare professionals (HCPs) and children with long-term conditions (LTCs) can improve physiological and psychosocial outcomes. As we observe a sharp rise in the use of telecommunication in healthcare, children are an emerging audience in which technology can be used to build fundamental self-management skills such as problem-solving and decision-making. This study aimed to evaluate the effectiveness of technological interventions used to improve communication between HCPs and children with LTCs.

Methods
PROSPERO: CRD42020221977. This systematic review searched five electronic databases (inception to May 2021) for randomised controlled trials. Study characteristics were extracted and random-effects meta-analysis was conducted. Effectiveness was evaluated using a number of cognitive, affective, physiological and health outcomes.

Results
Nineteen studies were included (total N=1995). Technological interventions significantly improved participants' knowledge of their condition (standardised mean difference [SMD] 0.39; 95% CI 0.07-0.71; p=0.02) and lead to a more internal health locus of control (SMD 0.50; 95% CI 0.25-0.76; p<0.0001). No statistically significant improvement in physiological measures or emergency healthcare use was found.

Discussion
Findings suggest that communication technologies which aim to support continuity of care and patient-clinician relationships between healthcare visits are valuable for children with LTCs. Enhancing knowledge and internal health locus of control should better equip children to participate in decision-making about their LTCs. Future research should use rigorous methods to allow subsequent reviews to draw conclusions with greater confidence. Establishing a core outcome set within this field of study would enable consistent measurement of outcomes.

Conclusion
Using technology to improve communication between HCPs and children with LTCs is beneficial. These technologies should provide more seamless and accessible multidisciplinary healthcare for children by empowering and facilitating the self-management of their LTCs.

195: Shared Decision Making (SDM) positions patients equally with clinicians in managing their health - Implementing SDM in the ADLIFE project (Poster)

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Introduction

In the ADLIFE project, shared decision-making (SDM) is a core concept with the purpose of giving patients, especially chronic patients, the opportunity and power to participate constructively and actively in the decision-making processes involved in managing their health and health condition. To get optimal outcomes and intended results, SDM must be utilised in a new kind of equal partnership between patient and clinician, which traditionally has taken a more paternalistic approach where the clinician tells patients what to be decided.

Methods

To explore the concept of SDM a literature review was performed to investigate the impact SDM has on patients with chronic diseases.

The search in PubMed and CINAHL (May to July 2021) and abstract reading were performed by two researchers. The most senior researcher performed the final selection. Inclusion criteria: peer-reviewed scientific articles in English and studies focusing on the effects on applying SDM to adults/elderly patients with chronic conditions (particularly COPD/CHF). Exclusion criteria: validation studies, study protocols, abstracts from congresses or meetings, and decision aids tools.

Discussion

Results show SDM interventions are complex but mainly has a positive effect improving: adherence, knowledge, decision quality and chronic illness care, decisional conflict and decision self-efficacy, perceived health status, perceived symptom severity and have an economic benefit.

Most studies showed a positive effect of the SDM approach, but a clear outcome for these patients is difficult to define. However, multi-factor programmes involving different healthcare professionals and several approaches, such as various information material, consultations and follow-up, has the best effect.

Conclusion

The SDM process enhance clinicians and patients' cooperation to reach the best decision for the individual patient, considering the professional and scientific angle, and the patient's values. Only limited amount of literature clearly describes the effect and significance of SDM for patients with chronic disease.

196: Momentum Trial: A Digital tool To Support Shared Decision Making and Patient Activation – a randomized trial (Oral presentation)

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Introduction

A person with a severe mental health condition such as schizophrenia will encounter situations where complex treatment decisions must be made. To provide better support for the patient, the process of shared decision making is becoming increasingly popular in mental healthcare. This study aimed to assess how a digital tool can be utilized to support shared decision making.

Methods

This study was designed as a randomized, assessor-blinded, two-armed parallel-group, multi-center trial in the Capital Region of Denmark. The intervention lasted six months and aimed to assess the effectiveness of a digital tool to promote patient activation and support shared decision making for people with a diagnosis of schizophrenia. The primary outcome was self-reported level of activation at post-intervention.

Results

The trial recruited 194 patients and 76 mental health providers. Intention-to-treat analyses revealed a statistically significant effect favoring the intervention group on patient activation (mean difference = 4.39, CI: 0.99 to 7.79, d=0.33, p=0.01); confidence in communicating with one's provider (MD = 1.85, CI: 0.01 to 3.69, d=0.24, p=0.05) and; feeling prepared for decision making (MD = 5.12, CI: 0.16 to 10.08, d=0.27, p=0.04). We found no effect of the digital tool on treatment satisfaction; hope; self-efficacy; working alliance; severity of symptoms nor level of functioning.

Discussion

While the effect size was smaller than the 0.42 that we had sampled for, the trial contributes to the evidence on how digital tools may support patient-centered care and shared decision making in mental healthcare.

Conclusion

Our randomised trial had a significant effect on patient activation and important secondary outcomes. The study contributes significantly to the existing literature by showcasing the effectiveness of digital interventions to promote patient activation and support shared decision making.

197: An integrative model of shared decision making and advance care planning: the example of people with aortic stenosis (Oral presentation)

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- University Hospital Zürich

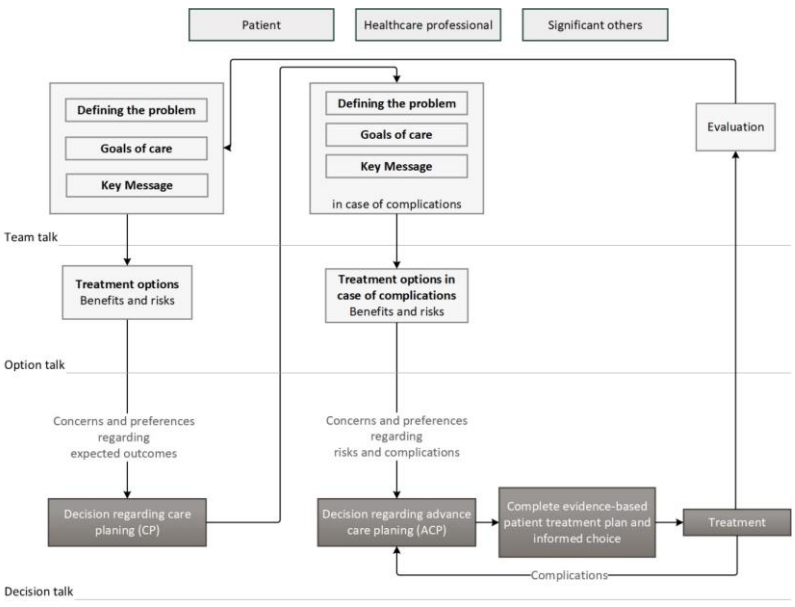
Introduction
Shared decision making (SDM) and advance care planning (ACP) are two patient-centered concepts that support patients, their relatives and healthcare professionals engage in a decision-making process in which patient autonomy is best put into practice. Combining the two complex interventions into one process may support patients with moderate and high treatment complication risks make better evidence-based informed choices.

Aim
(1) To assess how SDM and ACP is being applied in the care of patients with high and moderate treatment complication risks and (2) propose a model to best combine the two tools and integrate them into the care process.

Methods
(1) Systematic integrative literature review with focus on the decision-making process of patients with aortic stenosis who need to decide between transcatheter aortic valve implantation (TAVI), surgical aortic valve replacement (SAVR) or palliative care. (2) Abductive reasoning for developing new concepts based on the ones most broadly used.

Results
(1) From 1843 identified individual publications only eight were included. Based on the SDM Model by Makoul and Clayman, seven studies report the integration of some SDM components in the decision-making process and one study reported the use of goals of care (important ACP component). (2) Based on the decision-making process described in the included studies, the existing SDM and ACP literature as well as guidelines, we have developed an integrative SDM and ACP model (please see figure below), which can be integrated in the treatment decision-making process of patients with moderate or high treatment risks.

Conclusion
Integration of SDM and ACP for patients with moderate and high treatment risks may ensure a continuous patient-centered support for short and long-term decisions and outcomes.



198: Interventions And Improvement Initiatives to Improve Shared Decision Making in Surgical Specialties: A Systematic Review (Oral presentation)

Author(s): *Maryam Jamshaid,[1] Omolara Akinnawonu, [1] Emma Thomas-Jones, [1] David Bosanquet, [2] Adrian Edwards,[1] and Brenig Gwilym [2]*

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Background

Shared decision-making (SDM) helps patients and clinicians choose the treatment option that best fits a patient's preferences. This systematic review is being conducted as part of a BSc medical degree programme. It will conclude in April 2022. It aims to measure the effectiveness of different SDM interventions and quality improvement initiatives undertaken to improve the practice of SDM during surgical consultations.

Methods

This is a systematic review of randomised controlled trials, controlled before-after studies, interrupted time series, and quality improvement projects that aim to evaluate the impact or implementation of interventions intended for consultations in which surgery was a treatment option. MEDLINE, Embase and Cochrane Library will be searched. All steps of the systematic review will be carried out in accordance with the Cochrane Handbook for Systematic Reviews of Interventions.

Results

3,233 studies were identified. After de-duplication, 2,796 studies remained. Studies will be selected according to the inclusion criteria, and primary and secondary outcomes reported. Primary outcomes will include observer-based SDM measures, patient-reported SDM measures and surgeon reported SDM measures. Secondary outcomes will include decisional conflict measures, decisional regret measures and quality of life measure. For the included studies, we will report the results in relation to the quality and strength of the evidence. If meta-analysis will not be possible, we will report the results through narrative synthesis.

Discussion

There are a variety of SDM interventions that can be implemented during a surgical consultation. We will discuss which types of interventions and quality improvement initiatives are most effective, in relation to the primary and secondary objectives. We will discuss the implications of our findings on clinical practice, patient involvement and future research.

Conclusion

We will provide a conclusion on which types of SDM interventions and improvement initiatives are most effective at implementing SDM during a surgical consultation.

199: Equity-centered development of a decision aid to improve shared decision-making for labor induction in healthy pregnancies (Oral presentation)

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Background
Shared decision-making is recommended for routine labor induction in healthy pregnancies. Many people, especially those with marginalized identities, do not experience shared decision-making regarding labor induction and there are no patient decision aids on this topic.

Methods
We used quality improvement and qualitative methods to develop, test, and refine a patient decision aid on labor induction in healthy pregnancies at or beyond 39 weeks to support shared decision-making. Outcomes included patients' understanding of their choices, pros and cons of choices, and their role as primary decision-maker. A quality improvement team developed an initial prototype and used Plan-Do-Study-Act cycles to get patient and provider feedback. The decision aid was tested in three languages by providers across obstetrics, family medicine, and midwifery at a tertiary safety net hospital and two community health centers in Boston, MA between September 2020 and December 2021.

Results
Shared decision-making on labor induction in healthy pregnancies was achieved. Across three Plan-Do-Study-Act cycles 24 pregnant people were interviewed. Most were people of color and publicly insured. Many were recent immigrants and/or non-Native English speakers. Nearly all interviewees experienced shared decision making: 22/24 understood their role as the decision-maker and the majority could name two or three choices they had with pros and cons. Many described the process as empowering and positive. Nine medical providers tested the decision aid and gave feedback. Providers said using the tool helped improve the consistency and content of their counseling and reduce the role of bias.

Conclusion
We will provide a conclusion on which types of SDM interventions and improvement initiatives are most effective at implementing SDM during a surgical consultation.

200: Patient participation in medical decision making -\Short- and long-term results of the SHARE TO CARE program from the patient perspective (Oral presentation)

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Introduction

SHARE TO CARE (S2C) is a holistic, multi-component implementation program for SDM. It was applied to the entire University Medical Center Schleswig-Holstein (UKSH) in Kiel, Germany. The aim of this study was to examine the short- and long-term effects of S2C within the Neuromedical Center comprising the Departments of Neurology and Neurosurgery.

Methods

The S2C program consists of four coordinated intervention modules addressing healthcare professionals and patients: (1) multimodal training of every physician (online + 2 individual feedback sessions regarding videotaped consultations), (2) empowerment of every patient using the ASK3 approach, (3) training of medical staff (nurses, caregivers, physiotherapists) as decision coaches to facilitate patients' decision processes, (4) web-based decision aids developed within the particular department by S2C team and physicians.

The SDM level before and after the implementation and at follow up was judged retrospectively by randomly selected patients on the subscale 'Patient Decision Making' ($PICS_{PDM}$) of the Perceived Involvement in Care Scale. Mean scores were compared with t-tests.

Results

The S2C program could be rolled out completely within the Neuromedical Center: 89% of all physicians (N=56) finished SDM training. 12 web-based, IPDAS compliant decision aids were developed. Patients' pathways were adjusted to embed use of decision aids. 2 decision coaches were educated.
Immediately after implementation, patients reported a significant increase in participation (p<.001; Hedges' g=0,49) in medical decision making. 6 – 18 months after implementation the level remained significantly increased, although slightly lower (p = .010, Hedges´g=0,31).

Discussion

The S2C program proved practicable and effective within the Neuromedical Center at UKSH Kiel. This is the first study also demonstrating its sustainability.

Conclusion

S2C paves the way to a successful and sustainable implementation of SDM.

201: Implementing shared decision making in two entire pediatric departments: efficacy and practicability of the SHARE TO CARE program (Oral presentation)

Author(s): *Anabel Schrader[1], Salim Greven[1], Christine Wagner-Ullrich[1], Katja Meyer-Schell[2], Margarethe Gregersen[3], Gesine Sommer[1], Viktoria Beckmann[1], Gunnar Cario[2], Katy Rinne[4], Anselm Uebing[4], Martin Schrappe[2], Friedemann Geiger[1,2,4]*

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3. MSH Medical School Hamburg, Germany
4. Department of Congenital Heart Disease and Pediatric Cardiology, University Hospital Schleswig-Holstein, Kiel, Germany

Introduction

Ignoring patient's preferences strains the doctor-patient relationship. Doing so with pediatric patients may ultimately ruin their willingness to cooperate. This makes SDM particularly valuable. Especially as decision processes involving patients and parents with potentially diverging views requires thoughtful handling.

In this study, we evaluated the efficacy and practicability of the global implementation of SDM within the Department of Pediatrics and the Department of Congenital and Pediatric Cardiology in Kiel, Germany, using the SHARE TO CARE program (S2C).

Methods

S2C combines 1) training of all physicians, 2) decision coaching by nurses, 3) online decision aids and 4) patient empowerment including the Ask-Share-Know method (ASK3). The implementation process was evaluated regarding practicability.

Efficacy in terms of an increased SDM level was judged by analyzing video-taped consultations before (t0), during (t1) and after the intervention (t2) with the MAPPIN'SDM observer instrument. The pre and post levels were compared using a priori contrast tests.

Results

In both departments, the intended threshold of 80% trained physicians was passed (N=46). Five decision aids were developed covering antithrombotic management after Fontan procedure, pulmonary valve replacement, appendicitis, rheumatoid arthritis (for parents and children). Nurses were involved to support SDM and 2 decision coaches were trained. All patients were systematically addressed by the ASK3 module.

In pediatric cardiology, the SDM-level after the implementation increased significantly (p=.02; effect size=.61). In general pediatrics, the implementation process was finished after the evaluation phase, so no data at t2 exist. However, the increase at t1 was already significant (p=.002; effect size=.86).

Discussion

The S2C program proved practicable and appeared effective in both pediatric departments, although the database in general pediatrics was incomplete. This study shows that the S2C implementation modules can be applied to the pediatric setting with only minor modifications.

Conclusion

The S2C program can be applied successfully in pediatric settings.

202: Essential elements of shared decision making teaching that promote learning and clinicians readiness for educating own colleagues (Poster)

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3. COO, Center for Shared Decision Making, Department of Clinical Oncology, Lillebaelt University Hospital of Southern Denmark, Vejle, Denmark.

Introduction

As part of an implementation effort of Shared Decision Making (SDM) in The Region of Southern Denmark, the method of train-the-trainers was chosen, to prepare clinicians for educating own colleagues. The course developed lasts 2 days and includes elements such as knowledge of SDM, Patient Decision Aids and implementation strategies. Teaching methods include presentations, discussions, simulations, self-reflection and homework assignments. Evaluation results are presented in this abstract.

Methods

Through electronic questionnaires, we evaluated whether the participants felt prepared to apply newly acquired competencies in teaching their own colleagues, as well as which elements of the course particularly led to learning. Before the course, a questionnaire was answered to clarify participants' knowledge, prerequisites, motivation and learning styles. After the course, a questionnaire was distributed after day 1 and 2 concerning the evaluation of the learning outcomes. It was possible to write free-text comments.

Results

94% rated the course to a four or five on a 5 point Likert-scale. 68% rated themselves "some" ready for teaching own colleagues. See other results in table 1.

Discussion

Even though only 17% reported simulations as a preferred learning method, this was spontaneously mentioned in positive phrases in free-text comments. This indicates that participants have changed their views on learning methodology.

Conclusion

Free-text comments showed that active involvement of participants' own practice and simulations of consultations are essential for learning. More simulations are requested instead of teacher-centered teaching.

Experience with the new competencies must now be acquired and possibly studied.

Table 1: Teaching results

Number of educated teachers 2019-2021:125

Number of educated clinicians by teachers 2019-2021: 1016

Pre-course questionnaire sent by e-mail

Response rate

99/111 = 88%

Professionals (Which professional group did the participants belong to)
Response rate:
119/138 = 86 %

MD	28%
Nurse	51%
Therapist*	1%
Pedagogue	0
Other**	20%

* E.g. physiotherapist, occupational therapist
**E.g. midwife, psychologist, secretary

Motivation (To what extent were participants motivated for the course)
Response rate:
119/138 = 86 %

A lot	52%
Some	44%
A little	1%
Not at all	2 %
Don´t know	1%

Participants preferred learning methods.
Do any of the following work particularly well for you in teaching situations? (please add more crosses)
Response rate:
105/118 = 89 %

Teamwork	65%
Simulations of consultations	17%
Being in motion (physically)	16%
Case work	71%
Presentation from teacher	84%
Plenary discussion	73%
Time for self-reflection	41%
E-learning	18%
Other	1%

Post-lesson questionnaire Sent by e-mail

Questionnaire 1: DAY 1

Questionnaire 2 DAY 2

Questionnaire 3 The course as a whole

DAY 1
Response rate
89/89 = 100 %

Simulation exercises of consultations
Positive free-text comments
56/103
= 54%

Less teacher-centered teaching
Positive free-text comments
11/70
= 15%

I got a good insight into Shared Decision Making

A lot	84%
Some	16 %
A little	0
Not at all	0
Don´t know	0

DAY 2
Response rate
87/88 = 99%

Simulation exercises of consultations
Positive free-text comments
25/105
= 23%

Less teacher-centered teaching
Positive free-text comments
1/94
= 0,9%

I gained the necessary knowledge to contribute to the successful implementation of Shared Decision Making in my own practice

A lot	38%
Some	57%
A little	5%
Not at all	0
Don´t know	0

Homework assignment
Positive free-text comments
5/105
= 5%

Lego exercises
Positive free-text comments
13/105
= 11%

THE COURSE AS A WHOLE
Response rate
83/88 = 94%

Readiness for teaching of colleagues

A lot	26%
Some	68%
A little	7%
Not at all	0
Don't know	0

To what extent do you find it relevant to use Shared Decision Making in your practice?

A lot	78%
Some	20%
A little	1%
Not at all	0
Don´t know	1 %

The overall assessment of the course (1 is worst and 5 is best)

1	1 %
2	0
3	5%
4	30%
5	64%

203: Construction of a patient decision aid for the treatment of uncomplicated urinary tract infection in primary care (Poster)

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Affiliation(s): Université de Bordeaux, Université de Paris Créteil

Introduction

Uncomplicated urinary tract infection (uUTI) is very common among women in primary care. The risk of developing pyelonephritis remains low after uUTI, nonetheless, empiric antibiotic therapy is frequently prescribed for symptomatic purposes. This may lead to adverse effects and antibiotic resistance. Furthermore, patients may express the will to limit the use of antibiotics. Some European countries recommend discussing a delayed prescription with the patient and developing a shared decision. The aim of this study is to create a patient decision aid (PtDA) used in primary care settings to make a shared decision between practitioners and women about whether or not to treat uUTI with antibiotics.

Methods

We followed the steps recommended by the International Patient Decision Aids Standards, with a scoping phase, a design phase (including focus groups and literature review), and an alpha-testing phase. A steering group, made of patients and physicians, met throughout the study to develop a prototype PtDA.

Results

The information included in the PtDA is the definition of uUTI, information on the options, their benefits, risks, and consequences, based on a review of the literature. The results of the focus group made possible to determine the patient's values and preferences to consider in decision-making, including: the discomfort felt, the impact on daily life, patients' perceptions of antibiotics, and the position relative to the risk of adverse effect. The choices in presentation, organisation and design are the result of the work of the steering group, improved by feedback from alpha testing. We confirmed the need for shared decision-making and the equipoise in this situation.

Conclusion

We developed a PtDA to be used in primary care for sharing decision on the use of antibiotic in uUTI. It needs to be validated in a beta-testing phase, with complementary advice from peers, and then tested in a clinical study comparing its use with the systematic prescription approach.

QUEL TRAITEMENT POUR MA CYSTITE ?

Ressentez-vous ces symptômes ?

Brûlures en urinant
Douleur ou pesanteur dans le bas ventre
Envies fréquentes d'aller aux toilettes
Difficultés à vous retenir d'uriner
Sang dans les urines

Si oui, il s'agit probablement d'une cystite.

Qu'est ce que la cystite ?

C'est une inflammation de la vessie qui peut être due à une bactérie.

L'infection des reins (pyélonéphrite) est une complication rare des cystites, elle peut survenir même si la cystite a été traitée par antibiotique.

Il n'y a pas d'autres complications médicale, notamment pas de risque sur la fertilité.

Il est conseillé de beaucoup boire et de consommer du cranberry même si les preuves scientifiques sont minces.

Quel traitement prendre ?

Les cystites peuvent guérir naturellement mais leur guérison nécessitera plus de temps qu'avec une prise d'antibiotique.

Lorsqu'un traitement antibiotique est proposé, il s'agit le plus souvent d'un sachet en prise unique.

Récidives
Le risque de récidive est de 10 à 20% avec ou sans antibiotique.

Effets indésirables des antibiotiques
1 **femme sur 10** en ressent au moins un :

Résistances
Utiliser des antibiotiques peut rendre les futures infections plus difficiles à traiter.

AVEC ANTIBIOTIQUE

4/10 femmes soulagées après 3 jours

SANS ANTIBIOTIQUE

2/10 femmes soulagées après 3 jours

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1/2 Version : 1.1

PRENDRE OU NE PAS PRENDRE UN ANTIBIOTIQUE ?

Pour chaque facteur, situez-vous sur l'échelle correspondante à l'aide d'un trait.

Par exemple :

Pour la prise d'antibiotique ?

Contre la prise d'antibiotique ?

LA GÊNE PHYSIQUE RESSENTIE

Mes symptômes sont insupportables — Mes symptômes sont supportables

L'IMPACT SUR MA VIE
(professionnelle, sociale, sexuelle...)

Mes symptômes sont insupportables — Mes symptômes sont supportables

MON OPINION SUR LES ANTIBIOTIQUES EN GÉNÉRAL

Je suis favorable aux antibiotiques — Je suis défavorable aux antibiotiques

MA POSITION VIS-À-VIS DES RISQUES LIÉS À LA PRISE D'ANTIBIOTIQUES
(effets indésirables, résistance...)

Je ne suis pas inquiète — Je suis inquiète

UN QUESTIONNEMENT SUPPLÉMENTAIRE ?

En faveur des antibiotiques — En défaveur des antibiotiques

Précisez : .....

CONCLUSION

Dans ma situation actuelle et après mes échanges avec le médecin, nous décidons ensemble de la solution qui me correspond le mieux :

☐ SANS antibiotique

☐ AVEC antibiotique

.....

.....

.....

.....

.....

Date : 25/10/2019 — 2/2 — Version : 1.1

204: Does a clinical practice guideline facilitate shared decision making? Creation of an assessment tool by Delphi Consensus Method (Oral presentation)

Author(s): *Yves-Marie Vincent, Aliénor Daron, Pauline Panek, Nora Moumjid, Jean-Philippe Joseph, Matthieu Frasca*

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Introduction

Modern medical practice relies on two main concepts: evidence-based medicine (EBM), for its scientific approach, and shared decision making (SDM), as a way to optimize health care through the patient doctor relationship. Where clinical practice guidelines (CPG) have made their way into daily practice as an operational form of EBM, shared decision making is struggling to settle in. It appears that CPGs do not encourage shared decision making but there is no tool to verify it. Using the Delphi Method, we translated and converted strategies put forward in *How can CPGs be adapted to facilitate SDM* into a French appraisal tool that could quantify SDM in CPGs.

Methods

Three rounds of online questionnaires enabled 7 international SDM experts from the FREeDOM collaboration to reach consensus for the translation, pertinence and adjustment of these 19 strategies into assessment criteria.

Results

The 17 criteria produced include general strategies such as adding a specific chapter on SDM, using wording that makes patient involvement explicit, presenting outcomes, benefits and harms of all options including “doing nothing”; as well as recommendation-specific strategies such as giving the patient a copy of his individualized treatment plan, recommending which patient decision aid should be used and when, or encouraging the patient to engage a proxy for the deliberation.

Conclusion

By assessing whether a CPG facilitates SDM, this appraisal tool could help bridge the gap between EBM and patient-centered medicine. It will need to be tested for ease of use, pertinence and reproducibility.

Tables and figures

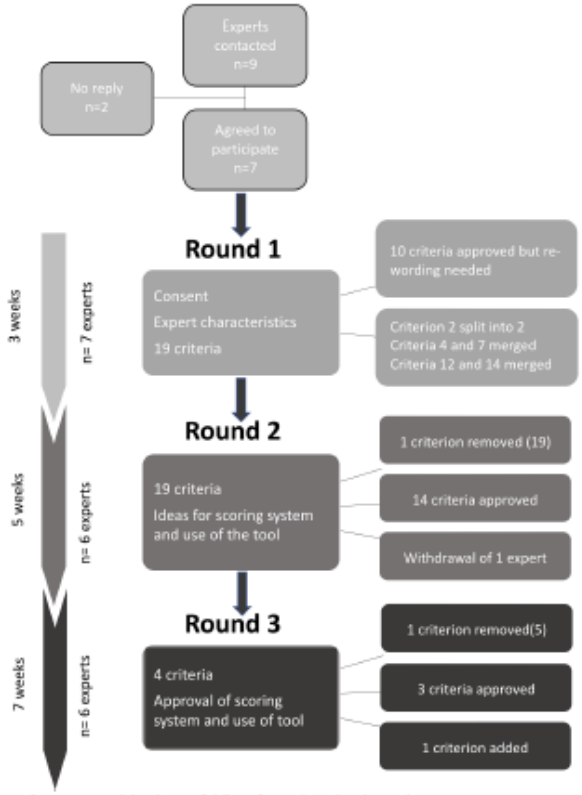

Figure 1 : expert participation, unfolding of rounds and main results.

205: Rapid review methods and evidence summarization for PDAs (Poster)

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Introduction

A 2021 International Patient Decision Aids Standards Collaboration (IPDAS) review and analysis of all publicly available PDAs (n=471) found that 86% did not report any step in the evidence summarization process (i.e., how the evidence was found, appraised, *or* summarized). Transparent and robust evidence summarization processes would support the best available evidence about the benefits and harms of available options. However, stakeholders often require this evidence in a timely manner. A rapid review (RR), defined as a form of knowledge synthesis that speeds the process of conducting a traditional systematic review (SR) by streamlining or omitting a variety of methods to produce evidence in a resource-efficient manner, may be helpful in these situations.

Methods

A set of clear, actionable recommendations and minimal standards have been developed for RRs by the Cochrane RR Methods Group. These were based on up-to-date empirical evidence evaluating RR methods and a survey, and may be used as a guide for a streamlined evidence summarization approach for PDAs. We will extend the preliminary mapping comparison of RR methods to Cochrane's Methodological Expectations of Cochrane Intervention Reviews (MECIR) guidance for full traditional SRs.

Results

We will present/summarize Cochrane RR minimum standards for each step of review process, and the few instances in which the MECIR guidance is more abbreviated than the Cochrane RR minimum standard (eg, Cochrane RR recommends two reviewers to exclude at title and abstract screening whereas Cochrane MECIR allows for both dual and single).

Discussion

RR approaches can be applied when systematically summarizing evidence to inform a streamlined approach to evidence-based PDAs.

Conclusion

Incorporation of RR methods as minimum standards for evidence summarization for PDAs would help efficiently meet the IPDAS domain of "…basing information on comprehensive, critically appraised, and up-to-date syntheses of the scientific evidence".

208: An Interactive E-learning tool can increase knowledge and motivate Healthcare Professionals for Shared Decision Making (Poster)

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Introduction

As part of the implementation effort of Shared Decision Making (SDM) in the Region of Southern Denmark, it was decided to develop an online educational tool, to offer an add-on to the more common classroom education of clinicians.

Many Clinicians have experience with online e-learning material but are depleted of energy of the name alone. Center for Shared Decision Making (CFFB) and the Department of E-learning wanted to reconsider the method of learning through e-learning. Therefore, a novel online-based interactive educational tool, that trains shared decision-making as well as highlights the potential pitfalls that may be in a conversation between clinicians and patients, was created. The concept uses immersive-branched video simulation to demonstrate a realistic case where learners are tasked with making choices to achieving a shared decision. The program provides dynamic feedback based on the choices made. This abstract presents evaluation data from after release of the program.

Methods

Through an electronic quantitative questionnaire with the possibility to write free-text comments, we evaluated the learning outcome and experience.

Leaners automatically received the questionnaire after completing the course.

Results

65.9% strongly agree that the professional content is satisfactory and 62.7% find the interactive program engaging. Similarly, 91% agree or strongly agree the program motivates them to use SDM. See Table 1.

Discussion

With a positive learning outcome and satisfaction with the e-learning program, there is a consideration of making the E-learning program a mandatory part of the implementation effort

Conclusion

E-learning increases knowledge, motivation and application level of SDM.

Table 1: Evaluation of the e-learning course
465 completed the e-learning/258 evaluations (response rate 465/258 (55,5%))

N =258	Strongly agree	Agree	Neither/nor	Disagree	Strongly disagree
I was satisfied with the professional content of the e-learning programme	65,9%	27,1%	5,4%	1,2%	0,4%
Through the e-learning program, I have increased my knowledge of Shared Decision Making	69,4%	25,2%	4,7%	0,4%	0,4%
Through the e-learning program, I have increased my knowledge on how to use Shared Decision Making	63,6%	31,4%	3,9%	0,8%	0,4%
The e-learning programme motivates me to use Shared Decision Making in the consulation with patients	61,6%	29,1%	7,8%	0,4%	1,2%
I would recommend immersive-branched video-simulation (e-learning programme) to a colleague	60%	21,8%	15,1%	1,3%	1,8%
The feedback from the e-learning program gave me a better understandingof Shared Decision Making	59,1%	31,1%	8%	1,8%	0%
I found the immersive-branched video-simulation (e-learning programme) more engaging than traditional e-learning	62,7%	23,6%	10,2%	1,3%	2,2%
Which five words from the adjective list with 63 positive and negative words do you find most descriptive of your experience with the e-learning program?					
The five **most** chosen words	**Useful** 125 ticks	**Simple to use** 103 ticks	**Relevant** 97 ticks	**Meaningful** 97 ticks	**Motivating** 84 ticks
The five **least** chosen words	**Incomprehen-sible** 0 ticks	**Self-contradictory** 0 ticks	**Scary** 0 ticks	**Of no relevance** 0 ticks	**Refined** 0 ticks

210: The impact of sharing audio recorded clinic visits on self-management in older adults: a multisite pilot trial (Poster)

Author(s): *Paul James Barr, Meredith Masel, Reed Bratches, A. James O'Malley, Elizabeth Carpenter-Song, Martha Bruce, Hyunouk Hong, James Goodwin, Sunil Kripalani, Roger Arend, Sheryl Piper, Susan Tarczewski, Sonya Williams, Isamar Ortiz, Kerri Cavanaugh*

Affiliation(s): Dartmouth College, Dartmouth-Hitchcock Medical Center, University of Texas Medical Center, Vanderbilt University Medical Center, Patient Partners

Introduction
Up to 80% of visit information is forgotten by patients, a barrier to self-management which is amplified in older adults. Visit information is communicated through written summaries. Summaries are challenging for patients due to medical jargon, low patient health literacy and incomplete information. We evaluated the feasibility of a novel strategy of communicating visit information with patients, sharing visit audio recordings.

Methods
We conducted a multi-site, two-arm, parallel group, patient-randomized, blocked, controlled, pilot trial with 3-month follow up at three sites (Dartmouth-Hitchcock, Vanderbilt University Medical Center, and University of Texas Medical Center). Patients were ≥65 years, spoke English or Spanish, with diabetes and one or more other chronic diseases. Patients received written summaries (as usual), or summaries plus audio-recordings for any non-urgent primary care visits over three months. Audio-recordings were shared using an open-source audio library, HealthPAL. We assessed recruitment feasibility and retention. Feasibility, acceptability and appropriateness of the intervention were assessed using validated metrics. While not powered, we explored the impact of recordings on patient activation, satisfaction, adherence, quality of life, and interpersonal communication.

Results
We enrolled 16 of 17 clinicians approached, exceeded patient enrollment (n=91/90 patients), with high retention (98%) and high fidelity to the protocol. Patients were 74 years (SD 5.7), 65% female, 82% non-Hispanic White. 73% of participants completed consent and study assessments online**.** Additionally, 38 of 41 patients (93%) accessed their visit recordings independently at home, and 97% of all patients accessed their visit summaries. Feasibility, acceptability, and appropriateness of intervention were a median of 4 out of 5. Exploratory outcomes analysis is pending.

Discussion
Our results indicate the high feasibility of trial procedures and acceptability of visit recording.

Conclusion
Visit recordings are feasible and acceptable in older adults; a powered trial is needed to determine impact on patient outcomes.

211: A pilot trial to determine the feasibility and acceptability of a data science powered personal health library, HealthPAL (Poster)

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Introduction

Digital recordings of clinic visits offer an opportunity to promote patient and family engagement in care. Using advances in natural language processing, we have developed HealthPAL (Personal Audio Library) with older adults and caregivers. HealthPAL is open-access software that automatically highlights key information (e.g., medications, tests) from visit recordings, and links to trustworthy web-based resources. The primary objective of this trial is to demonstrate successful use of HealthPAL at home by older adults with multimorbidity.

Methods

We conducted a multi-site, three-arm, parallel group, patient-randomized, blocked, controlled, pilot trial at Dartmouth-Hitchcock. Patients were ≥65 years with two or more other chronic diseases. Patients visiting primary care were randomized to 1) usual care, 2) simple recording or 3) HealthPAL. We assessed recruitment feasibility and retention. Assessments were completed at baseline and 2 weeks from enrollment. System usability, feasibility, acceptability, and appropriateness of the recording interventions were assessed using validated metrics. While not powered, we also explored potential impact on patient activation, satisfaction, adherence, QOL, interpersonal communication, electronic health literacy, and caregiver preparedness.

Results

We enrolled 4 of 4 clinicians approached, we exceeded patient enrollment milestones (n=45 of 45 patients) with high retention (91%) and high fidelity to our trial protocol. Patients were 78 years old (SD 5.9) and 65% female. Feasibility, acceptability, and appropriateness of intervention were a median of 4 out of 5, and system usability score was 70.6 for HealthPAL, indicating above-average usability. There was a large, but non-significant increase in electronic health literacy in the HealthPAL group from baseline (+3.2/40).

Discussion

Our results indicate the high acceptability and above-average usability of HealthPAL in older adults and their caregivers.

Conclusion

Visit recordings are a highly usable, feasible and acceptable way of curating complex visit recordings for older adults; a powered trial is needed to determine impact on patient outcomes.

213: The feasibility of sharing audio-video recordings of ALS clinical encounters with patients and their caregivers: a randomized controlled pilot trial (Poster)

Author(s): *Reed WR Bratches, Michelle Dannenberg, Tanya H Butt, Daniel Peipert, William Haslett, Jeffrey A Cohen, Paul James Barr*

Affiliation(s): Dartmouth College, Columbia University, University of Vermont, Massachusetts General Hospital, Dartmouth-Hitchcock Medical Center

Introduction
Multi-disciplinary clinics are the gold standard of care for amyotrophic lateral sclerosis, where patients and caregivers meet for up to 3 hours with 8-12 specialists. Recall of visit information is a barrier to effective self-management of care. After-visit summaries are inadequate for providing patients and their caregivers the information they need to succeed. Audio/video recording of clinic visits is a novel alternative that could improve patient and caregiver outcomes.

Methods
Patients and their caregivers were randomized to either receive the standard after-visit summary (AVS), or the standard AVS plus recording sof their multidisciplinary clinic visit through a HIPAA-compliant system. The primary outcome measure was feasibility and acceptability of audio/video recording. Exploratory outcome measures were assessed at one week and three months, and include health confidence and understanding, self-efficacy, patient satisfaction, adherence to recommendations, adherence to medications, anxiety, depression, caregiver preparedness, and caregiver burden. Clinicians completed brief surveys at the end of data collection.

Results
The trial is ongoing and we anticipate recruitment to end in March. We will be able to report a full analysis by the time of the conference. So far, we have recruited 20 out of a planned 24 patients, 20 out of a planned 12 caregivers, and all clinicians at the ALS multidisciplinary clinic. Participants have a mean age of 64 (patients) and 60 (caregivers). Patients were primarily male (67%) while caregivers were more commonly female (72%). One-third of patients had a bachelor's degree (33.3%) and most (62%) made less than $75,000 per year. We have recorded 124 clinic encounters from neurology, physical and occupational therapy, sleep medicine, speech language pathology, nutrition, social work, and support group visits. 69 of those videos have been viewed 152 times by participants. Qualitative interviews are also ongoing.

Discussion
Findings will inform the feasibility and acceptability of a novel method of communicating visit information to patients and caregivers with complex conditions. These results will help inform a larger trial powered to detect differences in important patient and caregiver outcomes.

Conclusion
Pending results.

214: How do family caregivers interact with clinic visit information? A national survey (Oral presentation)

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Introduction
Family caregivers are an important part of the clinic encounter and perform a critical role in patient care. Information from clinic visits is important for caregivers to effectively manage care, but the association between the methods to engage them with clinic visit information and important caregiver outcomes are poorly understood.

Methods
We conducted a cross-sectional web-based survey of a national sample of adult family caregivers (July 2020). Respondents reported caregiving experiences, modes and frequency of care-recipient clinic visit information, and caregiver burden, preparedness, and positive aspects of caregiving. Multiple regression determined associations between visit communication modes on caregivers burden, preparedness, and positive aspects of caregiving, adjusting for sociodemographic covariates.

Results
Caregiver respondents (N=340) were mostly male (58%), White (59%), ranged from 18 years old to 85 years old, and supported conditions including diabetes, dementia, and cancer. Utilizing patient recall was associated with higher levels of the positive aspects of caregiving (ß 3.72; 95%CI 2.01, 5.42) and a printed paper summary was associated with increases in positive aspects of caregiving (ß 1.94; 95%CI 0.4,3.56) and preparedness for caregiving (ß 1.88; 95%CI 0.61, 3.15). We did not observe an association between any method of visit communication and caregiver burden.

Discussion
Using a national survey of 340 family caregivers, we found associations between patient recall and printed paper summaries and higher levels of caregiver preparedness and positive aspects of care but not burden.

Conclusion
Future work should explore potential causal pathways between methods of communicating clinic visit information and caregiver outcomes.

215: Multimorbid home-living older adults' experiences with eHealth to support Shared Decision Making (SDM) (Poster)

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Affiliation(s): Faculty of Health Science, Department of Public Health, University of Stavanger

Introduction

Older adults living with multimorbidity must navigate fragmented healthcare systems, making it challenging to manage their health conditions. In SDM patients and healthcare professionals work together to plan care and make treatment decisions, promoting self-management. Using eHealth such as mobile applications or electronic communication in SDM has been considered promising, and in some cases ensured greater patient participation and satisfaction. The objective of this study is to explore multimorbid older adults' experiences with the use of eHealth to support SDM.

Methods

A longitudinal qualitative interview study was conducted in an urban/rural mixed Norwegian municipality. Individual semi-structured interviews were conducted with 20 older adults over 65 years with multimorbidity living at home and receiving nursing care from the municipality home healthcare services and follow-up from their general practitioner (GP). Data were analyzed using content analysis.

Results

Our results indicate that older adults have individual preferences on how much they want to be involved in information sharing about their treatment and care. Often they didn't know what information home care nurses or the GPs shared about them. Some wanted to be informed about what healthcare professionals wrote in the electronic health journals, whilst others didn't want to be involved. The telephone was an important eHealth tool. Some wanted to receive health-related information over the telephone instead of via text messages.

Discussion

Individual preferences on how much older adults want to be involved in treatment and care makes it important for healthcare professionals to customize SDM. Despite the fast development of eHealth, telephone conversations remain important to ensure sufficient information sharing and to engage older adults in the dialogue with professionals.

Conclusion

eHealth and telephone are important to ensure sufficient information sharing and involvement for multimorbid older adults living at home.

216: Consultation length and decisions. A prospective cohort study of the Decision Helper (Oral presentation)

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Introduction

Doctors may restrain from adopting principles of shared decision making (SDM) due to concerns of increased time consumption and of adverse impact on clinical decisions.

The aim of this study was to evaluate the impact on time usage and clinical decisions using SDM and an in-consultation Patient Decision Aid, the Decision Helper (DH).

Methods

This prospective cohort study compared an unexposed cohort with a cohort exposed to SDM and the DH. Two different preference-specific decision making situations were chosen: Lung cancer diagnostics (small suspicion of cancer) and adjuvant treatment for breast cancer patients.

Results

In total, 261 consultations (115 with the DH) were included in the study. Consultations were insignificant longer in the SDM cohort; 2 min, 11 s (p = 0.2774) for lung cancer diagnostics and 3 min, 57 s (p = 0.1128) for adjuvant breast cancer treatment. In lung cancer diagnostics, consultation length became more uniform and decisions tended to become more conservative after introduction of SDM and the DH (p = 0.098). For adjuvant breast cancer, slightly more patients in the SDM cohort chose to decline treatment (p = 0.047).

Discussion

Even though doctors in the SDM cohort were at the beginning of their SDM learning curve, consultation lengths were not influenced significantly by introduction of the DH. In an era of overtreatment, conservative decisions are not necessarily negative aspects of SDM.

Conclusion

Shared decision making supported by the DH did not take significantly longer time and led to slightly more conservative decisions.