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Merci à nos précieux collaborateurs / Thanks to our precious collaborators:



001 - Shared decision-making in cancer care: Process evaluation of a stepped wedge cluster randomized implementation trial

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Background and Aims: Shared decision-making (SDM) is highly relevant in oncology, where many high-impact preference-sensitive treatment options exist, and many patients want active engagement in decision-making. Despite scientific evidence and promotion by health policies, routine implementation of SDM continues to lag. As known from implementation science, a thorough process evaluation is key to conducting implementation studies. The main aim of this study is to evaluate the process of a multicomponent implementation program designed to foster SDM in routine cancer care.

Methods: The stepped wedge implementation study is conducted in three cancer care departments. The program consists of training and individual coaching of clinicians, patient activation, provision of information material and decision aids, revision of quality management documents, and reflection of current organization of tumor boards. The mixed methods process evaluation can be used to understand effects of the program, and to adapt the program, if necessary. Qualitative data include interviews with recipients of the implementation program and field notes generated by the research team. Quantitative data include documentation of actual delivery of implementation strategies in each clinic, giving insights into reach and fidelity of implementation.

Results: We concluded the first of three implementation phases. We trained 55% of eligible doctors and 37% of eligible nurses. Facilitators included leadership support and delivery of training during regular meeting slots. Barriers included staff shortage and competing demands. 33% of clinicians participated in individual coaching. Some adaptations regarding dose and timing of delivery were necessary. Information material, decision aids, and patient activation material was distributed in all parts of the clinic. Revision of quality management documents and reflection of tumor boards progressed well, but its implementation could not be completed by the end of the first implementation phase. Results of process evaluation of the second implementation phase will also be presented at the conference.

Conclusion: This detailed process evaluation offers reliable insights into the realization of a complex SDM implementation program in cancer care. Although we were generally able to pursue the implementation strategies, adaptations to the study protocol were necessary. Outcome evaluation will reveal whether reach was sufficient to foster SDM implementation.

004 - Using an APP as a decision aid for women making breast reconstruction surgery decision

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Women have difficulty deciding whether to undergo breast reconstruction. A computer-based decision aid is helpful for women considering breast reconstruction surgery. The aim of this research is to evaluate using an app as a decision aid for women making breast reconstruction surgery decision on decision-related and psychological outcomes.

Randomized controlled trial using permuted block randomization was used to evaluate the long-term effects of the APP based decision aid on women's decision conflict, decision regret, body image, anxiety and depression. Women allocated to the intervention group received a pamphlet as well as an App education with value clarification. Women allocated to the control group received care as usual using an education pamphlet from the health care providers. Outcomes were evaluated at baseline (T0), and follow-up assessment at 1 week after intervention (T1), 1 month (T2), 8 months (T3), and 12 month (T4) after baseline. The trial was approved by the Institutional Review Board in a medical center in Southern of Taiwan.

Forty-seventy women were randomized in which 23 received an app intervention and 24 received a usual care until now. In addition, 21 women completed one week follow-up for T1 for each group and 15 in intervention group and 13 in control group for T2. Preliminary results found that both two groups had a significantly decreasing for decision conflict after one week follow-up ($P < .001$). However, there is no significantly trend in the decreasing of decision conflict between groups ($P = 0.879$). In addition, both two groups had a significantly decreasing for anxiety on T1 ($P < .05$), but no significantly trend in the decreasing for anxiety between groups ($p = .654$). Furthermore, both two groups failed to reach a significantly decreasing on depression and decision regret on T1 ($P > 0.05$).

Long term assessment for decision regret and psychological outcomes & larger sample size is needed for further analysis in the future.

005 - The Self-Match Study

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Background and aims: Research on matching alcohol use disorder patients to treatment has shown that matching grounded in expert views is little better than allocating patients by chance. Emphasis on involving patients in their own treatment as a key to health behavior change is still increasing; however, research on the benefit of having patients choose their own treatment from among options has been limited. Consequently, we designed a rigorous test of patient self-matching to determine whether it does improve retention, adherence and outcome in alcoholism treatment.

Method: The Self-Match Study is a randomized controlled trial. 400 consecutive patients aged 18 or more will be enrolled and randomized to either self-matching or expert-matching to one of five different treatment options. All patients entering the alcohol outpatient treatment center in Odense, Denmark are offered to participate in the study. Exclusion criteria: cognitive dysfunction measured by mini mental state examination, and non-Danish or non-English speaking individuals. English speaking individuals must understand Danish to see a video presentation of treatment options. The following instruments will be administered at intake: Addiction Severity Index, Time Line Follow Back, WHO quality of life questionnaire, NEO Five-Factor inventory-3 and Personal Happiness Form. Decision aid is a video presentation of treatment options.

Results: Intention-to-treat analyses (ITT) will be carried out with all patients, irrespective of whether they completed the interventions or were re-interviewed. Regarding incomplete data, multiple imputations will be used together with ITT. Completer analysis will also be carried out with patients who complete their respective interventions.

Primary outcome: Decrease in number of monthly excessive drinking days 6 months after initiation of treatment.

Secondary outcomes: (1) Compliance. (2) Quality of life. The influence of personality traits on outcome will also be examined in both groups.

Enrollment is expected to end in March 2019. Follow-up is 6 months; hence data analysis begins September 2019. Results presented on the poster will be preliminary data based on baseline interviews.

Discussion: The Self-Match Study is investigating informed choice in the Shared Decision-Making continuum. Results will contribute to the discussion on how to design Shared Decision Making in addiction treatment.

006 - The effect of education on shared decision-making for confidence in the evidence-based practice of physiotherapists and occupational therapists: A multicentered randomized controlled trial

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We examined the effectiveness of a theory-based workshop on shared decision-making implementation for confidence in evidence-based practice in physical and occupational therapy.

A total of 126 therapists (68 physiotherapists and 58 occupational therapists) in four hospitals was randomly assigned by an independent center to a shared decision-making education (SDM-E) group or two control groups that included a two-hour lecture on evidence-based rehabilitation or clinical practice guideline. The SDM-E group included a two-hour lecture and workshop of shared decision making designed using Theory of Planned Behavior models. We measured participants' hospital information (phase of main disease, number of associated therapists, number of beds), working time, whether they participate in research activities or not, cognition, and thought for evidence-based practice as confounders. The main outcome was the average of an evidence-based practice confidence scale that included 11 items concerning knowledge of critical appraisal/judgement skills related to adopting evidence into practice. Each item was rated on a 0-100% scale by increments of 10%. We translated them into Japanese and evaluated them in pre and post interventions. The statistical analysis employed an analysis of variance with a mixed model.

All participants finished the study. The confounders' assessment revealed no difference between the SDM-E group and the control groups. There was a significant interaction with group and pre/post time course ($p < 0.01$). The difference in intervention at the baseline was not significant, but there was significant differences between SDM-E group and both control groups at the post intervention ($p < 0.01$).

We concluded that a theory-based workshop in shared decision-making can change the confidence in evidence-based practice.

007 - Which 'major' complications do patients want to be informed about prior to abdominal aortic aneurysm surgery?

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Aims

Surgeons greatly vary in the major complications they discuss with patients, also in patients with an abdominal aortic aneurysm (AAA). It is unclear which complications these patients consider 'major' enough to affect their treatment decision. In a previous Delphi-study a consensus was reached among vascular surgeons about what they consider as 'major' complications after AAA-surgery. This study aimed to reach consensus among patients on a severity-based ranking of possible complications following AAA-surgery.

Methods

A national population of patients diagnosed with an AAA, being either under surveillance or after surgery, were invited to participate. A list of 33 complications known from the literature was used, with additional information in nonprofessionals' terms explaining what each complication would entail for the patient. Patients scored the complications in sets of three, using best-worst scaling.

This method implies that within each set of three complications, patients label one complication as 'major' and one complication as 'minor', while one complication remains unlabelled. After all participants had completed the questionnaire, the number of times a complication was labelled as major was subtracted from the number of times that complication was labelled as minor by patients.

Results

A representative group of 50 patients completed the questionnaire. Nearly half of the patients underwent endovascular repair. Sixteen out of the 33 complications were more frequently considered as 'major' than 'minor', while 17 complications were more frequently considered as 'minor'.

Below-ankle amputation following thrombo-embolic event was the highest-ranking major complication, since it was considered as a 'major' complication by 43 out of 50 patients (86%), followed by aneurysm rupture and stroke. Hematoma was considered as a 'minor' complication by 40 out of 50 patients (80%).

Conclusions

This best-worse scaling study enabled patients to rank complications based on perceived severity. In addition to frequently occurring complications, we recommend vascular surgeons to discuss also the highest-ranking major complications with their patients, when considering AAA-surgery.

This will harmonise risk communication by vascular surgeons and will allow patients to weigh effectively the benefits and harms of their treatment options. This will likely facilitate the shared decision-making process.

012 - Does current reporting of benefits and harms in trials foster shared decision-making?

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Background

Correct and complete reporting of the outcomes of clinical trials is mandatory to appreciate available evidence and to inform patients properly before asking informed consent and to let them share in the decision-making process. The CONSORT statement was developed to improve the reporting of randomized clinical trials (RCTs).

The aim of this systematic review was to assess current reporting of the benefits and harms to support clinical decision-making in recently published surgical RCTs in leading medical journals.

Methods

We systematically reviewed RCTs, published between January 2005 and January 2017 in 15 leading scientific journals, comparing a surgical treatment to any other treatment. The CONSORT checklist, including the extension for harms, was used to appraise the publications. Primary and secondary beneficial and harmful outcomes were assessed by extracting data and definitions of the outcome measures, and the precision measures used.

Results

A random sample of 1200 RCTs was screened to arrive at a total of 100 RCTs to be assessed. After full-text screening of eligibility, 88 trials were included. For the differences in effect size of beneficial outcomes, 68% of the trials reported a p-value only, and not a 95% confidence interval. For harmful effects, this was 67%. Only 5 out of the 88 (6%) trials reported a number needed to treat (NNT), and none of them a number needed to harm (NNH). Only 61% of the trials reported on both the beneficial and harmful outcomes of the intervention studied in the same paper.

Conclusions

Despite the CONSORT statement, the reporting of benefits and harms in surgical trials hampers a clear communication of treatment outcomes with patients. Therefore, researchers, reviewers and journal editors should be more keen on the proper reporting of benefits and harms in trials to foster a true informed consent and shared decision-making.

013 - Creation of a decision support tool for the use of antibiotics, as part of a consultation for simple cystitis in primary care

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Introduction:

In France, cystitis is a frequent reason for consultation in primary care (the third most frequent infectious reason) and usually leads to an antibiotic intake (80% of the consultations). According to french society of infectiology (SPILF), the antibiotic treatment must be systematically prescribe to a symptomatic purpose, but he can have some personal and communal side-effect and may not be the best option according to the situation. The risk-benefit balance would be to weigh for each patient. In front of this equipoise situation, we have developed a tool to help in making decision for the patient and the practitioner during a consultation for cystitis in primary care. We will develop here the conception of this tool's prototype.

Method:

Relaying on the French Hight Health Authority (HAS) guidelines, we used a qualitative method with an anchored theorization during focus group of patients recruited through patient organization, paying attention to the perception and personnel experiences of the simple cystitis, to the therapeutic options they would knew and to the information they'd like to have. A working group thereafter synthesized those focus group data.

Results:

Between May and September 2018, we have realised 4 focus groups of 4 to 6 patients. A work group of 2 patients and 4 general practitioners had then realise specifications for the tool, using the 4 focus groups codes. Additional bibliography work was done focusing on specific data used on the prototype. Then a graphist realised the formatting of the decided help tool.

Conclusion:

We have realised the first prototype of a tool to aid decision for antibiotic on simple cystitis. It is undergoing development with new interviews and focus groups with patients and general practitioners before being finalized by a new work group. It will be used from mars to October 2020 as part of a study comparing the use of this tool to the application of the recommendations of the SPILF.

014 - Research Progress on Shared Decision Making in China and Possible Future Directions

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Shared decision making (SDM) is widely accepted as the standard of practice in the United Kingdom, the United States and other developed countries. In China, SDM could be a key component in providing better healthcare and improving the currently low levels of trust between doctors and patients, as part of an ongoing health care system transformation. SDM research in China is needed to assess the level of demand and awareness for patient involvement in decisions about their care, in order to guide implementation and evaluation. We used keywords SDM, decision aids or tools and China to search several databases including PubMed, Scopus, MEDLINE, EMBASE, CINAHL, PsycInfo, Wanfang, CNKI and clinical trial registries without language restrictions from the time of their inception to December 2018. Few research and reports on SDM were found in mainland China before 2014 and numbers of research in SDM increased after 2014. English literature focusses on patient preferences, cancer, surgery and feasibility of decision tools, while almost all the Chinese literature is about theoretical aspects of SDM. Most of Chinese language articles were published in one journal, and near half of the first authors are non-clinical professionals. Despite the increasing interest in SDM research in China, there are still few related studies. Lack of awareness may be a huge challenge for conducting SDM research. We conclude that the future SDM research in China could be in four areas: to identify demands and gaps and improve knowledge and skills through medical education and training, to design and test decision aids based on the local context, to increase awareness and participation through patients' involvement and to combine SDM with health care system reform by incorporating it into policy support.

015 - Development of a patient decision aid for shared decision making in primary care in Singapore: for maintenance inhaled corticosteroid therapy in asthma (Part 1)

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Background and aims

Asthma is a prevalent chronic inflammatory respiratory disease that affects about 339 million people worldwide. To reduce airway inflammation, international guidelines recommend the use of inhaled corticosteroids (ICS). However, adherence to ICS is poor. According to a recent primary care study in Singapore, only 40.9% of adult respondents were adherent to ICS. Poor adherence was related to patients' misunderstanding and concerns about asthma medications, which are not elicited nor adequately addressed by their physicians. The latter infrequently involve patients in deciding on their asthma treatment options, as shared-decision making (SDM) is uncommon in local clinical practices. In addition, another study showed suboptimal understandability and readability of local asthma education materials, which further hinder patients from making informed decision on their treatment options.

Studies have reported that clinicians who used SDM had better patient involvement, improved adherence and clinical outcomes. In contrast to conventional educational materials, a patient decision-aid (PDA) organises information into evidenced-based information on disease and treatment options, enables patients to recognise their values and preferences in selecting their treatment options. Currently, only a French PDA on ICS has been developed which will not cater to the needs of local English literate multi-ethnic Asian patients with asthma. We postulate that addressing the misunderstanding and concerns of patients via SDM and facilitated by a English PDA on ICS will enable them to make informed decisions on their treatment options and contextualised to their values and references. The healthcare providers' feedbacks on the novel PDA are critical in the design and development of its content, as they will be the future PDA users. This study aims to explore the views of healthcare providers on the content, design and implementation of a PDA prototype on ICS.

Methods

This qualitative research study will interview 30 healthcare providers (respiratory physicians, family physicians and nurses) involved in the management of patients with asthma. The in-depth interviews and focus group discussions will be audio-recorded, transcribed and analysed to identify emerging themes relating to the design, content and implementation of the PDA. The results will be reported when the study is completed.

016 - Development of a Patient Decision Aid for Shared Decision-Making in Primary Care for the Management of Lower Urinary Tract Symptoms in Men

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Background

Lower urinary tract symptoms (LUTS) in elderly men are common medical problems but are often underdiagnosed in primary care. Symptom severity can be misrepresented by the International Prostate Symptom Score (IPSS). Timely identification of LUTS and quick severity assessment are essential for its optimal management. We postulated that a pictorial tool would facilitate LUTS identification and support decision-making in its management.

Aim

The study aims to determine the (1) prevalence of LUTS among men in primary care; and (2) in those with moderate-to-severe symptoms or symptomatic to the detriment of quality of life (QOL), the effect of the Visual Analogue Uroflowmetry Score (VAUS) on quality of shared decision-making (SDM) with their polyclinic physicians, referral rate to the urologist and rate of acute urinary retention (AUR) as outcome at 6 months.

Methods

A cross-sectional survey will first be conducted on 320 multi-ethnic Asian men aged 50 years and above attending a public primary care clinic (polyclinic) for general consultations in southern Singapore. The questionnaire will cover socio-demographic characteristics and medical conditions. LUTS status will be assessed using IPSS and QOL scores and assessed with the demographics using Chi-square test and independent t-test. Potential variables with p-value < 0.05 will be entered into the multivariate logistic regression model to obtain the adjusted odds ratio.

The second stage is a pilot unblinded, randomized controlled trial involving 60 men with moderate-to-severe LUTS (IPSS ≥ 8 and/or QOL > 3) identified from the survey. 30 randomly selected men will undertake VAUS (intervention) and another 30 men without as controls. Physicians will be blinded to the IPSS. The intervention group will use VAUS to discuss their symptoms with their physicians while the control will not. The outcome measures are referral rate to the urologists; quality of the SDM process using SDM-Q-9 and SDM-Q-Doc questionnaires and rates of AUR based on electronic medical records six months after study enrolment. SDM-Q-9 and SDM-Q-Doc between both groups (with VAUS vs without VAUS) are compared using Mann-Whitney U test. AUR at 6 months between the two groups will be tested using Chi-square test.

Results will be reported upon study completion.

017 - Online decision aids for primary cardiovascular disease prevention: Systematic search, evaluation of quality, and suitability for low health literacy patients

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Background and aims: Recent guideline changes for cardiovascular disease (CVD) prevention medication have resulted in calls to implement shared decision making rather than arbitrary treatment thresholds. Less attention has been paid to existing tools that could facilitate this. Decision aids are well established tools that enable shared decision making and have been shown to improve CVD prevention adherence. However, it is unknown how many CVD decision aids are publicly available for patients online, what their quality is like and whether they are suitable for patients with lower health literacy, for whom the burden of CVD is greatest. This study aimed to identify and evaluate all English-language, publicly available online CVD prevention decision aids.

Methods: Systematic review of public websites in August–November 2016 using an environmental scan methodology, with updated evaluation in April 2018. The decision aids were evaluated based on: 1) suitability for low health literacy populations (understandability, actionability and readability); and 2) International Patient Decision Aids Standards (IPDAS). Evaluation of materials included the understandability and actionability scores of the validated Patient Education Materials Assessment Tool for Printed Materials (PEMAT-P scale); readability using Gunning–Fog and Flesch–Kincaid indices; and IPDAS versions 3 and 4.

Results: A total of 25 unique decision aids were identified. On the PEMAT-P scale, the decision aids scored well on understandability (mean 87%) but not on actionability (mean 61%). Readability was also higher than recommended levels (mean Gunning–Fog index = 10.1; suitable for Grade 10 students). Four decision aids met criteria to be considered a decision aid (i.e. met IPDAS qualifying criteria) and one sufficiently minimised major bias (i.e. met IPDAS certification criteria).

Conclusions: Publicly available CVD prevention decision aids are not suitable for low literacy populations and only one met international standards for certification. Given that patients with lower health literacy are at increased risk of CVD this urgently needs to be addressed.

018 - Online Decision Aids for Knee Pain and Low Back Pain: An Environmental Scan and Evaluation

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Background and aims: Musculoskeletal conditions are leading causes of disability. Management options are plentiful, but the current evidence base suggests many are ineffective or unproven. Online decision aids can help support patients make informed healthcare choices. However, there is little data on the quality of online decision aids for common musculoskeletal conditions such as knee or low back pain. This study aimed to identify all publicly available online decision aids for knee pain and low back pain and evaluate them against the International Patient Decision Aids Standards Inventory (IPDASi).

Methods: Systematic review of public websites in April-May 2018 using an environmental scan methodology. Two reviewers independently screened websites for inclusion and assessed the quality of included online decision aids using IPDASi Version 4. Included online decision aids were free, provided information about knee or low back pain and written in English. Online decision aids that required payment, targeted health professionals, addressed rheumatoid arthritis, or addressed a screening decision, were excluded.

Results: Twenty-five online decision aids were identified: 15 knee pain and 10 low back pain. Only three online decision aids (12%) provided a “wait and see” option. Nineteen (75%) met IPDASi criteria to be considered a decision aid and three (12%) met IPDASi criteria to state that the online decision aid was unbiased.

Conclusions: Few good quality online decision aids are available for people with knee pain or low back pain. Most online decision aids failed to explicitly provide a “wait and see” option suggesting a bias towards intervention. These online decision aids would benefit from explicitly highlighting a “wait and see” option to support informed choice.

025 - Development of a Theory-Based Intervention To Prepare and Support Adolescents With Long-Term Conditions To Participate In Shared Decision Making about Their Healthcare

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Background

Many adolescents with long-term conditions (LTCs) feel that their involvement in healthcare decision-making is neither important nor supported by clinicians. Shared-decision making (SDM) in adolescent care is actively supported by healthcare policy and patient organisations. However, SDM does not occur consistently in clinical encounters. An intervention that prepares and supports adolescents' participation in SDM could potentially alter their behaviour, and improve involvement. Furthermore, patients who are aware of SDM and knowledgeable about its benefits may prompt physicians to adopt SDM behaviours.

The Intervention Mapping Approach (IMA) allows for intervention development to be guided by the problem. Appropriate theory is then selected based on the behaviours required to change to meet the intervention outcome. Our objective is to develop an intervention to prepare and support adolescents with LTC to participate in SDM using the IMA.

Methods

IMA was used in combination with the COM-B model and Theory of Domains Framework (TDF) to guide development. Decision making and involvement needs of adolescents with LTCs were identified via thematic analysis of qualitative interviews. Themes were mapped onto the COM-B Model and TDF. The coinciding TDF components were used as determinants in matrices of change in the IMA, and change objectives were established. Intervention components were developed to address the change objectives.

Results

Intervention components were compiled to create a 12-page booklet titled "It's my body, I should have a say". Different sections of the booklet address the common needs identified by adolescents including: the benefits of SDM; how to be involved in decisions; how to evaluate options in line with personal values and preferences; responses to common questions and concerns (for example: "What if I make the wrong decision?"); quotes and stories from adolescents with LTCs; and a section for parents.

Conclusion

A data-driven, theory-based intervention was developed in the form of a booklet. This booklet will be user tested for acceptability, and ideas for improvement. Focus groups of adolescents with LTCs, and interviews with clinicians will be take place using the 'Think-aloud' method and follow-up questions relating to the relevant TDF components. Amendments will be made in line with user feedback.

030 - Singapore abstract 2 - Developing a Novel PDA on Gout Management in Primary Care: Feedbacks from Patients and Providers

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Introduction

Management of gout is often suboptimal. In a local study, the serum uric acid (SUA) was above the recommended level in majority of patients with gout, of which only 25% were treated to target SUA level. Lack of awareness of patients on their therapeutic options and treatment goals and that of healthcare providers on the best clinical practices for gout are missed opportunities to allow both stakeholders to deliberate and decide on mutually agreed treatment plan. Shared-decision making (SDM) is a process to inform the patients on the available treatment options in relation to their values and preferences and to allow the providers to address their concerns during their consultations. A patient decision aid (PDA) to describe the gout treatment options, address common concerns and seek to identify values and preferences of patients will facilitate the SDM but such a PDA is not available locally. We postulate that a PDA on gout management will enable patients to make decision on their treatment options based on best clinical practices and facilitate healthcare providers to address the patients' concerns and understand their values and preferences. Gathering input from the providers and patients will be essential steps in the design and development of a novel PDA on gout management.

Aim

This qualitative research study aims to explore the understanding of available treatment options and goals; values, preferences, concerns; concept of SDM of both the patients and healthcare providers on gout and its management. Their views will also be sought and collated pertaining to a newly developed PDA prototype on gout management.

Method

The investigators will interview patients with known gout (based on their electronic health records) who are managed in a public primary care clinic (polyclinic) in Singapore and local healthcare providers who manage such patients. The interviews will be audio-recorded, transcribed and analyzed with the aid of NVivo software to identify emergent themes. Such information will allow the investigators to enhance, refine the design and content for a novel PDA on gout and its management to be implemented in primary care practices.

The results will be reported when interviews are completed.

031 - Development of PDA for SDM on Colorectal Cancer Screening in primary care in Singapore

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Introduction:

Colorectal cancer (CRC) is the most common cancer diagnosed in Singapore. The progression from adenoma to carcinoma takes approximately ten years, making it ideal for screening. Studies have shown a reduction in CRC mortality with case detection from CRC screening. This is due to early intervention to remove pre malignant adenomas by colonoscopy and treatment of early stage CRC. Despite establishment of CRC screening guidelines in 2003 in Singapore, the CRC screening rate for the local population remains low at 20-30%. Common barriers identified include paucity of symptoms, lack of knowledge, having no family history of CRC as well as social reasons such as inconvenience, a lack of time, and a lack of reminders and physician recommendation. Patient decision aids (PDAs) are tools that support decision making, taking into account an individual's values and preferences. Randomised controlled studies have shown that PDAs used for CRC screening have increased patient's knowledge, intent and decision for screening. We have adapted an American PDA for CRC screening to be used in the multi-ethnic Asian population in Singapore. We hypothesize that there will be variable opinions on the PDA for CRC screening on the PDA in view of the social and cultural differences between the two target populations.

Aim:

The study aims to explore the perceptions of healthy individuals on a PDA prototype for CRC screening and to gather their views on its implementation in primary care in Singapore

Method:

This is a qualitative study involving in depth interviews and focus group discussions of multi-ethnic Asian adults, aged 50 years old and above of both gender at a public primary care clinic (polyclinic) in eastern Singapore. The PDA prototype has been developed based on recommendations from the Ottawa Hospital Research Institute guidelines. The feedbacks will be used to refine the PDA before it is finalised and printed for preliminary implementation in primary care practices.

The results will be reported upon completion of the interviews.

033 - La création d'un outil d'aide à la décision chez les couples porteurs de l'Ataxie spastique autosomique de Charlevoix-Saguenay

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Au Saguenay-Lac-Saint-Jean (SLSJ), une personne sur 22 est porteuse de l'allèle récessif du gène de l'Ataxie spastique autosomique de Charlevoix Saguenay (ARSACS). La prévalence de cette maladie orpheline est estimée à une naissance sur 1 932. À ce jour, à l'aide du programme de dépistage disponible au SLSJ depuis 2010, 22 couples ont été trouvés porteurs. À chaque grossesse, il existe un risque de 25 % que leur enfant soit atteint de la maladie. Lorsque ces porteurs sont confrontés à la réalité de cette maladie, ils se trouvent confrontés à une prise de décision difficile quant à l'avenir d'un enfant à naître. Lorsque cette situation survient, il est primordial de soutenir les futurs parents à prendre une décision. L'utilisation d'un l'outil d'aide à la décision (OAD) est une avenue prometteuse afin de soutenir la prise de décision partagée. Présentement, aucun outil n'est disponible pour soutenir la prise de décision chez les couples porteurs de l'ARSACS. Cette absence amène une inadéquation en matière de soutien à la prise de décision. Les objectifs sont de créer un OAD permettant de soutenir la prise de décision des couples porteurs à la suite de l'annonce d'un dépistage de l'ARSACS et, de décrire l'acceptabilité de ce dernier.

La présente étude est composée de deux phases (le prototype et l'*Alpha testing*). 1) Le prototype consiste à la création d'un OAD basé sur les directives du modèle d'aide à la décision d'Ottawa, les critères de l'*International Patient Decision Aid Standards* et les résultats d'une revue systématique présentant les options possibles lorsqu'un choix doit être fait. 2) l'*Alpha testing* consiste à soumettre l'OAD à un prétest, sous forme d'entrevues cognitives, auprès de personnes porteuses et des professionnels de la santé. La rétroaction reçue permettra de valider le processus de lecture, la compréhension du contenu ainsi que la perception du format. Ainsi il sera possible proposer une version améliorée de l'OAD.

Actuellement, aucun résultat n'est disponible, la problématique ainsi que la méthodologie peuvent être présentées.

Au terme de ce projet, une stratégie d'implantation pourra être définie afin d'être en mesure d'appliquer l'OAD pour individus porteurs dans un contexte clinique.

036 - Patients Desire for Prognosis in Shared Decision Making for Advanced Chronic Kidney Disease: A Qualitative Study

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Background: Prognostic information is key to shared decision making. Efforts are underway to enhance and implement prognostic tools for prediction of CKD progression and mortality. Whether patients are receptive and value such individualized risk predictions is unclear.

Methods: Semi-structured telephone or in-person interviews were conducted following routine visits to a multidisciplinary CKD clinic. Each patient was asked about his or her perspectives and experiences related to sharing dialysis risk prediction and prognosis with patients. Interviews were audiotaped, transcribed verbatim, and analyzed. Our team engaged in line-by-line, open, axial, and selective coding followed by content analysis.

Results: We enrolled 19 patients stage 3b-5, age 67-89 (avg. 78.57), 74% men. Often patients dreaded the possibility of starting dialysis, considering it a “last resort.” Most patients understood that dialysis would impose significant limitations on their freedom. Almost all patients reported that they wanted to receive (or would not object to) a prediction of their risk of progressing to dialysis, even if it would be “kinda scary.” Patients reported this could help them “plan for the future” and motivate them to adhere to preventive measures, but noted that the prediction might be upsetting to some. There was less agreement about the value of receiving a life expectancy prediction. Patients suggested that it should be offered only when a patient requests it or agrees to it. A life expectancy prediction would help patients “make an informed decision” about how to treat their CKD, and help them make preparations for the end of life if needed. We identified that several patients conflated the risk of progression to dialysis with the risk of death, equating refusing dialysis with rapid death.

Conclusions: This prospective patient-centered qualitative study confirms previous survey results suggesting that CKD patients are interested in prognostic information. Furthermore our findings add context and depth to the value of risk prediction in the clinical encounter and suggest ways in which to address individualized prognosis with patients. This can help further the development of intuitive shared decision making tools to relay this information to the patients who want it.

037 - Implementation of Patient-Centered Shared Decision Making in Advanced Heart Failure: A Multi-Site Study

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Background: Past research indicates a lack of uptake of tools developed to increase shared decision-making (SDM) between patients and providers. This project aims to implement a validated and patient-centered decision aid (DA) as the standard of care for patients considering a left ventricular assist device (LVAD) for heart failure at 10 high volume clinical sites in the U.S. as well as provide training and support in SDM.

Methods: 10 clinical sites were identified based on interest and LVAD volume. Each site received a tailored implementation plan and training webinar. Coordinators complete a 10-item Fidelity Checklist (score 0-10) for each patient encounter with the DA which identifies aspects of SDM that are implemented. DA “reach” is calculated by dividing the number of checklists received by the total number of LVAD education sessions. Sites receive ongoing monitoring and support from the coordinating center as well as monthly interviews about barriers and motivators to use of the DA.

Results: Nine clinical sites started implementation of the DA. Across sites, 84 patients received a DA since September 2018 with an average Fidelity Checklist score of 9.4 (range 5-10). DA reach ranges from 12.1%-88.9% of patients across sites. LVAD coordinators report that they are motivated to use the DA because it provides access to clear, unbiased information and increases patient and caregiver engagement. Reported barriers include lack of time for SDM, difficulty integrating the DA with required institutional materials, and difficulty engaging in SDM with patients who are sick or overwhelmed.

Conclusion: This project is obtaining evidence of how clinical staff utilize and sustain a validated tool to increase patient-oriented SDM for LVAD treatment. Early results indicate that it is feasible to implement the DA with high fidelity in busy clinical settings. Increasing the reach of decision support tools requires a tailored approach that addresses individual sites’ differences in requirements for education, clinical flow, patient population, as well as staff capacities and workload. During this two-year project, sites will continue to receive training and support in order to increase SDM and their ability to use the DA long-term.

038 - Shared Decision Making: The Language of What Isn't Shared

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Background

Statements of the underlying philosophy of shared decision making focus on what is shared. However, what is not shared, and not mentioned, is important to decision making and the interaction of patient and physician.

Healthcare systems are often governed by actors who intend to bring patient and clinician into alignment, attracted by the rhetoric of SDM. In certain areas there is a pernicious assumption that an act of empathetic bridging is enough to bring patient and clinician into alignment.

Methods

Empathy in itself does not guarantee an inclusive space, due to the power-relations of the epistemic gap between practitioners and patients. If empathy is seen as foundational for SDM, then SDM must provide answers to the problem of alterity. One particularly salient form of alterity is language, crucial in SDM by facilitating the kind of joint intentionality that enables the decision-making process. Where there exists a language barrier, empathy can become particularly alluring, perceived as a quick fix that supposedly bypasses communicative challenges.

This assumption can overestimate the capacity of the practitioner to successfully put themselves in the patient's shoes. For another, the allure of empathy as a fix for language barrier can further exacerbate an experience of social and political marginalisation among linguistic minorities.

Results

Addressing the challenge of language barriers requires thinking about the system as a whole, not merely relying on individual clinicians to exercise their linguistic faculties if and as they see fit.

The system cannot realistically be expected to provide comprehensive care for each person in their own preferred language. At the same time, the growing recognition of the role that language barriers play in health disparities emphasises the urgency of increasing the accessibility of health services to linguistic minorities. A more language-concordant care implies a systemic-minded set of measures designed to increase the linguistic independence of linguistic minority patients..

Conclusions

We propose a set of institutional approaches, not merely programmatic fixes, to promote linguistic independence. We ground these approaches in the goal of normalizing linguistic alterity, identifying best practices, troubling overt and covert linguistic norms, and areas of uncertainty (including communicative anxieties).

044 - SHARED DECISION MAKING IN CARE COORDINATION IN MENTAL HEALTH

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Background: The coordination of mental health services to meet an individual's needs across service providers and sites of care is an essential feature of health care quality. Shared decision-making can support the involvement of the individual and family members in decision-making regarding medications and in psychosocial and rehabilitation related decisions, such as work, housing, and psychotherapy. It can be a tool to enhance the knowledge of those with severe mental illness and their caregivers regarding the admission and discharge transition and may ease the individual's concerns before discharge about the unknown factors waiting for them in the community.

Study aim: The presentation takes a patient-centred perspective to explore how providers in a community mental health center and their collaborative mental health services in the municipal setting involve individuals with severe mental illness in care coordination. It also aims to assess opportunities and barriers to shared decision-making in admission and discharge transitions.

Methods: 12 individual interviews with five administrative leaders and seven clinicians (nurse, social workers and social educators). To include multiple perspectives we conducted six interviews in one community mental health center and six interviews with healthcare providers in three of the center's collaborating municipalities.

Results: There are opportunities for individuals with severe mental illness to be involved in decision-making about psychosocial and rehabilitation related issues. Collaborative meetings are taking place across the settings during the inpatient stay and in discharge situations when the individual is transferring home with follow-up from municipal mental health services. Challenges to shared decision-making occur in an acute admission to inpatient care when healthcare providers make the decisions about medications and treatment. Other challenges occur when the individual refuses to participate in collaborative meetings with providers or in discharge situations with insufficient preparation of both the individual and receiving providers' in the municipal mental health services for the discharge.

Conclusion: As coordination of mental health services is essential for the individual with severe mental illness, it is important that health providers address the challenges to shared decision-making to facilitate involvement of the individual.

046 - Helping women to make informed decisions about breast cancer screening: the development of a decision aids in the Chilean primary health care

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Breast cancer (BC) is one of the most common cancers in Chilean women. Governmental efforts are focusing on early detection, offering universal access to BC screening through mammography to women at risk age. Although access to mammography is free of charge, up to 45% of risk women do not undertake it. The main reasons are lack of knowledge and anxiety when facing the decision. Aim: To develop and pilot test a decision aids (DA) for BC screening for the Chilean women. Methods: Following the Medical Research Council guidelines for the development and implementation of complex intervention, the research team conducted: 1) linguistic and cultural adaptation of the German DA for mammography; 2) focus groups with experts to further develop the DA; 3) pilot the DA with 40 women in two primary care centres in Santiago. The primary outcome for the pilot phase was informed decision (using a validated questionnaire). Results: the translation and cultural adaptation were conducted by two independent researchers. Two focus groups were conducted with the expert group (compounded by 10 professional -clinicians, researchers, and policymakers), six women (users of primary care with and without the experience of mammography) and one professional designer. The main result of this phase was to set agreement on the patient journey when undertaking a mammography and the lack of consensus on the Ministerial information about the exam. The group iterated three versions of the DA and agreed on the content (simple, short and informative) and the designing (by using pictograms to communicate risk). This is an on-going project and the results of the pilot phase will be updated by the time of the conference. Conclusion: This study shows the development of the first decision aids for the Chilean population. During the process, key elements have been identified for the implementation process of the DA, particularly the need to reach agreement on the information given by clinicians and ministerial guidelines (e.g. periodicity of the exam, evidence to support advantages and disadvantages of the exam). This is particularly relevant for the development of the DA and its potential use across the country.

048 - Technology assisted Prenatal screening decisions (TOP-TEC): Study protocol of the evaluation of a digital decision aid

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Background: During their pregnancy, pregnant women have to make a decision about Down syndrome prenatal screening tests. The decision about prenatal screening is highly complex because it sometimes opens on other difficult decisions. Patient decision aids (PtDA) are shared decision making (SDM) tools that support decision making by providing factual information about health status, treatment options, associated benefits, disadvantages, probabilities, and scientific uncertainties. Moreover, mobile health tools (mHealth), such as tablets or smartphones, can have a favorable impact on SDM and on patient satisfaction with patient-provider interactions, as they include features (e.g. accessibility, easy-to-follow procedures, automated integration of the newest medical evidence). **Objective:** The aim of this study is to assess the usability and the usefulness of the newly developed digital decision aid amongst pregnant women and their partners. **Method:** We will conduct a cross sectional observational study using mixed methods analyses to pilot test the newly developed digital decision aid. We plan to recruit a purposive sample of 105 stakeholders: 45 dyads of pregnant women and their partner, 45 health professionals, and 15 policy/decision makers/managers from three main healthcare sectors (midwife-led birth centers, family medicine practice clinics and obstetrician led hospital based clinics) in Quebec City. To be eligible, pregnant women had must be aged at least 18 years old, have at least 16 weeks pregnant with a low risk pregnancy and be able to give informed consent. Partners should also give their consent to participate to the study. Clinicians should be involved in prenatal care and policy/decision makers/managers should be involved in prenatal care management and/or decision. Quantitative data will be collected using validated scales. Then, we will conduct interviews with stakeholders to complete quantitative data collected. **Result:** Expected outcomes are the usability of the digital decision aid using the System Usability Scale (SUS), the usefulness using the Preparation for Decision Making Scale and the assessment of the quality of the mobile health apps using the Mobile App Rating Scale (MARS). **Conclusion:** This technology has the potential of increasing patient-clinician relationship, and prevention of decisional conflict and regrets. Ultimately it could have a great impact on health outcomes.

051 - Using Evidence-based Medicine to Develop a Shared Decision-making Tool for Patients with Breast Cancer

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Breast cancer has been the leading type of cancer in women for a long period, and treatments are carried out on the basis of the physician's recommendation without considering the patient's self-expectations. In recent years, inaccurate medical information and flooding advertisements have resulted in frequent medical disputes. Our team used the shared decision-making tool and interviewed 5 patients who had undergone treatment and 5 medical staff who performed a needs assessment. We used evidence-based medicine techniques to examine 3 articles of National Comprehensive Cancer Network, 102 articles of Pubmed database, 49 articles of Cochrane database. We integrated medical experience and data analysis, and designed a graphical treatment manual that allows shared decision making between physicians and patients. We enrolled 8 subjects from August 2017 to September 2018, of whom 75% were 40-59 years old and 63% had an educational level of senior high school or higher. After using the shared decision-making tool, 3 patients opted for preoperative neoadjuvant treatment followed by surgery, while the remaining patients opted for surgery before radiotherapy or chemotherapy. The results showed that five of the patients had significantly reduced anxiety level, felt respect, and were more comfortable receiving treatment.

052 - Interventions supporting the decision-making needs of parents in pediatric palliative care: A scoping review

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Background/Aim:

The prevalence of children with life-limiting conditions has been gradually increasing. Parents of children with life-limiting conditions often experience curative and palliative therapies intertwine. The health management decisions that families face are value-sensitive and require supportive decision-making interventions..

The aim of this scoping review is to examine the characteristics and effectiveness of interventions used to support the decision-making needs of parents in pediatric palliative care.

Methods:

A scoping review is being conducted to identify published literature on interventions used to support parents' decision-making needs in pediatric palliative care.

A search strategy was designed with a reference librarian for the following electronic databases: Medline (Ovid), CINAHL, PsycINFO, Scopus, and the Joanna Briggs Institute EBP. A hand search of the reference lists of relevant articles was also conducted.

We included peer reviewed publications of studies focusing on interventions targeting parents making health and/or social decisions for their child with a life-limiting condition under the age of 19 with all patient and system level outcomes included.

Covidence was used to facilitate the screening process, which was conducted by two reviewers independently in two steps: title and abstract followed by full-text review.

A data extraction form included the following items: a) characteristic of parent participants, b) study methods, c) interventions and control interventions d) outcomes, e) results, f) limitations and conclusions.

Results:

While analysis is ongoing, 526 citations were identified. Systematic screening has resulted in the inclusion of 3 citations – a descriptive quantitative study, a descriptive phenomenological qualitative study, and a mixed methods design.

063 - Score your POR: Development of the SCPOR Patient-Oriented Research Evaluation Tool

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Background: In recent years there has been a significant demand to increase the quantity and quality of patient-oriented research (POR) at the local, provincial, national and international level. This has led to substantial increases in the funding opportunities for POR and a subsequent increase in the number of grants submitted to funding competitions.

The Saskatchewan Centre for Patient-Oriented Research (SCPOR) regularly engages patients and family advisors (PFAs) to help assess the degree to which research proposals are patient-oriented. However, PFAs found it difficult to evaluate the degree to which projects were patient-oriented. In response, the PFAs and staff at SCPOR have worked to develop an evaluation tool.

Methods: The team has worked to create, implement and evaluate a tool to measure the degree to which a project meets the definition of POR set out by the Canadian Institutes of Health Research (CIHR) Strategy for Patient-Oriented Research (SPOR).

Development: At SCPOR, PFAs sit on various review committees. In collaboration with these PFAs, SCPOR staff developed the Patient-Oriented Research Evaluation Tool using both the SPOR and International Association of Public Participation (IAP2) frameworks as guides. The tool is used to score research based on five categories: patients are partners, patient identified priorities, patient reported outcomes, multidisciplinary research team, and integration of knowledge into practice.

Evaluation: The SCPOR research team is collecting data on the tool's reliability and validity with a variety of stakeholder groups, including patient and family advisors as well as various committees and funding organizations. Analysis will include a measure of inter-rater reliability utilizing Cronbach's alpha. Testing and analysis is ongoing. We will continue to refine the tool as additional data is collected.

Discussion and Conclusion: Once refined, the tool can be used in grant reviews, patient review panels, as a resource for research teams and as a way to measure improvement in grant application quality over time. The tool will be shared with the broader stakeholder group, including SPOR Networks and other SUPPORT Units across Canada.

065 - Unidentified opportunities for engagement: Perspectives of US families of children with special health care needs regarding shared decision making

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Background and Aims: Shared decision making (SDM) is important for developing high quality care plans, particularly for children with special health care needs (CSHCN), but disadvantaged families may not be aware of the opportunity for SDM. Therefore, we describe characteristics of US families with CSHCN who report the need to make health care decisions, and among those who do, whether they report SDM. We further explore the role of a patient-centered medical home (PCMH).

Methods: Cross-sectional analysis of US representative 2016 National Survey of Children's Health, focusing on respondents whose child had >1 special need (19.4%, N=11,392, weighted 14,196,961). Outcomes were: (a) reporting needing to make a medical decision in the past year, and among only those who did, (b) whether they usually or always felt they were partners in making that decision. Multivariable logistic regression models with risk regression adjustment tested associations between PCMH components and decision-making experience, accounting for child age, sex, ethnicity, underlying chronic condition(s), poverty status, caregiver education, and insurance type.

Results: Among CSHCN, 46% reported making a decision in the past year whether to start, stop, or continue a treatment, of which 83% reporting the decision as SDM. 43% of CSHCN were seen in PCMH vs. 50% without SHCN. In multivariable analysis, PCMH was not associated with increased recognition of need for decision-making (ARR 0.98, 95%CI: 0.80 – 1.22) but was associated with 26% increased likelihood of reporting care consistent with SDM (ARR 1.26, 95%CI: 1.06-1.50). Families of CSHCN with mental health conditions (ARR 1.28, 95%CI: 1.04-1.60) and/or functional limitations (ARR 1.28, 95% CI: 1.01-1.63) were more likely to recognize decision opportunities, while low-income (ARR 0.79, 95%CI: 0.61-1.03) CSHCN were less likely to report such opportunities.

Conclusions: In the USA, despite the need for choices regarding starting, stopping, or continuing interventions, families of CSHCN do not always recognize opportunities for decision making regarding their child's care. In particular, low-income CSHCN may benefit from interventions to help them to recognize such decision opportunities. PCMH participation is associated with the reported use of SDM, but not increase the proportion who recognize the need for such decisions.

067 - Évaluation des besoins décisionnels des couples porteurs de maladies héréditaires rares

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En janvier 2018, une offre de tests de porteurs pour quatre maladies récessives a été déployée à l'ensemble du Québec. Ces quatre maladies, relativement plus prévalentes au Saguenay-Lac-Saint-Jean sont : l'acidose lactique congénitale, la tyrosinémie héréditaire de type 1, la neuropathie sensitivomotrice avec ou sans agénésie du corps calleux et l'ataxie récessive spastique de Charlevoix-Saguenay. À ce jour, 2600 personnes ont reçu un statut de porteur pour l'une de ces quatre maladies, dont 76 couples. Les couples porteurs doivent faire face à un processus décisionnel important concernant leur planification familiale qui peut causer une très grande source d'incertitude et d'inconfort. Les cliniciens qui les accompagnent doivent être en mesure d'identifier leurs inquiétudes et de les guider dans leur prise de décision. Pour ce faire, ils doivent pouvoir fournir aux couples toutes les informations nécessaires afin qu'ils puissent faire un choix éclairé, qui tient compte à la fois des évidences scientifiques, de l'ensemble des options, de leurs valeurs et de leurs préférences. Des outils sont utilisés par les cliniciens pour informer les couples en vue d'une prise de décision. Actuellement, il est inconnu si ces outils répondent aux critères de qualité en matière d'outils d'aide à la décision (OAD). Afin de permettre l'élaboration d'OAD qui diminuent le conflit décisionnel et améliorent la qualité de la décision qui sera prise, il est essentiel de déterminer quels sont tous les éléments pouvant influencer le processus décisionnel des couples porteurs. Le présent projet vise à décrire les besoins décisionnels des couples ainsi que les barrières, les facilitateurs, les sources d'informations et le réseau de soutien nécessaires à leur prise de décision. Une étude qualitative descriptive sera réalisée à l'aide d'entrevues semi-dirigées qui seront effectuées auprès de couples porteurs volontaires et de cliniciens qui soutiennent ces couples dans leur prise de décision. Les résultats issus de ce projet permettront, à terme, de développer des OAD qui pourront être utilisés par les cliniciens afin de soutenir les couples dans leurs choix.

070 - Factors affecting the understanding of pictographs for risk information among Japanese adults

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Background and aims

Recently, pictographs have gained attention as a tool for conveying quantitative information. As compared with simple numerical displays and other types of visual displays, they have several advantages; for example, they 1) are the most salient frequency representations, 2) have higher iconicity, and 3) overcome the problem of base-rate neglect. However, evidence regarding how pictographs influence understanding of numerical information and factors affecting the understanding of pictographs is limited. Therefore, aim of this study was to identify how individual characteristics affect the comprehension of pictographs.

Methods

A total of 1062 Japanese adults were recruited through an internet research service company. Participants were randomized to receive numerical information about the risks and benefits of a hypothetical medical treatment in one of the three formats: text, bar graphs, and pictographs. The main outcome variables were adequate verbatim understanding and adequate gist understanding. These understandings were based on the dual-process theory that humans have two types of decision processes: one for automatic and easy decisions (Type 1), and another for more contemplative decisions (Type 2). Moreover, a previous study stated that having adequate understanding of both verbatim and gist signifies medically superior decision making. The primary independent variables were types of formats, gender, age, highest level of education, and numeracy.

Results

Viewing a pictograph was associated with adequate gist understanding ($p < .05$), as compared to viewing text, especially for higher numeracy individuals ($p < .05$). Pictographs were not significantly different from text and bar in establishing verbatim understanding. The multiple logistic regression analysis of each format, regarding verbatim understanding of pictographs, was associated with numeracy ($p < .05$), but not with gender, age, and education level. Gist understanding for pictographs was associated with numeracy ($p < .001$), but not with gender, age, and education level.

Conclusion

Pictographs enhanced understanding of numerical information regardless of individual characteristics such as gender, age, and education level. Numeracy affected understanding of pictograph, and therefore was effective for people with higher numeracy. However, there was no negative impact on lower numeracy people.

072 - To explore the effect of shared decision making on women's willing of rooming-in during late pregnancy

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Background:

The World Health Organization has developed the ten steps to successful Breastfeeding. Step 7 is practice rooming-in allow mothers and infants to remain together 24 hours a day.

The aim of rooming-in is to facilitate breastfed through promotion of mother-infant bonding. Although evident proved rooming-in increased breastfeeding successful rate, many mother refused rooming-in Liouying area in Taiwan. One of the major factor is lack of complete information. We hypothesized that shared decision making (SDM) may increase rate of rooming-in.

Purpose: The purpose of this study is to explore the influence of SDM on willing of rooming-in of mother during puerperium.

Methods: It was a cross-sectional study. Designing image-based education information decision aids and QR Code image links with the concept of SDM. Pregnant women less than 38 gestation weeks visited our prenatal care clinic were recruited. Questionnaire were used to collect data through November 2017 to March 2018. Data were analyzed with SPSS 18.0.

Results: Total 107 pregnant women were recruited. 51% of primipara, 49% of multipara, college degree (74%), and 61% of spouses participate in shared decision making. Data shown 44.9% pregnant women decided rooming-in, 24.3% refused and 30.8% did not make decision during pregnancy. Our study result shown SDM increased choice of rooming-in during increased significantly ($P < 0.01$).

Conclusion: SDM is effective for promotion of choice of rooming-in during late pregnancy.

078 - Using multiple methods promote shared decision making

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The purpose of this study is to implement shared decision making(SDM) into a medical center in northern Taiwan in order to improve communications among medical staffs by developing patients decision aid(PDA) which suit for the hospital. The communications among medical staffs and patients is the key factor which influence to patient safety.

In order to improve patient safety, the strategy to implement SDM includes leadership announcement, developing PDA, held employee training, promoting activity and clinical implementation. We held online course which allows employee to understand the purpose and implementation process of SDM implementation. There were 450 employees to participate the course, and their cognitive score increased from 84.5 to 94.6. It is easy to use for medical staffs and patients, the PDAs placed on the hospital official website and HIS system.

This medical center in northern Taiwan has developed 6 subjects including insulin usage, cessation medication choices, colon cleansing choices, prostate cancer treatment, cataract treatment, surgical for breast cancer choices. By evaluate acceptance of SDM to patient and medical staffs, we analysis the understanding of the actual acceptance for medical staffs to patients decision aid in order to know the direction in which can be improved. In conclusion, the acceptance for medical staffs to patients decision aids is 81.2%, the highest category is "to improve the communication among me and patients"; the acceptance for patients to patients decision aids is 79.6%, the highest category is "guide me to identify the questions I would like to ask for medical staffs".

The Implementation for SDM are affective to communications among patients and medical staffs by making patients to ask key questions to doctors, and reduce the burden of medical staffs for preparing informations. In the future, medical center will placed the PDAs on outpatient orders system for clinical use, and to be able to count the actual use of the situation, by benchmarking other outstanding hospitals.

081 - SDM module promoted the home-Care participation of foreign caregiver in agricultural and fishery village of south Taiwan

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Background statement : Our hospital located in agricultural and fishery village of south Taiwan. As many aging countries, there not enough domestic caregivers to serve the growing population of disabled people in the agricultural and fishing villages in Taiwan. By this reason , the unauthorized of migrant nursing workers, household has increased .However ,they are having a difficult time understanding doctor discourse when they took the patient to the hospital and caused medical malpractice sometime such as took wrong medication. These foreign caregiver will suffered high pressured and decreased the home care participation.

Aims : We used the SDM module as a tool to promote the foreign caregiver home-Care participation.

Method

We focused on patient who was diagnosed with Atrial fibrillation(Af) because it is the common disease in old age .After SDM project approved by our hospital special committee ,we organized the SDM team, include our hospital CEO, the direct of cardiovascular department , nurse practitioner and nurses . We used the public edit PAD, translated the Chinese words to Vietnam and Indonesia language because these two groups have high population percentage in our country .If SDM team member found the Af patient visited to our doctor for help, we requested the patient to join the SDM project .

When we got the patient permission, we began the SDM process: choice talking , option talking and decision talking; at the same time when we knew the caregiver is foreign family or household , we used the translated edit PDA. After patient finished SDM process, we measure the effectiveness by public edit satisfaction questionnaire.

Results

The SDM project began working in 2017 and received 44 copies satisfaction questionnaire which the foreign caregiver answer, and we got the high satisfaction score (98% very satisfaction rate and 94% satisfaction rate) and the feedback of open-end survey date were positive.

Conclusion

SDM is an excellent module to improve the communication between patient –patient caregiver-and healthcare giver, even though the caregiver is foreign caregivers.

084 - Needs assessment for development of the decision aid for considering participation in clinical trials, using patient blog posts in Japan

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o Background and aims

In development of decision aid, it is necessary to clarify the information, values and problems examined by patients during decision making. In recent years, there are many patients who use blogs, and their real feelings may be written in a timely manner. The purpose of this study is to report the content analysis of the patient's experiential blog as a need assessment for development of the decision aid for clinical trials in Japan.

o A brief description of methods

At the portal site of a patient blog in Japan, we conducted a search using "participation in a clinical trial" as a keyword. The main criterion of the analysis subject are that the blogs are written by patients themselves in Japanese and they are related to decision making regarding participation in clinical trials.

o A summary of results to support conclusions

As a result of the search, 2,113 articles were hit and 55 subjects were analyzed. When patients made decisions, many of them were comparing "expectation for the effect of investigational drug" with "uncertainty of the effect of the investigational drug", "anxiety of side effects", "possibility of placebo", "contribution to medical care".

In addition, posts on "reduction of burden of medical costs" and "contribution to medical care" were seen in the same number of cases as "expectations for the effect of investigational drug". On the other hand, there were no posts comparing the numerical information of side effects. There was also "anxiety about uncertainty of effects and side effects", "impatience", "regret", "difficulty in refusing participation", "feeling guilty refusing participation" existed.

o A conclusion.

Japanese patients are anxiety about the effects and side effects uncertainty, sometimes they can't tell the real feelings to their physician and they feel regret or guilt in the decision results. Therefore, the decision aid for clinical trial should include contents that promote comparison of numerical information and communication with medical personnel, and clarify their own values.

086 - Communicating numeric uncertainty in a decision aid.

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Background and aim: Decision aids should provide evidence based information on the advantages and disadvantages of different treatment options. In oncological treatment options, the advantages of choosing a certain treatment mostly involves advantages in recurrence rates and/or survival. There is a lot of uncertainty in exact recurrence rates with or without treatment, and due to lack of evidence there is no consensus on how to communicate these uncertainties in a patient decision aid.

Therefore, the aim of this study was to assess opinions and attitudes of patients and professionals on how to communicate uncertainties in recurrence rates, with as ultimate aim to incorporate this knowledge in a patient decision aid for breast cancer patients to support their decision on their radiation treatment.

Methods: Interviews were held with 15 patients and 15 health care professionals before the start of the decision aid development. They were asked on what and how recurrence and survival benefit should be communicated. In the development phase of the decision aid, thinking out loud sessions with patients and group meetings were organized with patients and health care professionals. They were asked their opinion on different ways of communicating risks and uncertainties until consensus was reached.

Results: From the development phase a pictorial chart was chosen to communicate risks. Health care professionals worried mostly about how to communicate epistemic uncertainty (reliability of the estimates) whereas patients did not mention epistemic uncertainty at all. After several meetings there was consensus on a pictorial chart with the whole width of uncertainty, in combination with the explanation that a more exact risk for the individual patient would be explained by their own physician. After several options a pictorial chart was chosen consisting of a 100 female icons in a 10 x 10 array. The icons were given different colours to indicate a given risk.

Conclusion: Consensus was reached between patients and health care professionals for a pictorial chart and explanation to communicate risks and uncertainty in a decision aid. The utility of this way of communicating risk uncertainty, understandable for patients is currently being tested in a clinical trial: BRASA study.

094 - La décision médicale partagée : Quelle efficacité sur les résultats de santé ? Une revue systématique de la littérature

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Introduction : Pratiquer la décision médicale partagée (DMP) sous-entend que médecin et patient s'impliquent dans la discussion, partagent des informations, expriment leurs préférences et se mettent d'accord sur la décision finale. Malgré des raisons éthiques et sociologiques évidentes en faveur de la pratique de la DMP, ainsi que la promotion de sa pratique dans de nombreux pays, peu d'informations sont disponibles concernant son efficacité sur les résultats de santé des patients.

Méthode : Nous avons donc réalisé une revue systématique de la littérature sur les effets objectivables de la DMP sur les résultats de santé entre Mai 2015 et Août 2016 en suivant les recommandations PRISMA. Afin de nous assurer que les articles correspondaient bien au modèle de la DMP, nous avons utilisé la définition originale de C. Charles pour sélectionner les articles. Ont été sélectionnées des études interventionnelles et observationnelles, en ambulatoire et hospitalier impliquant tout type de professionnel et de patient et évaluant un lien entre DMP et résultats de santé. Nous avons inclus 26 articles et avons analysé leur qualité avec la grille de Down's and Black.

Résultats : Cette revue systématique suggère que la DMP améliore certains résultats de santé, surtout indirects. Concernant les résultats indirects, la DMP semble améliorer la satisfaction des patients, leur adhésion au traitement, leur qualité de vie, favorise un renforcement de la relation et une diminution des conflits décisionnels et du regret lié à la décision. Concernant les résultats de santé directs, la DMP semble améliorer la détresse psychique et la douleur dans le syndrome fibromyalgique. La pratique de la DMP pourrait réduire également la surutilisation des antibiotiques et ne semble pas allonger le temps de consultation. Aucune augmentation significative des coûts n'a été observée dans une étude.

Conclusion : Ces résultats semblent en faveur d'une pratique de la DMP en consultation médicale de routine. Cependant, l'absence d'outil de mesure standardisé pour l'évaluer rend difficile la recherche sur son efficacité. Des études supplémentaires sur son effet sur la morbidité et une analyse coût-bénéfices sont nécessaires pour poursuivre la réflexion sur le sujet.

095 - Engaging patients with complex care needs who frequently use healthcare services in a case management program: Development of an interprofessional shared decision-making tool

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Background: Patients with complex care needs (PCCN) who frequently use healthcare services often encounter difficulties in care integration. Case management (CM) programs are a promising approach in dealing with complex needs, fostering coordinated care among healthcare providers (HCP) and self-management support. However, opting for a CM program or not remains a difficult decision as perceived by PCCN and HCP.

Objective: To develop an interprofessional shared decision-making (IP-SDM) tool to support patients and their interprofessional team's decision to opt for a CM program or not.

Method: We performed a mixed-method study, combined with a user-centred approach, to identify the decisional needs of patients with complex care needs who frequently use healthcare services, the facilitators and barriers to the future implementation of a decision-making tool, and desirable formats and features of the IP-SDM tool. Based on the Ottawa Decision Support Framework and Interprofessional Shared Decision-Making (IP-SDM) model, we first established a steering committee with PCCN, researchers, HCP and representatives of decision-makers. Second, we conducted individual interviews and focus groups with stakeholders (PCCN, caregivers, case managers, HCP and decision-makers) to identify decisional needs, facilitators and barriers to the IP-SDM tool implementation, and features of the IP-SDM tool to adopt. Third, based on a realist synthesis conducted by Hudon *et al.* (2018), we extracted data related to the effectiveness of CM programs for PCCN. We performed a meta-analysis, to identify harms and benefits of CM programs for PPCN. Finally, with our steering committee, we co-created an IP-SDM tool based on the International Patient Decision Aid Standards criteria. The IP-SDM was reviewed by stakeholders in terms of content and acceptability.

Results: Our mixed-method study combined with a user-centred approach allowed us to create a useful IP-SDM tool. The final version of the IP-SDM tool will be presented during the 10th International Shared Decision Making Conference.

Conclusion: This new IP-SDM tool will help patients in targeting values and preferences related to the healthcare and social services they want. This will improve the IP-SDM process to support PCCN in the decision to engage or not in a CM program.

098 - Exploration de l'effectivité du consentement éclairé aux soins : résultats d'une étude juridique empirique

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L'effectivité du droit s'intéresse au degré de réalisation des normes dans les pratiques. En matière de consentement éclairé aux soins, nous avons voulu déterminer dans quelle mesure l'obligation légale d'information et d'obtention d'un consentement éclairé des médecins est réellement mise en œuvre dans les pratiques cliniques.

Afin d'atteindre cet objectif, nous avons procédé à une étude juridique empirique visant à évaluer la conformité des comportements par rapport à la prescription normative du droit. Nous avons ainsi procédé à une analyse critique combinée des résultats d'une étude de cas que nous avons réalisée auprès de patients et de médecins en contexte de chirurgies de remplacement total de la hanche ou du genou au Québec, et d'une recension de la littérature scientifique occidentale (Canada, États-Unis, Europe de l'Ouest, Australie, Nouvelle-Zélande) portant sur la prise de décision partagée, la communication et les relations patients-médecins. Cette analyse visait à déterminer dans quelle mesure 1) les patients participent à la prise de décision médicale, 2) quelle information leur est divulguée, 3) leur compréhension de cette information et 4) la possibilité qu'ils ont de poser des questions et recevoir des conseils.

Notre analyse révèle plusieurs constats quant à la conformité des comportements à la norme. 1) De façon générale, moins de la moitié des patients considèrent être suffisamment impliqués dans les décisions de soins qui les concernent. Pourtant, le droit prévoit que le patient doit décider des soins qui lui sont administrés. 2) Alors que les médecins décrivent généralement le soin envisagé, les informations concernant les bénéfices, les risques et les alternatives thérapeutiques sont soit incomplètes, soit absentes. 3) La compréhension du patient, bien qu'elle soit un critère légal du consentement éclairé aux soins, est rarement évaluée par le médecin. 4) La majorité des patients hésitent à poser des questions, même en cas d'incompréhension. Les conseils sont généralement donnés sans être expliqués aux patients.

L'effectivité du consentement éclairé aux soins est faible. Bien que la norme soit légalement bien définie et impose théoriquement l'adoption de comportements précis par les médecins, la mise en œuvre de ces comportements dans les pratiques cliniques est fortement lacunaire.

102 - Guiding the development of a risk communication tool through user feedback: A case study of RESPECT

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Background and aims

As people age, the need for health care and support services increase. Sometimes it is difficult to identify those who are most in need of supportive care or they are identified too late; which can lead to poor quality of life, distress for the individual and their caregivers, and sub-optimal health system resource use. RESPECT is a validated tool that provides a personalized, precision risk estimate and reliably identifies future health and health care needs for people in elder-life, living within the community. Based on our previous research, focus group results determined that there is acceptability and a need for a risk prognostication tool for end-of-life within the community. This second phase of evaluation is using agile development to refine this risk communication tool and summary report.

Methods

As part of program evaluation, patients, informal caregivers and healthcare professionals who expressed interest in viewing the tool were invited to use the calculator and provide feedback. Pre- and post-questionnaires, user analytics, as well as informal discussions with a subset of users has contributed to the ongoing improvement of RESPECT.

Results

Using an iterative process, the calculator wording, visualizations, and summary have been changed to reflect user preferences, usability, and clarity. The summary report has been modified from a simple read-out to a more informative presentation of results, context, comparison to others, uncertainty, and next steps.

Conclusion

Through user engagement, we have been able to create an understandable, useful summary report that users are able to incorporate in conversations with loved ones and healthcare professionals. The tool has been refined and will be publicly released in Winter/Spring 2019.

105 - A review of carer-directed interventions, tools and online resources to enhance involvement in medical consultations and decision-making

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Background and aims: Most patients want their family member/s to be involved in medical consultations and decisions, however some family carers report feeling overwhelmed and unsure of their role. We aimed to understand what help and guidance exists for family carers on how to be effectively involved in their loved one's consultations and decision-making, by reviewing the academic evidence-base as well as the web-resources directly available to carers.

Methods: Relevant studies of carer-directed interventions or tools published from 1950-2018 were identified via database searches (Medline, Scopus, CINAHL, PsycINFO). Searches were also performed using lay search strings on Google, to identify websites directed at carers that provided information or advice on being involved in medical consultations, communicating with health professionals, patient advocacy, or treatment decision-making.

Results: Twelve eligible studies were found through academic database search, most of which targeted carers in the cancer setting. Interventions and tools reported were question prompt lists, communication skills workshops and coaching, and checklists and written guides. Positive carer outcomes included increased self-efficacy, greater involvement in consultations and reduced distress. However, only two of the interventions/tools were rigorously tested in RCTs. The Google searches yielded 24 relevant websites, including 9 targeting carers of people with cancer and 2 carers of people with heart disease. Websites provided advice on preparing for medical consultations (e.g. self-educating, writing question lists and negotiating roles) and participating in consultations (e.g. how to communicate assertively with HPs, ensure understanding, and record information).

Conclusion: This review provides insight into the existing carer-directed interventions and tools, and the online resources for carers. Interventions to enhance family involvement in cancer care have been delivered across diverse formats, with some positive behavioural and psychological outcomes reported. Several websites are also available to guide family carers' involvement in consultations, particularly in the cancer setting. Only a few interventions or websites adequately addressed carer involvement in decision-making or how carers can navigate challenging situations (such as advocating for their loved one's needs). Comprehensive evidence-based resources are needed to address the paucity of guidance for carers in these areas.

108 - Community implementation of RESPECT: Using data linkage to evaluate a risk communication tool

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Background and aims

A risk prediction algorithm was developed: Risk Evaluation for Support: Predicting Elder-life in the Community Tool (RESPECT). RESPECT provides personalized, patient-oriented risk estimates to identify future health and health care needs for community-dwelling older people. In partnership with the Windsor-Essex Compassion Care Community, RESPECT is being implemented within their compassionate neighbourhood program. The aims of this study are to further validate the RESPECT algorithm through data linkage and to examine its impact on health care utilization.

Methods

RESPECT is being implemented within the Windsor-Essex Compassion Care Community compassionate neighbourhood program. Participants who screen as high or very high risk on their baseline quality of life survey are invited to use RESPECT. Participants and family members or informal caregivers can use the calculator to identify those at greatest risk of further cognitive or health decline and to plan community support to meet their needs. For those who consent to data linkage, their RESPECT risk estimate will be linked to their administrative health care data housed at ICES (using deterministic and probabilistic data linkage).

Results

Outcome evaluation will focus on the utilization of health care services – including both care that is potentially avoidable (e.g., unnecessary hospital and emergency department admissions) or could be enhanced (e.g., home care). The study is ongoing and results will be updated

Conclusion

The development of an online risk communication tool with the ability to link with health administrative data is an innovative approach to not only providing individuals with information to help plan out their care but also to provide health utilization information to system planners.

109 - Prise de décision partagée pour la clientèle pédiatrique ayant un trouble neurodéveloppemental : Vers un modèle intégré de l'approche famille-partenaire

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Les troubles neurodéveloppementaux (TND) sont de plus en plus abordés comme étant une problématique chronique de santé. Pour conjuguer avec les défis associés à la chronicité, le mouvement actuel usager-partenaire est considéré comme une piste d'action prometteuse et humaniste en santé. Pour les jeunes ayant un TND, la reconnaissance du rôle central des parents amène à suivre ce mouvement en abordant l'approche famille-partenaire (AFP). Cette approche s'inscrit en continuité avec les écrits qui associent la collaboration parent-intervenant à des retombées positives, mais qui relèvent des écueils importants pour une mise en œuvre réelle. L'étude présentée vise à explorer la perspective des parents, des professionnels de la santé et des gestionnaires en regard de l'AFP afin de favoriser l'implication des familles dans le continuum de soins et de services offerts aux enfants présentant un TND. Une recherche exploratoire descriptive, à méthodologie qualitative, a été réalisée auprès de gestionnaires (n=4), d'intervenants (n=7), de représentants d'organismes communautaires (n=3) et de parents d'enfants ayant TND (n=8). Les résultats confirment une volonté commune de tous les groupes d'acteurs clés de tendre vers une approche de partenariat malgré un vécu actuel qui démontre de nombreux défis pour une manifestation réelle dans la pratique. Il en ressort que l'implication des familles dans la prise de décision est influencée par une multitude de facteurs et qu'une diversité de pistes d'intervention peuvent contribuer à améliorer ce partenariat en s'actualisant à différents niveaux : niveau de la pratique, niveau de l'organisation des services et de la gouvernance et niveau de l'élaboration des politiques. En se basant sur les résultats, cette présentation propose un modèle intégrateur qui vise à guider une implantation réelle du partenariat famille-intervenant. Dans le but d'agir sur les symptômes sociaux associés aux TND, ce modèle souligne, entre autres, l'importance d'établir un rapport égalitaire entre la famille et l'intervenant et la nécessité de considérer une responsabilité partagée entre les acteurs œuvrant aux différents niveaux mentionnés précédemment. En considérant le thème de la conférence, ce modèle peut assurément mener à des réflexions supplémentaires sur la responsabilité attribuable aux acteurs agissant au niveau de la recherche.

111 - Shared decision-making in Brazilian cancer guidelines

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Shared decision-making in Brazilian cancer guidelines

Successful experiences of shared decision-making demonstrate the importance of health policy in clinical scenarios. For diseases such as cancer, which is chronic and life threatening, this shared decision becomes especially relevant because there are many options with different outcomes and substantial uncertainty of real benefits. These differences can cause physical and/or psychological damage.

The objective of this study was to identify the shared decision-making in Brazilian cancer guidelines.

Methods: A documentary analysis of the cancer-related guidelines in Brazil was carried out. The examined documents were taken from the website of the National Commission Technology and the National Cancer Institute of Brazil.

Results: The research retrieved 29 guidelines that were read in full (completely analyzed); 10 of them mentioned shared decision approaches in any part of document. the shared decision appears discretely in most of the guidelines, and it was conceptualized into only one document. This approach was common in those who have cancer and were able to go under screening for breast, prostate or cervical cancer. Individual preferences were also recognized in those guidelines that presented more than one treatment option or addressed to people with cancer in the early and asymptomatic stages. If there was need to interrupt the treatment, then the shared decision was also considered. The results show that cancer guidelines in Brazil recognize the importance of communicating the risks of health interventions, but few recognize the need to incorporate individual opinion into the decision-making process. This concern is expressed timidly throughout standardized texts, and the specific risks of the intervention were indicated only through the use of Terms of Responsibility that only serves as a bureaucratic support for professionals and health systems.

Conclusion: Most of the Brazilian cancer guidelines do not consider shared decision-making implementations, what reveals the great challenge of promoting autonomy in an ethical basis, respecting the individual preference.

113 - Pediatric Neurology Needs Assessment

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Background

Families struggle to make health care decisions, and many patients and families look to HCPs to make decisions for them. In many cases of medical decision-making, despite best efforts to reduce bias and to account for patient's values, cultural obligations and stress levels, a hierarchical paradigm, generally, continues to prevail. Making decisions in pediatric settings also has added complexities that cause decisions to be challenging including the inherent dynamic of a gradually changing maturity level of the child patient, and the possibility of multiple caregivers factoring into decision making, each of whom carry their own values and treatment goals. A commitment to the structure of a SDM environment assures that factors that support decision making such as reviewing evidence, considering preferences and goals, including important others in the process and recognizing decisional stress- all help to contribute to a better health care decision.

As part of a newly launched clinical program for pediatric SDM an initial Needs assessment was done to help identify:

114 - A quantitative analysis of the interventions used by the SDM Decision Coach for families and patient's who struggle with health care decisions.

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Background/Aims

Relatively few studies have been done about the impact of interventions to support shared decision making (SDM) specifically with pediatric patients. Many patients/families struggle to make a range of medical treatment decisions and often these decisions are made in a more traditional medical model rather than a SDM environment. At Children's Hospital LHSC, a clinical program involving a decision coach (outside the circle of care) has been designed and implemented.

The program will assess the quantitative analysis of the interventions used by the SDM Decision Coach for families and patient's who struggle with health care decisions. The assessment will focus on measuring decisional satisfaction, decisional conflict, readiness and compliance with treatment before and after the SDM coaching intervention.

Methodology

1. Feasibility will be measured by the number of decision coaching sessions completed compared to referrals.
2. Satisfaction will be measured by a SDM Counseling Satisfaction Scale (Barry 1995).

Decision process:

1. Decisional conflict: measured using the Decisional Conflict Scale.(DeMarco 2004)
2. Knowledge of intervention, benefits and drawbacks - measured by a likert scale response pre/post SDM.
3. Preparation for Decision Making Scale. Assess how well patients/families feel prepared to make a decision following a decision intervention (Graham 1995)

Results: Ongoing study and results will be updated.

Summary

The outcome of this assessment will measure the SDM impact for healthcare delivery and patient centred care; will serve as an indicator of organizational readiness for a SDM environment. The ongoing study will address whether decision coach services outside the circle of care result in known SDM benefits of improved compliance, reduced decisional conflict and increased decision satisfaction when applied to pediatric neurology.

115 - Measuring shared decision making using collaboRATE at a primary care clinic in Chile

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Background and aims

The Los Dominicos Medical Center in Santiago is part of IntegraMédica, the largest ambulatory health network in Chile, owned by Bupa, a global healthcare provider. The center provides insurance-based private patient care, from newborns to older adults. The aim of the project described here was to assess whether **collaboRATE**, a brief patient experience measure of shared decision-making, was feasible for use in a routine clinic setting.

Methods

Tablet computers were programmed with a patient survey collecting the name of the clinician seen and the **collaboRATE** measure. As patients finished their visits with clinicians, a staff member gave each patient a tablet computer until 25 complete reports per clinician were obtained. Patients were not asked to provide their names. The **collaboRATE** item score and top score (% giving the highest possible score) was calculated at clinician and clinic level.

Results

In the eight-week data collection period, we received 853 completed **collaboRATE** scores. Of the 38 clinicians working at the clinic during this time period, we were able to collect at least 25 patient reports for 17 individual clinicians. The clinic's mean **collaboRATE** top score was 75% (SD 43%), with scores ranging from 58% (SD 50%) to 91% (SD 30%) across clinicians. On the basis of the results, and the perceived ease of data collection, clinic managers plan to: 1) share individual-level results with each clinician, 2) compare each score to a range of available benchmarks, 3) consider suitable interventions for clinicians with low scores, and 4) repeat the assessment with **collaboRATE** to gauge improvement.

Conclusion

Routine assessment of clinicians' **collaboRATE** scores was considered valuable and feasible by clinic management. Future repeated cycles of measurement and improvement are planned.

116 - La Collaboration des patients et citoyens au Carrefour d'innovation en santé globale

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Introduction Le Carrefour d'innovation en santé globale (CISG) a pour but de contribuer au développement de personnes agissant avec une conscience collective pour leur santé globale et durable et outiller les personnes souhaitant devenir acteurs de leur propre santé. Initié par un patient, ancré dans la mission du Monastère des Augustines de Québec et soutenu par une équipe intersectorielle, cette recherche action participative (RAP) a pour but de déterminer l'offre de services du CISG selon les besoins exprimés par ses futurs usagers. **Objectifs** 1) Identifier les besoins et préférences des éventuels usagers ainsi que des autres partenaires impliqués dans le développement et la mise en oeuvre du CISG; 2) Concevoir un outil d'aide à la décision (OAD) basé sur un modèle multi-critères d'analyse décisionnelle utilisant une approche de décision de groupe qui considère les préférences et les besoins des personnes, proches aidants et citoyens par rapport aux services offerts en santé globale. *Phase 1*-Des focus group (n=4 incluant 8-12 personnes/groupe) et une analyse thématique ont été réalisés afin de déterminer une liste de services et de critères permettant d'orienter l'offre du CISG. *Phase 2*- Des questionnaires visant une pondération de ces services et de ces critères ont été distribués aux participants des focus groups. *Phase 3*-L'élaboration de l'outil d'aide à la décision est en cours. **Résultats** Cette conférence sera l'occasion de présenter le processus de recherche et les résultats obtenus lors des focus group au sujet des services souhaités par les éventuels usagers du CISG et les critères orientant leurs choix en santé globale. **Conclusion** L'outil développé permettra au CISG et à d'autres organismes de rendre plus concrètes et plus accessibles les meilleures pratiques et connaissances en matière d'implication et de participation des personnes dans les services qui leurs sont offerts. À terme, ce projet pourra avoir des impacts sur l'amélioration du système de santé et des pratiques de soins puisqu'il contribuera à instaurer des mécanismes et processus inclusifs pour guider les décisions concernant les services offerts en fonction des besoins et préférences des usagers actuels et futurs dans différents organismes.

117 - Personnaliser CONCERTO: l'expérience patient optimisée pour des soins intégrés, coordonnés et efficaces

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Introduction

Avec près de 70% des décès, les maladies chroniques représentent la première cause de mortalité dans le monde. Elles exercent une forte pression sur les systèmes de santé et entraînent la surconsommation de soins et de services. Le Programme Santé Concerto (PSC) a été développé pour optimiser la gestion des maladies chroniques dans les services de soins primaires au Québec. Cependant, dans sa version actuelle, le PSC s'adresse avant tout aux cliniciens et offre peu d'outils répondant directement aux besoins des patients et ses proches. Ces outils éducatifs doivent être adaptés en considérant à la fois les enjeux de littératie, les besoins et possibilités d'utilisation du patient. Ce projet vise à développer, implanter et évaluer CONCERTO+, afin d'optimiser la participation active du patient et celle de ses proches dans leur prise de décisions concernant leur santé.

Méthode

Phase 1. Une équipe multidisciplinaire formée de cliniciens, chercheurs, designers et programmeurs développe l'application personnalisée, multifonctionnelle CONCERTO+ destinée aux personnes souffrant de multiples maladies chroniques (diabète, dyslipidémie, hypertension) selon une approche itérative centrée sur l'utilisateur à travers trois séries de tests où les prototypes seront améliorés. Un patient partenaire est impliqué à toutes les étapes et est co-chercheur du projet.

Phase 2. L'utilisabilité et l'acceptabilité de l'application seront testées à travers un essai pilote où 100 patients d'un Groupe de médecine familiale utiliseront l'application CONCERTO+ pendant six mois et seront comparés à un autre groupe de 100 patients recevant des soins usuels.

Phase 3. Le potentiel d'expansion de la solution sera analysé à travers des entretiens de groupe et individuels avec les principales parties prenantes.

Résultats

Ce projet présentement en cours a été initié en 2017 pour une durée de deux ans. Un premier prototype a été présenté à un groupe de 10 patients et proches. Des améliorations sont actuellement en cours en vue de produire une version qui sera validée auprès de patients et cliniciens pour permettre l'implantation de la solution à l'automne 2019.

Conclusion

Cette présentation abordera la méthodologie et les résultats de la Phase 1, en plus de décrire les principaux défis à relever pour la poursuite de ce projet.

118 - Décision partagée dans le cadre du dépistage du cancer du sein en soins primaires : protocole de l'étude DEDICACES

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Contexte. En France, le cancer du sein est le premier cancer touchant les femmes avec 54 000 diagnostics et presque 12 000 décès par an. Le dépistage organisé a été mis en place en 2004 et consiste en la réalisation d'une mammographie bisannuelle entre 50 et 74 ans. Il réduit la mortalité spécifique de 15 à 20 % au terme de 10 ans de suivi. Cependant, les surdiagnostics font l'objet de controverses scientifiques et le rapport bénéfices/risques du dépistage est difficile à appréhender pour une femme dans une perspective individuelle. Différents auteurs et pays proposent des outils d'aide à la décision visant à aider patientes et soignants à prendre la décision de participer ou non. Aucun outil d'aide à la décision à destination des femmes éligibles au dépistage organisé du cancer du sein n'a été validé auprès des femmes et des soignants français.

Objectif. La première phase de l'étude DEDICACES a pour objectif de construire un outil d'aide à la décision pour le dépistage organisé du cancer du sein en France.

Méthode. Les deux étapes préliminaires sont une revue de la littérature sur les outils d'aide à la décision existant dans le dépistage du cancer du sein et une étude qualitative explorant les représentations et les attentes des femmes et des professionnels (généralistes, gynécologues, sage-femmes, radiologues, médecins des structures de gestion du dépistage organisé) vis-à-vis d'un tel outil. Ces étapes seront suivies de la construction d'un outil d'aide à la décision destiné aux femmes françaises selon une méthode de consensus formalisé de type Delphi. L'outil d'aide à la décision obtenu sera ensuite validé par une deuxième méthode qualitative.

Résultats attendus. Ce projet permettra de disposer d'un outil d'aide à la décision conforme aux standards internationaux, en français, construit avec les patientes et les professionnels, à destination à la fois des femmes et des professionnels de santé, pour le dépistage organisé du cancer du sein. La perspective de cette étude est de tester l'impact de ce futur outil sur la participation au dépistage et sur la qualité de la décision, et notamment la survenue de conflits décisionnels.

120 - La décision partagée en obstétrique: au-delà de la relation patient-soignant

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INTRODUCTION : Depuis les cinquante dernières années, l'univers de la naissance a connu plusieurs changements qui ont profondément bouleversé la manière d'intervenir auprès des femmes enceintes avec, entre autres, l'arrivée de la médecine obstétricale. Au Québec, le système de prise en charge des suivis de grossesse propose principalement trois trajectoires différentes, soit celle avec un médecin, une infirmière spécialisée en soins de première ligne (IPSPL) et une sage-femme. Peu d'études ont abordé la question de la décision partagée en lien avec le suivi de grossesse. De plus, la plupart des études sur la décision partagée se concentrent sur la relation patient-soignant. **OBJECTIFS** : Ce projet vise à combler ces lacunes en s'intéressant, d'une part, à la décision partagée lors d'un suivi de grossesse à partir d'une analyse comparative entre ces trois trajectoires de suivi. D'autre part, en élargissant la perspective afin de considérer l'influence d'autres acteurs sociaux dans la prise de décision concernant le suivi de grossesse (conjoint, parents, amis, collègues, etc.) **MÉTHODES** : Une méthodologie qualitative basée sur des entretiens individuels semi-directifs sera privilégiée. L'échantillon sera principalement composé d'une quinzaine de femmes ayant accouché depuis moins d'un an qui seront invitées à raconter leur parcours de grossesse et leur accouchement à partir des décisions qu'elles ont eu à prendre durant leur suivi de grossesse (5 par type de professionnels). Des entretiens seront également effectués avec un représentant de chaque profession pour mieux comprendre leur vision de ce processus décisionnel qui se vit pendant une grossesse. **RÉSULTATS ANTICIPÉS** : La collecte de données débutera à l'automne 2019. Cette recherche s'inscrit dans deux champs de recherche, soit celui des sciences sociales et de la santé. Les résultats permettront de mieux comprendre le processus de décision partagée et la manière dont il est vécu selon le professionnel choisi pour assurer le suivi de la grossesse. **DISCUSSION** : Les résultats contribueront à améliorer les connaissances sur la réelle implication des femmes dans ce processus décisionnel et les facteurs qui habilitent ou entravent une plus grande participation des femmes dans les décisions concernant leur grossesse.

124 - Development of a patient decision aid for the management of small renal masses

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Introduction:

Patients with small renal masses are candidates for surgery, ablation, or surveillance. The choice of management requires an assessment of benefits and risks of each option and incorporation of patients' values. We sought to develop a patient decision aid to facilitate shared decision making and patient-centred care for individuals with small renal masses.

Methods:

A structured development process was used following the International Patient Decision Aid Standards and the Ottawa Decision Support Framework. A literature review was performed to identify outcomes related to management of small renal masses. An iterative feedback process by a steering committee of content and process experts was used to determine the decision-aid prototype content. Figures and narrative text were developed to explain management options and outcome rates. A 10-question survey was created to assess the acceptability of the decision aid with patients, patient advocates, urologists and methodological experts.

Results:

An evidence-based decision aid was created. Management options included were partial nephrectomy, radical nephrectomy, ablation and surveillance. Benefits included were rates of overall survival, metastasis-free survival and length of hospital stay. Risks included were rates of post-procedural urine leak, bleeding and renal failure. A validated tool was included to explore patients' values and preferences. Pictures, diagrams and plain language were used to allow use by patients of various educational backgrounds. Knowledge questions were included to assess patients' understanding. The decision aid met the IPDAS defining criteria (6 of 6), certification criteria (6 of 6) and 17 of 23 quality criteria.

Conclusions:

A novel patient decision aid was created for the management of small renal masses following a systematic and evidence-based process. Acceptability testing is being performed in a prospective fashion with stakeholders.

126 - Challenges of scaling-up shared decision-making interventions in health

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Background and aims: Interest in scaling-up shared decision-making (SDM) is growing among both patients and healthcare professionals. Unfortunately, there is still a gap between evidence-based SDM interventions and practices. To better understand this gap, we sought to explore the challenges of scaling-up health interventions with SDM stakeholders.

Methods: We performed a qualitative study followed by a rapid review using a 3-phase approach: an interactive workshop (Phase1), a rapid review (Phase2) and a data synthesis (Phase3). **Phase1:** We invited SDM stakeholders from Laval University to a 3-hour workshop to identify the challenges of scaling-up health interventions. The workshop started with an introduction to the main concepts, followed by separate small-group discussions, and lastly a plenary session. **Phase2:** We performed a rapid review with the following inclusion criteria: 1) *study design*: any systematic review on an identified challenge or any primary study if a review was unavailable; 2) *participants*: no restriction; 3) *intervention*: any approach used to scale-up a health intervention; 3) *comparator*: no restrictions; and 4) *outcomes*: any challenge identified during the workshop. **Phase3:** We performed a thematic analysis of qualitative data and discussed them with rapid review results.

Results: Twenty stakeholders participated in the interactive workshop. Overall, the workshop generated discussion on six major challenges of scaling-up health interventions documented in the literature. First, *the cost-effectiveness estimation challenge*: accurate cost-effectiveness estimates about real-world implementation are almost impossible, making predictions of economies of scale unreliable. Second, *the health inequities challenge*: some people will necessarily be left out and therefore not benefit from the scaled-up health interventions. Third, *the health inequities challenge*: the harms as well as the benefits may be amplified by the scaling-up. Fourth, *the scaled-up harm challenge*: informed consent may be a challenge on a grander scale. Fifth, *the top-down challenge*: the needs, preferences and culture of end-users may be forgotten when scale-up is directed from above. Sixth, *the contextual challenge*: it may not be possible to adapt the health intervention to every contexts.

Conclusions: Scaling-up is powerful process for reducing evidence-practice gaps, but there are significant challenges. SDM Investigators need to develop rigorous methods for addressing these challenges.

127 - Use of a decision aid (DA) to inform the decision process on optimal central access devices for patients receiving chemotherapy

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Background and aims

Indwelling central access devices (CVADs) have been increasingly used to enable delivery of intravenous chemotherapy, but only few patients reported being involved in the decisions about vascular access. Patient decision aids (DAs) may be a useful resource in this setting to inform patients and guide decision-making. The aim of this study was to develop and pretest a DA to help patients facing CVADs choices during chemotherapy.

Methods

From August to November 2017, our team conducted a needs assessment to characterise the scope and range of issues that might be addressed with improved reporting of DA evaluation studies and used the International Patient Decision Aids Standards (IPDAS) framework as a basis for developing a validated instrument for assessing.

Results

The DA was well received among subjects and passed the review of experts from Joint Commission of Taiwan. The average of Preparation for Decision Making scale (from) was 4.52 ± 0.68 and showed patients giving higher acceptability scores.

Conclusion

International guidelines recommend sharing with the patient and caregiver the most appropriate choice of the CVAD type to be inserted for the administration of chemotherapy. Not only patients or their caregivers-family members need to acquire the appropriate knowledge and skills for the management of devices through educational intervention, but also the clarity of the information, and patient's preferences are important factors that affect the decision process. Patients found the DA acceptable and useful in supporting their decision about optimal vascular access and based on their informed values and preference. DAs are designed to support patients in this process and intended to supplement rather than replace patient-practitioner interaction.

128 - Strategies to evaluate health care provider trainings in shared decision-making: A systematic review of evaluation studies

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Background and aims

Health care provider (HCP) trainings in shared decision-making (SDM) are promising means to foster the implementation of SDM, but evidence on their efficacy remains unclear. Therefore, we sought to systematically review strategies to evaluate HCP trainings in SDM to develop an evaluation framework.

Methods

We searched scientific databases, performed reference- and citation-tracking, contacted experts in the field and scanned the Canadian inventory of SDM training programs for health professionals. We included articles reporting data of summative evaluations of HCP trainings in SDM. Two reviewers screened records, assessed full-text articles, performed data extraction and assessed study quality with the integrated quality criteria for review of multiple study designs (ICROMS) tool. Analysis of evaluation strategies included data source use, use of unpublished or published measures and coverage of Kirkpatrick's evaluation levels referring to study and article level, if applicable. Based on Kirkpatrick's evaluation levels, the Quadruple Aim Framework and present analysis, we developed an evaluation framework.

Results

Out of 6179 records, we included 34 articles reporting on 25 studies: cluster-randomized (n=7) and randomized (n=8) controlled trials, controlled (n=1) and non-controlled (n=4) before-after studies, mixed methods (n=1), qualitative (n=1) and post-test (n=3) studies. Most studies were conducted in the USA (n=8), Germany (n=6) or Canada (n=6) and evaluated physician trainings (n=19). Eight articles met ICROMS quality criteria. Almost all studies (n=23) employed HCP-reported outcomes for training evaluation and most (n=15) additionally used patient-reported (n=10), observer-rated (n=7), standardized patient-reported (n=2) outcomes or training process and health care data (n=5). Most studies employed a mix of unpublished and published measures (n=15) and covered two (n=9) or three (n=9) Kirkpatrick levels. We proposed an evaluation framework for HCP trainings in SDM.

Conclusion

We found a group of heterogeneous evaluation strategies with a focus on HCP-reported outcomes. The proposed evaluation framework for HCP trainings in SDM may provide orientation in choosing adequate evaluation strategies and may be a first step towards achieving consensus on relevant evaluation outcomes and measures. This may ultimately lead to better evidence on HCP trainings in SDM.

130 - “Renal Stone Chat Bot”, a communication app-based decision aid for patients with renal stones

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Background

Surgical intervention is indicated in patients with renal stones sized 0.5 – 1.5 cm. Both extracorporeal shock wave lithotripsy (ESWL) and retrograde intra-renal surgery (RIRS) are treatment of choices with variable success rates and complications. About 60% of residents in Taiwan can access Internet with their smart phones, and communication apps for instant messaging with words, graphics, files, or video are essential for users. Currently, the most popular app in Taiwan is Line®, and 90% of mobile phone holders are active users. We developed an interactive, communication app-based decision aid to help patients with renal stones make treatment decision between ESWL and RIRS.

Methods

We have interviewed patients with renal stone to understand their questions about ESWL and RIRS. We also reviewed the literature to identify the pros and cons of this two types of surgeries. It ended up with a paper document introducing why and how the surgeries are done, the treatment duration, the stone free rate, the potential complications, the costs, and the test of patients' understanding. Line® provides a free chat bot for online customer service. We have input the key information of the paper document and set the keywords to create a “Renal Stone Chat Bot” in Chinese. Patients can access the chat bot by scanning the QR code in the clinic.

Results

In the chat room, a welcome message will guide the patients how to interactive with the bot. Patients can watch a video of the comparison between ESWL and RIRS first, and read the messages of the details of surgeries with graphics steps by steps. They can ask to repeat any part of the information if they want to read it again. The bot will also guide the patients through tests of their understandings of the surgeries and to clarify their own preference. We are testing this chat bot on patients, and the results will be updated.

Conclusions

A free online communication app-based chat bot is a feasible platform to develop interactive patient decision aids with different forms of messages for clinical usage.

132 - The Shared Decision Making Impact on Early Tracheostomy in Prolonged Intubated Critical Patient

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Background and aims: Tracheostomy creation was poorly accepted, though with superiorly odds to pros, owing to cultural mis-understanding, in Taiwan. By retrospective cohort data analysis, we try to unveiled the impact of introducing SDM on early Tracheostomy(less than 14 days) in prolonged intubated critical patients.

Method: Medical record of tertiary medical center adult ICU admitted respiratory failure patient from Jan. 1st, 2016 to Dec. 31th, 2017 was retrospectively reviewed, and further subdivided into pre-SDM and post-SDM(after Jan. 1st, 2017) intervention period for analysis. Data including total Tracheostomy rate, early and late Tracheostomy rate, ventilator weaning rate and ventilator days, in-hospital mortality, and length of hospital stay of prolonged intubated patient were collected. SPSS was applied for statistically analysis, and a p value less than 0.05 was considered significant difference.

Result: Medical records from total 1253 patient from Jan. 1st, 2016 to Dec. 31th, 2017 were reviewed, and total 7137 patient ventilator days were recorded. By inclusion and exclusion, 128 patients from 2016 and 112 patients from 2017 were considered prolonged intubated for further analysis. Pre-SDM early and late Tracehostomy rate were 42% and 58% individually, with ventilator weaning rate(43(79.6%) v.s 46(62.2%), p: 0.034), ventilator days(35.3+/-18.1 v.s 47.2+/-16.1, p< 0.001), in-hospital mortality(1(1.9%) v.s 6(8.1%), p: 0.237), and length of hospital stay(59.7+/-35.1 v.s 69.2+/-24.6, p: 0.091) of prolonged intubated patient. Post-SDM early and late Tracehostomy rate were 39% and 73% individually, with ventilator weaning rate(27(69.2%) v.s 56(76.7%), p: 0.389), ventilator days(34.6+/-17.6 v.s 47.5+/-28.4, p: 0.004), in-hospital mortality(4(10.3%) v.s 6(8.2%), p: 0.737), and length of hospital stay(57.2+/-21.8 v.s 68.4+/-26.8, p: 0.028) of prolonged intubated patient. After SDM was introduced, ventilator days and length of hospital stay of prolonged intubated patient was found reduced 13 days and 11 days individually in compared in between groups. The Tracheostomy decision making time delay was found 5 days less after SDM introduced.

Conclusion: Our retrospective cohort study revealed introducing shared decision making on early Tracehostomy in prolonged intubated critical patient might improve total Tracheostomy rate, reduce ventilator days and length of hospital stay, and shorten the Tracheostomy decision time delay.

136 - Donner une voix aux personnes atteintes de maladies neurodégénératives

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Les personnes atteintes d'une maladie cognitive jouissent des mêmes droits que n'importe qui d'autre, y compris celui d'avoir le contrôle de leur propre vie. Cependant, avec l'évolution de la maladie, leur capacité à prendre des décisions concernant leur vie de tous les jours (leurs finances, leur santé et les soins à recevoir) est altérée, ce qui rend leur capacité à faire entendre leur voix plus difficile, surtout lorsque leurs droits sont menacés ou bafoués. Elles doivent souvent faire face à des attitudes stigmatisantes et discriminatoires, en raison de leur diagnostic, ce qui les rend d'autant plus vulnérables.

Cependant, une approche des maladies cognitives fondée sur les droits de la personne peut aider à aborder ce problème et faire entendre leur voix. Un comité de personnes atteintes d'une maladie cognitive, provenant des différentes provinces du Canada ont travaillé conjointement avec la Société Alzheimer du Canada pour créer la première Charte canadienne des droits des personnes atteintes de maladies neurodégénératives. La Charte a été dévoilée durant le mois international de la maladie d'Alzheimer en septembre 2018 et définit sept droits fondamentaux que les personnes atteintes de maladies neurodégénératives désirent faire valoir. À travers la charte, les personnes atteintes désirent voir leurs droits respectés, protégés et défendus par leur entourage. De plus, la Charte propose un cadre de travail pour les responsables politiques, les dirigeants des services sociaux et de santé, tout en permettant d'identifier les obstacles et d'effectuer les changements nécessaires pour améliorer le vécu des personnes atteintes d'une maladie cognitive et leurs proches aidants.

138 - Torbay Charts as a Shared Decision-Making Tool

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Effective Shared Decision Making (SDM) requires enthusiastic clinicians, willing patients and a good information repository in the form of efficient Patient Decision Aids (PDAs) to make an informed decision in collaboration. Lack of user-friendliness is one of the reasons why the current PDAs have not been widely adopted in clinical practice.

The components that are not captured in many current PDA's are:-

- (a) Lack of a simplistic **overview** of the whole disease progress,
- (b) Lack of display of appropriate **treatment options that are relevant to the stage** of the disease,
- (c) Lack of user-driven **inter-activeness** when comparing relevant treatment options.

The Torbay Charts PDA (TC-PDA) was developed to address the above issues and has a unique multi-layered approach. At the first level, the TC-PDA provides an overview of the progress of the disease, correlating various treatment options appropriate to the stage of the disease. At the next level, concise evidence based description of each treatment is provided as a table or as an infographic sheet. The information provided covers, benefits, risks, and burdens of each treatment. Furthermore, users can interactively compare various treatment options and display the results as a comparative table, infographic or both. This allows them to compare various treatments of their choice side by side.

The first pilot testing was conducted over an 8-week period and was focused on the management of hip and knee arthritis. 102 patients used the TC-PDA and a collaborative decision was reached. The usefulness of the TC-PDA was evaluated with a questionnaire. 93% scored excellent/very good in the TC-PDA helping with their SDM process and 93% scored excellent/very good for understanding the stage of the disease and its progress. The healthcare practitioners felt that they had an engaging conversation with the patients and on many occasions, with its focused approach, it sped up the consultation.

By having a layered approach, the TC-PDA addresses the issues missing in current PDA's. It allows excellent patient participation while considering all relevant options before choosing the most appropriate personalized treatment.

The modular approach of the TC-PDA can be easily adapted and transferred to other conditions.

141 - Analytical mobile application to support high quality shared decision making about prenatal screening: development and assessment

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Background: Decisions about Down syndrome prenatal screening among the available screening tests are complex decisions. Decision support empowered by mobile technology could facilitate shared decision making. Our objectives are to: (i) assess the needs and preferences of couples using an app for deciding about prenatal screening; (ii) develop a decision model using the analytical hierarchy process; (iii) develop an analytical mobile app and assess its usability and usefulness.

Methods: We propose a multipronged study design that have three phases: (1) needs assessment, (2) decision model development, and (3) mobile app development and pilot testing for usefulness and usability. Phase 1: we will assess the needs of 90 couples in three clinical sites (a midwife-led birthing centre; a family practice clinic; and an obstetrician-led hospital-based clinic) in Quebec City and Montreal. Using self-administered questionnaires and semi-structured interviews, we will assess participants' attitudes towards and preferences regarding mobile apps for decision-making about their health in general and prenatal screening decision-making, their current use of apps for this purpose, and perceived usefulness and expectations of an app for prenatal screening decisions. We will analyze quantitative data using descriptive statistics. Regarding qualitative data, we will transcribe and analyze the results. Phase 2: using analytical hierarchy process we will develop a decision model and validate it with potential users and multidisciplinary expert team. Phase 3: we will apply user-centred design to develop a prototype of the app. We will pilot test its usefulness and usability among a sample of 15 participants and improve it iteratively. We will collect data with a self-administered questionnaire, and analyze them using descriptive statistics.

Results: The study is ongoing and the final study results will be available in 2021.

Discussion: The results of this study will lead to the development of a validated analytical app that provide pregnant women and their partners with the most up-to-date information about the various screening options and their risks and benefits. It will enable them to rate the importance of factors to be considered, better clarify their values and preferences, and finally make informed choices consistent with their values and preferences along with their clinicians.

145 - Digital health literacy as a facilitator of shared decision making: the IC-Health Project

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BACKGROUND: Digital health literacy (DHL) is an essential element for successful eHealth deployment. However, citizens often do not have the necessary skills to find, understand and assess online health information and apply their knowledge for shared decision making (SDM). Digitally health literate citizens are empowered to play a more active role in their health self-management, resulting in improved prevention, adherence to a healthier lifestyle and better health outcomes.

AIM: The aim of this paper will be to present the objectives, activities and results so far achieved by the IC-Health project, which was funded by the European Commission (H2020) and whose objective was to increase EU citizens' competences related to DHL.

METHODS: An exploratory report on the evidence on the subject of DHL and health literacy (HL) was developed as a resource that provided the conceptual bases for the project's activities. In addition, a survey was conducted to find out the levels of DHL, as well as the problems, interests and needs of the specific population cohorts of the project: children, adolescents, pregnant and lactating women, elderly people and people affected by type 1 and type 2 diabetes. A participation strategy was designed with end users through a community of practice (CoP) for the cocreation of Massive Open Online Courses (MOOCs) with all the countries participating in the consortium and the evaluation of the quality and design of the MOOCs was carried out with new participants.

RESULTS: Each group of participants (749 participants in total: 73 Belgium; 88 Denmark/Germany/Netherlands; 226 Italy; 224 Spain; 101 Sweden; 37 UK) met off-line to create an initial storyboard of a MOOC. After that, participants from each group continued to provide MOOC feedback through a CoP until the details of the MOOCs were outlined. 35 MOOCs were developed in 8 different languages.

CONCLUSION: Evaluation of the quality and design of the MOOCs was carried out with new participants, results of this testing will be published soon. The usefulness of digital resources for the shared creation of contents has been demonstrated. This first results also suggest that DHL can be an effective facilitator of SDM processes.

146 - The effectiveness of a virtual intervention for primary care professionals to improve their attitude towards the empowerment of patients with chronic diseases (e-MPODERA project)

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Background: Communities of practice are based on the idea that learning involves a group of people who exchange experiences and knowledge. The e-MPODERA project aims to evaluate the effectiveness of a virtual practice community aimed at improving the attitudes of primary health care professionals for the empowerment of patients with chronic diseases.

Aim: Present the first results of a randomized controlled trial by conglomerates that evaluates the effectiveness of a virtual intervention (CdPV) aimed at professionals to improve their attitude towards the empowerment of patients with chronic diseases

Method: Primary care professionals from 3 Regions of Spain (Madrid, Catalonia and the Canary Islands) were randomly assigned to a virtual practice community for professionals or traditional training. These professionals recruited a sample of patients with chronic diseases. The primary results obtained were the questionnaire of the Patient Orientation Scale and the administered provider, assessed at baseline and at 12 months. The secondary results obtained were the sociodemographic characteristics of the health professionals, the sociodemographic and clinical characteristics of the patients, the questionnaire: Patient Activation Measure for Activation Patients and the results regarding the use of the virtual practice community.

Results and conclusion: To date, the first phase of the project has been conducted in which a systematic review was carried out and the virtual practice community was piloted. As well as the second phase, whose objective was the development of the randomized controlled trial. The third phase that is currently underway has to do with an open uncontrolled phase of the practice community in which it has been opened to large-scale participation of a greater number of health professionals. The analysis of the measures taken at 12 months, both professionals and patients are currently being carried out. The first results indicate that the community of virtual practice has generated a great participation among professionals and the analysis of those participations indicate favorable changes in their attitudes of patients with chronic diseases.

147 - A systematic review of decision aids for patients making a decision about treatment for knee osteoarthritis

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BACKGROUND: Patient's decision aids (DAs) are tools designed in different formats (i.e., paper, web-based, computerized), aimed to improve the decisional process of patients who have to decide among different treatment or diagnostic procedures. In the field of knee osteoarthritis (OA), a highly prevalent chronic condition that seriously hinders patients' quality of life, DAs represent a potentially valuable resource since treatment options for this disease (e.g., painkillers, anti-inflammatory drugs, orthoses, intra-articular corticosteroids, arthroplasty) are very sensitive to patients' preferences. Therefore, the aim of this study is to assess the effectiveness of decision aids (DAs) for patients with knee OA.

METHODS: A systematic review was carried out in MEDLINE, EMBASE and Cochrane Library databases, until April 2018. We included randomized (RCT) and non-randomized (nRCT) controlled trials that assessed the effect of a DA for patients with knee OA. The risk of bias of the included studies was assessed by means of the criteria developed by the Cochrane Collaboration.

RESULTS: Seven RCT (which assessed the same DA) and one nRCT were included; seven studies compared a DA to general information or no intervention, and one compared two different formats of the same DA. The methodological quality of the studies was low to moderate. We could not performed a meta-analysis due to the heterogeneity of the measures assessed and reported. Overall, significant effects favoring the intervention were observed on knowledge, decisional conflict, and decision quality. One study with Afro-American patients found a significantly higher rate of total knee replacement in the DA group after one year, whereas other study carried out in Canada found the opposite result after 2 years.

CONCLUSIONS: The evidence on the effectiveness of DAs in knee OA is scarce, and almost exclusively focused in one DA developed in the United States by the Informed Medical Decisions Foundation. Results suggest that this tool is effective for improving the decisional process of these patients. Future studies are needed that use other types of DAs, and that analyze their effect on patient-professional interactions, surgery rates, health outcomes and costs.

148 - The Quality of Patient Decision Aids for people making treatment decisions as their chronic kidney disease worsens: An Environmental Scan.

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AIM: To evaluate the quality of Patient (PtDA) and Shared Decision Aids (SDA) to support people making treatment decisions for their chronic kidney disease (CKD) stages 4&5.

BACKGROUND: Clinical guidelines recommend people with chronic kidney disease are offered conservative management, dialysis and transplant treatment options to support their future pathway of care when their kidneys start to fail. Internationally services provide education about renal replacement therapies, but there is variation in the way conservative management is offered and delivered. It is unclear if current patient decision aids support effectively people's thinking between conservative management, dialysis and transplant.

METHODS: an environment scan employing systematic review methods. PtDA and SDA identified by searching: Medline+Psychinfo publication databases; Pt/SDA+clinical trial+clinical guideline open access repositories; shared decision making (SDM) expert distribution list; article+author reference lists. Data Extraction Form elicited data about: resource characteristics: decision problem, options and consequences; components to boost/ bias reasoning (IPDAS-IDM-SDM); publication process. Descriptive and narrative analyses synthesised findings.

RESULTS: From 56 hits, 17 PtDA for people with CKD met the study criteria. All were available in English, 5 had versions in Arabic, Danish, French, Italian, Mandarin and Spanish. Delivery and content varied with 6 SDA and 11 PtDA designed to supplement education programmes; 4 were evaluated within usual care. The decision problem was described as: 9 between-dialysis options (haemodialysis/ peritoneal dialysis; home/ hospital; daily/ nocturnal); 4 between dialysis-conservative management, and 4 between dialysis-conservative management-transplant, with 10 different terms for conservative management. The health problem was described as CKD, End Stage Kidney Disease (ESKD) and Established Kidney Disease (EKD). Use of the 12 minimum PtDA components ranged from 3-11 (mean 8); readability from 55.4-88.6 (0-100, difficult to easy; acceptable 60+). No Pt/SDA mentioned consequences of treatment failure; 3 signposted end of life options. Fourteen resources used tasks to enable people's focus on what was important to them; risk figures were used within 3 resources.

CONCLUSION: Current Pt/SDAs do not represent the decision problem well enough in this complex and changing health context to support effectively people's decisions between conservative management, dialysis and transplant treatment pathways.

150 - Baseline results of a before-after intervention to improve shared-decision making skills of 5th-year medical students at the University of Lausanne, Switzerland

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Introduction: Shared decision making (SDM) is a core ethical concept and practical skill in the new Swiss Federal medical student curriculum and will be evaluated in the clinical skills portion of the state licensing exam. To date, the University of Lausanne (UniL) medical school has not had a formal SDM curriculum. We added a SDM station to the Objective Structured Clinical Examination (OSCE) for medical students at the end of their 5th year.

Methods: Comparison of 5th-year medical student performance and feedback on a SDM OSCE station before and after the implementation of a teaching module. Teaching module objectives are to increase knowledge (ethical basis, historical perspective), develop skills (identifying SDM situations, using decision aids), and change attitudes (importance of choice and patient preferences). A 1.5-hour lecture will introduce core concepts, expose variations in personal preferences, demonstrate SDM in a video consultation, and explore risk communication techniques. Students will then practice SDM for prostate cancer screening using role-plays.

Results: 81 students (59% women) completed the March 2018 OSCE station of a middle-aged patient choosing between the faecal immunochemical test and colonoscopy for colorectal cancer screening using a decision aid. Between 74% and 95% of students correctly completed each of 13 evaluation items (mean 82%). 51 students subsequently evaluated the station, of whom only 26% (13/51) felt they had adequate knowledge of SDM and 76% (39/51) reported having received between 0 and 1 hour of training in SDM. Many students reported using motivational interviewing techniques. Comments included “we have never had a real course on SDM, which must surely have its own specificities”, “we should be told what is expected”, and “we should practice, as done for breaking bad news or motivational interviewing”.

Conclusions: At baseline, the majority of medical students felt unprepared for a SDM encounter with a standardized patient. Though most students scored highly, they did not feel that SDM is adequately covered during existing clerkships. We will collect additional baseline results in spring 2019, implement the curriculum throughout 2019, and measure the effect of the intervention in spring 2020.

151 - Knowledge Gaps and Information-Seeking by Parents about Hypospadias

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Introduction and Objective: Parental decisions about hypospadias surgery are often complex and accompanied by anxiety/confusion related to multiple sources of information and their reliability and relevance to their concerns. The purpose of this study is to develop a parent decision aid based on identifying knowledge gaps, information-seeking behaviors and informational needs of parents making decisions about hypospadias surgery for their sons.

Methods: We conducted semi-structured interviews with English-speaking parents (≥ 18 years of age) of children with hypospadias, inquiring about gaps in their knowledge, information-seeking behaviors and informational needs. We conducted interviews until we reached thematic saturation and used qualitative content analysis to identify major categories and themes. Interviews were audio-recorded and professionally transcribed.

Results: Of the 43 eligible parents, 16 mothers and 1 father (39.5%) of 16 patients participated: 7 preoperative and 9 postoperative with distal (8) and proximal (8) meatal locations. Parents were ages 21-43: 15 Caucasians and 2 African-Americans with diverse educational backgrounds and marital status. Parents described feeling overwhelmed and lacking knowledge and guidance at the time of diagnosis. We identified five categories of knowledge gaps relating to hypospadias surgery: 1) epidemiology 2) timing/technique, 3) perioperative experience, 4) long-term cosmetic outcome and 5) long-term risk of complications. Information sources included the internet, the pediatrician and/or urologist and their social network. Most parents sought information online prior to consultation with the urologist from parent blogs/forums, medical school/hospital websites, journal articles and medical databases. They expressed concerns about the clarity and reliability of information and noted difficulty finding images of mild degrees of hypospadias and repaired hypospadias cases. They thought that video testimonials from other parents would help them relate to others in their social network and build confidence about the surgical process. Interactions with providers helped to clarify information they gathered online and helped build confidence and trust in the surgeon.

Conclusions: The Internet is the primary source of information most parents to address knowledge gaps about hypospadias. Parents expressed concerns about the reliability and clarity of information and identified informational needs, such as examples of mild hypospadias cases and outcomes, for inclusion in a decision aid.

155 - Spoilt for choice: An environmental scan of question prompt lists available via Google

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Background

There is increasing interest in shared decision making (SDM) in Australia. Question prompt lists (QPLs) support question asking by patients, a key part of SDM. QPLs have been studied in a variety of settings, and increasingly the internet provides a source of suggested questions for patients. Environmental scans have been shown to be useful in assessing the availability and quality of online SDM tools.

Objectives

To assess the number, clinical application, accessibility and readability of QPLs available to users via Google.com.au

Method

Our environmental scan used search terms derived from reputable websites to search for QPLs available via Google.com.au. Following removal of duplicates from the 4000 URLs and 22 reputable sites, inclusion and exclusion criteria were applied to create a list of unique QPLs. QPLs were further assessed for clinical setting, length of the lists, proxy measures of quality (date of review etc.), readability and evidence of doctor endorsement.

Results

Using the environmental scan method, we identified 173 unique QPLs available to users. Lists ranged in length from one question to over 200. Just over half (57%) had a listed date of creation or update and 24% had evidence of authorship or source. Analysis of readability and accessibility data of the QPLs will be presented.

Conclusions

People seeking information on Google.com.au encounter a vast number of questions lists which they can use to prepare for consultations with their doctors. Surrogate markers of the quality or usefulness of various types of online QPLs have not yet been established which makes it difficult to assess the value of the abundance of lists.

Doctor endorsement of question asking has been shown to be an important factor in the usefulness of QPLs (ref) but information regarding this is not readily available online. Whether these diverse question prompt lists are endorsed by medical practitioners warrants further investigation.

156 - A model to applying Patient Decision Aids Developing Model in Cross-Hospital

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Background

Hospitals should provide Patient decision aids(PDA) that can guide patients to participate in medical decision-making to improve high-quality services. The workshop is one of the pattern suit to put their heads together for the team. So the case hospital intends for holding is the workshop to develop PDAs.

Methods

The case hospital is hospitalized and is composed from 7 hospitals spread around in Taipei. Building the model of the PDAs, the cross-hospitals subcommittee is established. The conduct of developing PDAs, referred and designed for to plan structured questionnaire(Cronbach's $\alpha = 0.97$), which depends on purposive sampling which is to understand the difference of cognition, capability and willings. The questionnaire is according to Likert Scale, 1=Strongly Disagree, 5=Strongly Agree. The descriptive statistics, independent T-test, One-Way ANOVA were used in this study.

Results

The cross-hospital subcommittee is paying to PDAs module and facilitating 14 research teams. During that period, holding two PDAs workshop. The whole score of the first time workshop is increased from 4.10 to 4.28, especially the capability side has the most increase from 4.07 to 4.26. The second time, the whole score has a great growth(4.1 to 4.42) and the willings side has an substantial raise of 0.5.

All in all, there has an obvious increase among the whole and individual. The score of cognition of the seniority between 10 to 20 years is higher than those have 5 to 10 years seniority. ($p < 0.05$)

The result of the questionnaire has a significant meaning in statistics. The course reveals a great outcomes according to the elevation of various course targets. Moreover, four of the teams joining the class have outstanding performance in competition.

Conclusions

It's the first time we established a cross-hospital subcommittee to develop a model for PDAs by workshop. We intend to depend on the grade of member to enhance empirical part step by step. In conclusion, clinical test is still needed for developed PDAs and accept the suggestions of patients, their family and our colleagues, which leads the benefit of participation of patients. The process could be adjusted and offer an example to those hospitals willing to build PDAs.

160 - Shared decision making to promote high-quality primary care management of musculoskeletal disorders: protocol for a user-centred design and mixed-methods pilot trial.

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Background

Primary care management of musculoskeletal disorders (MSKD) includes rehabilitation to relieve pain and improve function. Yet fewer than 20% of patients are informed of this high-quality option, while overuse of imaging tests, surgery and opioids can harm chances of recovery.

Shared decision making (SDM) training and tools are effective for informing patients of the pros and cons of tests and treatments and clarifying their values and preferences. These discussions could help to reduce the problem of overuse and underuse in the primary care management of MSKD.

Aims and hypotheses

We will: **1)** co-design with users a theory-informed SDM intervention, *PRImary care Shared decision making for Musculoskeletal disorders (PRISM)*, and **2)** assess in consultations: **a)** elements of the SDM process, **b)** choice of tests and treatments, **c)** patient outcomes and **d)** feasibility and acceptability of *PRISM*.

We hypothesize that clinician/patient dyads exposed to *PRISM* will: **a)** show improved decisional comfort, **b)** choose tests and treatments more likely to improve their condition, **c)** have less pain at follow-up (patients) and **d)** will consider *PRISM* feasible and acceptable.

Methods

Aim 1: Co-design *PRISM* with patients and clinicians (user-centred design) to develop a workshop that will include SDM principles applied to MSKD decisions, training on using decision aids and role-play and feedback exercises with patient-partners.

Aim 2: Mixed-methods study and pilot clustered randomized trial (cRT). Primary care clinics (randomization unit, n=4) with MSKD patients (n=100) cared for by clinicians (e.g. family physicians,

physiotherapists) (**Population**). Two clinics will receive *PRISM* directly (**Intervention**) and two afterwards (**Comparator**). **Outcomes:** **a)** if and how SDM occurred; **b)** decisions made and patients' knowledge about preferred and chosen options; **c)** pain and quality of life; **d)** feasibility and acceptability of *PRISM*: proportion of recruited clinics (50%), clinicians (75%) and patients (75%), user satisfaction and uptake of educational material. Focus groups will perform process evaluation of *PRISM*. All will be filmed/audio-recorded and transcribed verbatim for qualitative analysis.

Conclusion

This intervention to integrate SDM into primary care management of MSKD will support discussion of overuse and underuse of tests and treatments in primary care between clinicians and patients with MSKD.

162 - Evaluation of the Readability, Understandability and Actionability of Patient Decision-support Aid on Insulin therapy

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Introduction

Patient decision support-aid (PDA) is a healthcare tool to facilitate decision-making by patients on their treatment options, underpinned by their values and preferences. The ability to read and understand the content of the PDA is necessary to make informed decisions. While PDA is often structured according to the Ottawa hospital Research Institute format, its content and layout can be variable, pending on the developer. For example, several PDAs have been developed to support decision-making in initiating insulin therapy targeting at patients with secondary drug failure in type-2 diabetes mellitus (T2DM). We postulated that these PDAs varied in their readability and understandability, which might influence their utility.

Aim:

The study aimed to determine the readability, understandability, format quality and actionability of PDA on the initiation of insulin therapy

Method

An internet search was conducted to identify PDA on insulin therapy. Four out of six related PDAs were selected for evaluation as they targeted patients with secondary drug failure for T2DM. Readability was calculated using the Flesch-Kincaid (FK) score and Simple Measure of Gobbledegook (SMOG). Lower scores indicated better readability for both tools. An online calculator was used to count the number of polysyllabic words and sentences. Format quality was assessed using the "Clear print and large print golden rules" of the UK Association for Accessible Formats (UKAAF). The Patient Education Materials Evaluation Tool – Printed (PEMAT-P) was used to assess understandability and actionability.

Results

The SMOG scores of the 4 PDAs ranged from 13.3 to 15.8. No PDA met the recommended reading level of 6 and below. FK scores ranged from 6.5 to 8.6. Gaps were identified in selected PDAs pertaining to key UKAAF recommendations: use of smaller font size (<12) and failure to adhere to left-aligned text. The mean PEMAT-P score was 88%, largely due to absence of summary to increase understandability. The paucity of visual aids for actionability resulted in a score of 81%.

Conclusion

The PDAs for insulin therapy have satisfactory readability and understandability. Further improvement should be considered to increase the font size, align the text, provide summary and visual aids to promote actionability.

163 - Use Quality Improvement Method to Establish a Clinical SDM Support Model

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Background

To assist healthcare providers in implementing Shared Decision Making (SDM), we execute plans systematically to analyze the clinical operation and carrying out progress counseling. It's purposed to establish a clinical supportive model for practice SDM in medical institutions.

Methods

We narrow down the topic by gathering various medical categories to form an executive team lead by physicians. Team members participate in SDM curriculums to fully understand SDM. Counseling is used to support hospital practitioners in clinical practice.

We form a priority focused theme developed by project team, then assign them a series of SDM curriculums. Firstly, understand the status of SDM. Study how to deal with "SDM" by "assessing patient needs and Health Literacy". Evaluate "medical situation suitable for decision making" and use the "Patient Decision Aid" to guide patient value decisions.

The project team forms a scheduled counsel using quality control circle (QCC) method. Then, the executive team arranges courses to acquaint QCC based on the procedure of analyzing clinical operation for the solution. During an informal discussion, QC and SDM expert support and assist the executive team to further practice SDM in clinical tasks.

The measurement indicator is the proportion changes in decision-making and satisfaction of completion of patient decision.

Results

We held 8 Courses and conferences between May and October of 2018. The results are 9 theme executive teams, including physicians, nurses, dietitians, and case managers. Both contain 9 occupations and 71 participants, about a third of both physicians and nurses (34% and 38%). As for results, assisting patients in completing decision-making was increased by 37.8% (42.35% to 80.15%). Health literacy increased by 34.59% (48.7% to 83.3%), with patient satisfaction increased by 36.75% (60.8% to 97.9%). While the confidence of team member using QC application increased by 32.28% (38.5% to 70.8%). And 94% believe that the knowledge learned can be applied to the work, with overall satisfaction of 94.4%.

Conclusion

We have developed a pattern to help hospital health workers to practice SDM . From the participants' perspective, the plan seems to be effective and satisfactory. Additionally, this experience can also be expanded to different topics.

165 - Development of a decision aid for pregnant women about analgesia before childbirth

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Background

There is an upward trend to choose analgesia during childbirth in Japan. According to Shishido's 2018 study of 609 pregnant women, 16.3% were undecided about analgesia during pregnancy and ultimately half received an epidural and half did not. The question was: would it be possible to develop a decision aid for pregnant women that midwives could use in providing sufficient information and decision making about analgesia before childbirth.

Aim

We aimed to describe the details of the development process of a decision aid enabling women to choose between no analgesia and epidural analgesia during labour.

Methods

This study was a descriptive study based on a literature review, in accordance with the systematic development process of a decision aid. It met the quality standards of the International Patient Decision Aid Standards instrument, version 4.0 (IPDASi). We searched using PubMed, Cochran Library, and Japan Medical Abstracts Society (Ver. 5) from 2003 to May 2018. The keywords were "decision making", "decision aid", "epidural analgesia", "pain relief", and "labour". Thus, 8 trials out of 179 were included in the final review.

The contents were listed in order to make it easier to compare the benefits and risks concerning no analgesia and epidural analgesia. Risks that could be caused by each method were presented in pictograms and a circle graph for clarity.

A decision aid was completed in consultation with a perinatal physician, anesthesiologist, experienced midwives, experts in decision-making, and the opinions of women with childbirth experience.

Results

The decision aid prototype included the four-step decision making process: 1) Know how to convince and decide myself, 2) Know the characteristics of the choices, 3) Clarify what you want to choose, 4) Decide. The content of Step 2 included side effects, satisfaction, postpartum pain compared with no analgesia and epidural analgesia. Step 3 of values clarification provided a scale that pregnant women to consider each value: labor pain, side effects, cost. The decision aid was 22 pages of A4 size paper and in color.

Conclusion

The next steps in the development are to have women who have experienced childbirth evaluate the face validity and the usefulness of the decision aid.

167 - Application an SDM tool among newly diagnosed HIV-positive patients to rapid initiation of ART

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Background and aims Combination antiretroviral therapy (ART) effectively suppresses human immunodeficiency virus (HIV) replication and is the cornerstone of fighting the current HIV epidemic. In order to achieve the UNAIDS 90-90-90 target, Taiwan Centers for Disease Control endorsed “treat all” policy and encouraged rapid initiation of ART (within 7 days of HIV diagnosis) for asymptomatic naïve patients. The public and the community of the key population remained familiar with the old concept of treatment until low CD4 counts. Strategies to improve patient awareness, retention in care are urgently needed. Shared decision-making (SDM) is believed to improve patient knowledge and satisfaction, adherence to prescribed medications, and quality-of-life. We implemented an SDM tool among newly diagnosed HIV-positive patients and reported their outcomes.

Methods This study included all patients with newly diagnosed HIV infection in a regional teaching hospital in Taiwan from August 30 to December 31, 2018. A paper-based SDM tool, which included evidence-based information on current HIV treatment options in plain language, the pros and cons of earlier treatment, identification of patient preference, self-evaluation and confirmation of understanding, was utilized on the date of confirmed HIV diagnosis to facilitate the communication between the HIV care providers and the patients. We recorded the date of ART initiation and the follow-up HIV RNA loads of the included patients. Satisfaction of the patients was evaluated 1 month after the initiation of ART by a standardized questionnaire provided by the Joint Commission of Taiwan.

Results During the study period, 8 patients were included. After the utilization of the SDM tool, rapid initiation of ART was achieved in all patients (7 decided to start ART within 2 days after their diagnosis, the remaining one patient started ART on the sixth day after his diagnosis). At 1 month after the initiation of ART, 6 patients achieved viral suppression (plasma HIV RNA load <200 cp/ml). Up until now, all were still retained in care. Patient satisfaction scores were high.

Conclusion Use of the SDM tool led to a high uptake of same-day ART and rapid initiation of ART. Viral suppression was also observed early in the treatment course.

168 - Pragmatic RCT protocol for evaluating an online training program on shared decision-making about screening for Down syndrome

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BACKGROUND AND AIMS: Pregnant women have difficulty choosing among the wide variety of prenatal screening options available. To help pregnant women and their partners make informed decisions based on their values, needs and preferences, we developed a decision aid and an online shared decision-making (SDM) training program for health professionals on the use of this tool. The decision aid was found relevant and acceptable to pregnant women and their partners; but we know little about the relevance and acceptability of the online SDM training program to health professionals involved in prenatal care. We aim to assess their knowledge acquisition and their use of SDM after taking our online training program as well to assess the program's acceptability and perceived usefulness.

METHOD: This is a multi-centre, two-arm, clustered randomized trial (cRT). We will recruit health professionals (obstetrician-gynecologists, physicians, midwives, nurses) from the province of Quebec. They will be randomly allocated to either an experimental group that is exposed to our online training program or to a control group that is exposed to the online training program for the province's routine Trisomy 21 Prenatal Screening Program. In addition to sociodemographic questions, we will ask about 1) knowledge acquired, 2) intention to use this knowledge in their clinical practice, 3) satisfaction with the training, 4) acceptability of the training, 5) perceived usefulness of the training and 6) their overall reaction to the training. Knowledge will be pre- and post-tested in both the intervention and the control groups (n = 36).

RESULTS: This study is ongoing and results will be updated.

CONCLUSION: Study results will inform us about the relevance and acceptability of our online SDM training program for health professionals involved in prenatal care and help us plan the dissemination of the program.

169 - Process evaluation of the Bridging the Age Gap in Breast Cancer decision support intervention cluster randomised trial

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Background

A UK-wide cluster randomised trial sought to test two “complex” decision-support interventions (DESI) for older patients with breast cancer facing a treatment choice of:

The DESIs each consist of an online decision tool, a brief decision aid and a booklet. A process evaluation was undertaken to identify how the interventions worked and aid interpretation of the trial results. **The primary aims** of the evaluation were to understand how the DESIs were implemented, the barriers and facilitators, and how acceptable and useful they were to staff and patients.

Methods

Multiple methods of data collection were used: questionnaires, interviews, case report forms and audio-recording of consultations. Of 46 trial recruiting sites, 16 were included in the process evaluation. Analyses were conducted to assess “dose”, “reach”, “fidelity” and “adaptation” of the interventions. Interviews were analysed using a framework approach and numeric data were analysed using SPSS.

Results

The main trial included 1321 participants. Of the 176 participants from process evaluation sites who were invited to participate 77 provided data. Ten healthcare professionals took part in a telephone interview and seven in audio-recorded consultations. The online decision tool was used by surgeons in a personalised way for the patient and their own practice, and provided structure to guide treatment options. The booklets were introduced predominantly by nursing staff, with the brief decision aid used as a summary sheet rather than to stimulate discussion as intended. The information provided encouraged more active involvement in decision making. Barriers to implementation included seeing the DESIs as time consuming as well as logistical problems e.g. access to computers.

Discussion

Patient and healthcare professional feedback on the tools was positive but utilisation was variable both between centres and healthcare professionals. DESI impact was limited by other information materials commonly provided to patients, time available and information technology constraints.

170 - Development of a brief decision aid for aspirin as a preventative strategy alongside bowel cancer screening in Wales (UK)

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Background and aims: Bowel cancer screening using faecal occult blood testing leads to a reduction in bowel cancer deaths by approximately 16%. A strategy for reducing bowel cancer incidence is regular low-dose aspirin (therapeutic prevention), which is supported by clinical evidence. However, this is not currently recommended in the UK. Combining the two strategies, bowel cancer screening and aspirin, may bring additional benefits, compared with either alone. This study aims to develop an acceptable decision aid that includes tailored risk communication, ensuring that decision-making is informed and aligned to individuals' values. In the future, low-dose aspirin could be offered alongside the bowel screening programme in the UK.

Methods: Three phases of work develop and examine the acceptability, feasibility and implementation of a brief decision aid for preventive low-dose aspirin use alongside the current UK bowel screening programme.

- 1) Summarise the clinical evidence in a scientific reference group (Dec 2018), and explore bowel screening responders' and stakeholders' perceptions of low-dose aspirin use in three focus groups (Jan 2019).
- 2) Integrate information needs, addressed in the focus groups, with clinical evidence, to develop a prototype decision aid that aims to help people decide whether or not to take low-dose aspirin as a preventive strategy for bowel cancer alongside bowel screening.
- 3) Gain feedback on the brief decision aid through interviews with people who have previously participated in bowel screening (n=10-15) (April 2019).

Results: The key outcome of this study will be a needs-led decision aid, presenting the benefits and risks of aspirin as a preventive strategy for bowel cancer, with a suggested pathway for implementation integrated with the bowel screening programme. This study is ongoing and results will be available for conference presentation (July 2019).

Conclusions: This study will develop a patient-focused decision aid for members of the public who are eligible for bowel cancer screening in the UK. The decision aid will support decision-making about whether or not to take low-dose aspirin to reduce bowel cancer risk alongside the bowel screening programme. This development work is necessary for future evaluation of a combined risk-reduction strategy for bowel cancer.

171 - Développement de compétences réflexives chez les étudiants en médecine : conception, mise en œuvre et évaluation d'une intervention pédagogique fondée sur la participation de patients-formateurs (Protocole de recherche)

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Depuis quelques décennies, un changement de paradigme favorable à l'adoption d'une posture de partenariat avec le patient s'opère à différents niveaux du système de santé. Le nouveau paradigme, reconnaissant la valeur des savoirs expérientiels du patient et sa place centrale dans l'équipe de soin, propose aussi d'accorder un plus grand rôle aux patients dans l'enseignement en santé. Ce projet veut comprendre, en contexte québécois, les effets de l'expérience d'apprentissage enrichie de la collaboration du patient sur le développement, chez les futurs médecins, de compétences réflexives.

Le projet comporte 3 étapes :

(1) Le co-développement de l'intervention par un comité de pilotage regroupant responsables du cours, patients, étudiants et chercheurs.

(2) L'implantation de l'intervention assurant l'implication de patients-formateurs auprès de deux cohortes consécutives d'étudiants du cours du doctorat de premier cycle en médecine à l'Université Laval MED-1210.

(3) L'évaluation (d'implantation et des effets) de l'intervention reposant sur :

(a) L'analyse d'implantation fondée sur l'observation du déroulement des cours ainsi que sur des entrevues individuelles avec diverses parties prenantes.

(b) L'évaluation des effets de l'intervention sur les compétences réflexives *via* un devis expérimental randomisé avant-après avec groupe témoin. Des questionnaires basés sur l'échelle validée « Self-Reflection and Insight Scale » seront auto administrés aux étudiants des groupes expérimentaux et témoins d'une même cohorte en début et fin de session. Ce volet sera enrichi par la tenue de groupes de discussion formés d'étudiants.

La participation des patients est prévue à toutes les étapes de la recherche.

Ce projet innove en impliquant activement des patients sur la base de l'apprentissage réflexif en éducation médicale au Québec. Il contribuera à investiguer les déterminants de l'efficacité de l'implication des patients dans la formation médicale et à comprendre ses effets sur l'acquisition de compétences réflexives. À terme, les résultats pourront mener les décideurs institutionnels à mieux saisir les avantages de l'implication active des patients dans la formation. Ainsi sera favorisée la structuration d'une expérience d'apprentissage réflexive, disposant les apprenants à collaborer efficacement avec les patients dans leur future pratique. La démarche proposée pourra éventuellement être systématisée, élargie, adaptée et transférée à d'autres programmes de formation en santé.

173 - A discourse analysis of definitions of shared decision making

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Introduction and Objectives

Shared decision making as a practice is not consistently defined. Borrowing from Halliday his basic model of representing reality, rendered by reference to a participant (normally rendered by nouns or pronouns), the process ascribed to the participant (normally rendered by a verb), and circumstances in which it happens, we assume a representation of SDM:

Persons – communicate – in circumstances

We assume that SDM, at its highest level, involves acts of communication between people with equal communicative rights. We want to use our 'model' as a lens through which to look at the definitions and the extent to which the model is represented in them.

Methods

We searched the string "definition shared decision making" in Google Scholar and in Pubmed; the search was conducted in August, 2018. The first 10 articles from Google Scholar were read to look for definitions of shared decision making. The results from Pubmed were sorted using the Best Match short order, and then read for explicit definitions of SDM. Definitions were collected from sources in which an explicit definition was presented or quoted, not referenced; meta-analyses and literature reviews were excluded.

Results

Our search found clinicians constructed as active, while patients were passive. While SDM is explicitly constructed as a process between partners, the definitions suggest SDM to be the clinician's gift over which they have full power.

The definitions construct an asymmetrical relationship in which only one party seems to speak. Such phrases as:

make health care decisions; take into account patient's values goals, and preferences; establish conducive atmosphere

render the clinicians as participants having the power to take health care decisions, while the patients are those whose view are only to be taken into account.

Conclusions

The reality constructed by these SDM definitions is underpinned by a paternalistic view of medicine: the physician communicates, while the patient listens.

An alternative definition might be conceptualised in terms of the multistage consultation process suggested in the three-talk model approach, constructed through references to joint activity via sentences in active voice.

177 - Patients' Opinions on Patient Decision Aids for Carpal Tunnel Syndrome in a District Hospital in Southern Taiwan

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Background and objectives: The prevalence rate of carpal tunnel syndrome (CTS) in Taiwan is approximately 5%. When making medical decisions for CTS, shared decision making tools can be used to compare the advantages and disadvantages of various treatment methods. Accordingly, the objective of this study was to investigate patients' opinions on patient decision aids for CTS by conducting clinical survey.

Methods: The research participants comprised patients with CTS who received treatment in the rehabilitation department. Effectiveness assessment questionnaire was used to survey the patients' opinions of patient decision aids; the 5-point Likert scale was used for scoring.

Results: A total of 15 patients participated in the survey, consisting of nine men and six women. The majority of the patients were aged between 40 and 49. Patients who regarded that the aids can facilitate their decision making obtained a score of 4.31. Those who believed that the aids can help them consider the advantages and disadvantages of the treatment received a score of 4.43, and those who deemed that the aids can assist with question clarification received the same score. Patients who thought the aids can help them express their concerned problems to medical personnel obtained a score of 3.58. The level of concern about disease prognosis before the use of the patient decision aids was 4.3, which reduced to 1.8 after the use of the aids.

Conclusion: After the clinical patients adopted the patient decision aids, the results showed that a comprehensive disease introduction at the beginning and an explanation of subsequent treatment steps, the merits and shortcomings of the treatment, and the potential risks involved can substantially reduce patients' senses of unsafety and uncertainty toward the treatment. However, the patients had relatively low satisfaction with the aids in the aspect of "expressing their concerned problems to medical personnel;" therefore, further studies should be conducted to determine whether the patient decision aids is applicable to improving this concern.

179 - Implementation of decision aids in patients with gallstones or inguinal hernia is associated with reduced operation rates and high patient satisfaction

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Background

Gallbladder removal and inguinal hernia repair are the most commonly performed surgical procedures worldwide. For both operations, it is important to include patients' perspective in the decision making process, as watchful waiting is an accepted alternative in selected patients. The aim of this study was to evaluate operation rates before and after implementation of decision aids (DA's) and to assess patient compliance with the use of DA's and satisfaction with final treatment.

Methods

A single centre retrospective study was performed, including all patients ≥ 18 years referred to the surgical outpatient clinic with symptomatic gallstones or an inguinal hernia between January 2014 and December 2017. Operation rates before and after the implementation of DA's (December 2015) were compared mutually and to nationwide operation rates. In addition, patient compliance with the use of DA's, satisfaction with final treatment and persistent pain were assessed.

Results

Overall, 1,945 patients with gallstones and 1,845 patients with an inguinal hernia were included. Before implementation the gallbladder removal rate was 76.1% and the hernia repair rate was 78.4%. After implementation operation rates decreased to 64.6% and 65.4% respectively (both $p < 0.001$). Both operation rates decreased below the nationwide average (both $p < 0.05$). DA's were provided to 512 patients (63.1%) with gallstones of whom 80.7% (413/512) used the DA. Fifty-nine percent of the inguinal hernia patients ($n=528$) received a DA, which was used by 80.7% (426/528). Patient satisfaction with final treatment was high (9/10) and reported persistent pain was low (16.4% of patients with gallstones and 10.0% of patients with inguinal hernia repair).

Conclusion

Implementation of DA's in the surgical outpatient clinic for patients with gallstones or an inguinal hernia results in reduced operation rates and is associated with high DA compliance, high patient satisfaction and low rates of persistent pain.

182 - How prognostic are patient treatment preferences and personal values assessed in an online decision for treatment in patients with an inguinal hernia?

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Background

Shared decision making, facilitated by decision aids, is indicated for inguinal hernia repair as watchful waiting is an accepted alternative in selected patients. We aimed to assess the prognostic value of patients' treatment preferences and personal values in an online decision aid for the performed treatment.

Methods

A single centre retrospective study was performed. All patients >18 years with an inguinal hernia who filled out the decision aid between December 2015 and August 2018, were included. The decision aid was provided after the first consultation with the surgeon, but before the decision consultation. In this decision aid a value clarification exercise is carried out, asking the patient to consider which benefits and risks (*(not)much discomfort, (not)concerned about surgery, (not)concerned about incarceration, (not)concerned about surgical complications*) matter most to them. Secondly, the patient pointed out their preferred treatment classified as watchful waiting, no preference or surgery. We performed regression analysis to associate the preferred treatment and personal values with surgical treatment.

Results

In total, 585 patients (age 60, 92.1% male) were included, 452 patients (77.3%) preferred surgery, 56 patients (9.6%) had no preference, and 77 patients (13.2%) preferred watchful waiting. In total, 438 patients (74.9%) underwent surgery, and 147 patients (25.1%) were treated conservatively. The treatment preference of patients corresponded in 87.4% of patients (n=395) and 77.9% of patients (n=60) with performed treatment for respectively surgery and watchful waiting. In univariate analyses much discomfort, not concerned about surgery, lower age, and preferring surgery were significantly associated with a surgical treatment. In multivariate analysis only preferring surgery (OR 5.169 95%CI: 2.514-10.626) was an independently prognostic factor for a surgical treatment.

Conclusion

Inguinal hernia patients' treatment preference assessed in a decision aid corresponds in approximately 80% with performed treatment. Patients' treatment preference is the only independent prognostic factor for surgical treatment compared to age, discomfort, concerned about surgery or incarceration.

183 - How to make multidisciplinary team meetings in cancer care more patient-centered? Recommendations from a narrative review

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Background and aims: In multidisciplinary team meetings (MDTMs, also called tumor boards) physicians with different specializations and sometimes other health care providers come together to discuss and recommend paths of treatment for a specific patient. MDTMs are considered best practice in cancer care. However, MDTMs have been found to mostly discuss medical information and pay little attention to the patient's perspective and psychosocial situation. Hence, the current organization of MDTMs has been argued to not support patient centered-care and shared decision-making (SDM). Thus, this review aimed to identify recommendations for MDTMs to become more patient-centered and enable SDM.

Methods: A narrative review of existing literature recommending strategies to foster interdisciplinary communication and patient-centeredness in MDTMs was conducted. Two researchers with ample experience in SDM research in cancer care, who previously conducted observational studies in MDTMs, reviewed the literature. The two researchers structured extracted recommendations in order to function as the basis for an implementation strategy to foster SDM in cancer care. Then, the recommendations were discussed with clinical cooperation partners at a comprehensive cancer center in Germany.

Results: We extracted recommendations from 30 publications, which included original research and reviews as well as opinion pieces. This led to 13 recommendations regarding the following areas: 1) routine pathways and quality management standards (e.g., consistent denomination as MDTM recommendation instead of decision); 2) participants (e.g., discussion of a case only if at least one MDTM participant has met the patient); 3) information discussed during MDTMs (e.g., documentation of more than one possible treatment, if uncertainty exists during meeting); and 4) tasks of the MDTM coordinator/chair (e.g., communication and leadership training for MDTM chairs). After discussion with clinical cooperation partners, changes in the setting emerged as a fifth area for change (e.g., changing the seating arrangement into a u-shape).

Conclusion: Since MDTMs in their current organization do not foster patient-centered care and SDM, recommendations for changes towards more patient-centeredness and SDM in MDTMs were reviewed and consolidated. Those recommendations can be used to inform implementation effort to foster patient-centered MDTMs and SDM in cancer care.

184 - Cancer patients' preferred and perceived roles in decision-making in a representative German sample

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Background and aims: Shared decision-making is especially relevant in cancer care. Previous studies focused on single cancer entities and/or used small samples to gain insight into treatment decision-making processes in oncology. The aim of this study was to analyze the preferred and perceived levels of involvement of patients in treatment decision-making from the patients' perspective in a large-scale and representative sample of German patients with various cancer diagnoses.

Methods: We conducted a multicenter, epidemiological cross-sectional study with a proportional stratified random sample based on the nationwide incidence of all cancer diagnoses in Germany. Patients from acute care hospitals, outpatient cancer care facilities, and cancer rehabilitation clinics in five regions in Germany were included in a consecutive sample of adult cancer patients across all cancer entities and disease stages. The study at hand reports a secondary analysis using the Control Preferences Scale (CPS) assessing the preferred level of involvement in decision-making and the 9-item Shared Decision-Making Questionnaire (SDM-Q-9) assessing the perceived level of involvement as outcomes.

Results: 4,020 patients (mean age of 58 years, 51% female) completed the self-report questionnaire. About a third each preferred patient-led, shared, or physician-led decision-making, respectively. 50.7% perceived high levels of shared-decision-making, and about a quarter each reported moderate (26.0%) or low (24.3%) levels of shared decision-making. Of those patients who preferred shared decision-making, about 50% perceived high levels of shared decision-making. Sex, age, relationship status, education, occupational status, health care setting, and tumor entity were linked to preferred and/or perceived decision-making.

Conclusion: The majority of patients with cancer wanted some level of involvement in decision-making. Many patients reported having perceived a high level of shared-decision making. However, there is a considerable proportion of cancer patients that did not perceive their preferred level of involvement. This large-scale epidemiological study provides a solid basis for implementation efforts to improve shared decision-making in German cancer care.

188 - Wiki Head CT Choice study: adaptation of two decision aids to support shared decision making about performing a head CT for adult and pediatric victims of mild traumatic brain injury

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Background/objectives: Minor traumatic brain injury (mTBI) is among the most common neurological conditions with an estimated annual incidence between 450 and 650/100,000 in Canada. This leads to frequent consultations in primary care and Emergency Departments (EDs). Despite the use of clinical decision rules (Canadian Head CT Rule and Pediatric Head Injury/Trauma Algorithm (PECARN)), head CTs remain overused in mTBI. Our objective was to adapt two decision aids (DAs) (pediatric and adult) developed in the United States to the Québec context. **Methods:** Six phases were planned with a focus on user-centered design: (1) Consensus meeting using nominal group technique with experts in shared decision making, decision makers and patients representatives on what should be changed in the DAs to adapt them to the Canadian context. Proposed adaptations were analysed using thematic analysis, (2) ethnographic observation of interactions between emergency health professionals and mTBI patients to understand the needs of patients, family members and health professionals in deciding to order a head CT, (3) presentation of tools to emergency physicians from two EDs for feedback, (4) interviews with patients for feedback and (5) usability testing using a think aloud method in real life clinical encounters. **Results:** (1) Participants came to a consensus on the adaptations to be included in a Canadian version of the two DAs. Results from our thematic analysis showed that the tools should target the right population, risk communication needs to be improved and there is a need to clarify wording. These results from our consensus meeting and others from our ethnographic observations, helped us adapt the two DAs. These prototypes were then presented to physicians in two emergency departments (n≈40) for feedback. Results suggest that not all emergency physicians perceive the need to use this tool and some are reluctant to use DAs because it could make medical encounters more complex and could provoke anxiety for some patients. **Conclusion:** Feedback from experts, patients and physicians suggest we improve risk communication. Design and appearance of our prototypes were not an issue but the need for tools to avoid CTs overuse in Québec's emergencies is not unanimous for physicians.

189 - Triggering Advance Care Planning in Inpatient Oncology

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Background: In cancer patients, goals of care discussions tend to occur in the last few months of life. The literature highlights that while patients want to be involved in decision-making, they want providers to initiate these discussions. A systematic method that identifies seriously ill patients early in their admission may encourage consistent advanced care planning (ACP), shared decision-making, and improve access to palliative care.

Research Objectives: To promote earlier ACP discussions and shared decision-making through standardization of: 1) triggers for ACP for hospitalized patients with advanced cancer; and 2) ACP documentation in the Electronic Medical Record (EMR).

Methods: A novel Severity of Illness (SOI) tool was created. ACP and/or palliative care consults were indicated within 72 hours for those who scored 4 or greater on the SOI. All patients admitted to the hematology-oncology (hem/onc) service over a 6-months period were scored during multi-disciplinary rounds; residents were prompted regarding the proposed interventions when applicable. Retrospective chart reviews determined completion of the proposed interventions. Hem/onc attending physicians were surveyed regarding their perception of ACP.

Results: 352 patients admitted to the hem/onc inpatient service were scored using the SOI tool. 111 (31.53 %) of these patients received a score of 4 or greater; 53 (47.74%) of this group received a palliative care consult and/or ACP. While all survey respondents felt that ACP was an important part of patient care, 33% indicated provider discomfort with ACP and 63% believed an electronic trigger would be helpful in prompting initiation of ACP.

Conclusions: While the SOI tool appears to have increased ACP, it alone did not translate into consistent application of interventions. Barriers included providers' discomfort in initiating ACP, and inconsistent use of the ACP documentation template, creating ambiguity regarding previously held discussions and patient goals.

Implications: This highlights the need to formalize the use of the SOI tool to prompt initiation of shared decision-making processes. There is a need for broader provider education about ACP. This research has the potential to improve the quality of care seriously ill cancer patients receive through earlier identification of patients that would benefit from ACP and palliative care involvement.

190 - The Anatomy of Difficult Decisions: An Activity-Theory View of Decision Making for Physicians Treating Children with Medical Complexity

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Background and aims: The decision making surrounding the care of individuals with chronic conditions such as for children with medical complexity (CMC) is a complex process involving people, evidence and tools working within a system of intersecting rules and conventions. Activity Theory (AT) is a cross-disciplinary framework for studying different forms of human practices as developmental processes, with both individual and social levels interlinked at the same time. Application of AT may provide novel insights into decision-making of physicians caring for CMC. The aim of the study was to apply AT to reveal what elements comprise the activity of making complex decisions and identify areas for improvement, which may support the development of future interventions for improving the decision making process.

Methods: This study consisted of interviews, based on a Critical Decision Method (CDM) storytelling methodology, with 11 physicians who treat CMC. Taking a framework analysis approach, interview transcripts were analyzed by mapping their contents to the elements of AT. Analysis was focused on identifying the goals of decision making (objective), sources of information used to inform decision making (tools), people involved in the process (community), roles each member undertakes (division of labour), the norms and conventions governing the system (rules) and identifying “growth points”, which are areas for improvement and potential scope of future interventions.

Results: Our study found that the rules, tools, division of labour, community and object categories of the activity system comprised of numerous, often conflicting, elements. When viewed together as an activity system it highlights the competing aims physicians encounter with making a complicated decision and maps them back to the influences, which we identified as hospital rules, competing norms and the effect of mediating tools.

Conclusion: Our findings demonstrate that the activity of making a decision, is not limited to access to evidence or tools, but is a complex process that must take into consideration systemic rules, personal beliefs and an understanding of people’s roles in the activity.

193 - Contraceptive method choice decisional needs assessment of Chinese women living in Australia: A qualitative study

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Background: Decisions about contraceptive methods are preference sensitive and ideal for shared decision-making (SDM). Migrant and refugee women are vulnerable in terms of accessing evidence-based and culturally and linguistically sensitive contraception information and services. In Australia, Chinese is one of the largest, youngest and fastest growing overseas-born groups. Yet, less is known about their decision-making needs when faced with choosing a contraceptive method.

Aim: Explore Chinese women's information, communication and support needs when choosing contraceptive methods.

Methods: We conducted semi-structured in-depth interviews with 22 women from Chinese background, aged between 18 and 45 and who had been living in Australia for no more than 10 years. The sample consisted of international students and immigrants with a variety of relationship status. We adapted our interview guide from the Ottawa Decision Support Framework. Interview audio-recordings were transcribed verbatim and will be analysed using thematic analysis approach.

Results: This study is ongoing, and results will be updated. Overall, condom and withdrawal methods were commonly known and used by Chinese women because of their convenience, easy access and also because of Chinese women's lack of knowledge about other available methods. There is a lack of awareness of the role of general practitioners and other healthcare providers role in assisting the decision-making about contraceptive methods. There is also a reluctance to accept hormonal contraceptive methods due to fear of side effects, such as reduced menstrual bleeding, pain, weight gain and effect on future fertility. Participated indicated relying on information from Chinese websites from China or Chinese social media platforms or friends. Some women who've sought medical advice from doctors expressed feelings of not being well informed about side-side effects, which contributed to them discontinuing the chosen method.

Conclusions: The study results highlight the need for improved, linguistically and culturally appropriate contraceptive method decision support strategies for Chinese women. Use of Chinese language decision aid tools along with preferences, concerns and values clarification exercises are likely to be useful.

194 - Contraceptive choice decisional needs assessment of Chinese women living in Australia: a qualitative study of healthcare professionals' views

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Background: Decisions about contraceptive methods are preference sensitive and ideal for shared decision-making (SDM). Migrant and refugee women are vulnerable in terms of accessing evidence-based and culturally and linguistically sensitive contraception information and services. In Australia, Chinese is one of the largest, youngest and fastest growing overseas-born groups. Yet, less is known about their decision-making needs when faced with choosing a contraceptive method.

Aim: Explore healthcare providers' perception on Chinese women's information, communication and support needs when choosing contraceptive methods. It also aims to explore healthcare providers' own in supporting Chinese women's decision making about contraceptive methods.

Methods: We conducted semi-structured in-depth interviews with 20 healthcare providers, including general practitioners, specialised sexual and reproductive health doctors and nurses, who had substantial experience in providing contraceptive services to women from Chinese background. We adapted our interview guide from the Ottawa Decision Support Framework. We will take thematic analysis approach to analyse the interview transcripts.

Results: This study is ongoing, and results will be updated. Overall, healthcare providers highlighted the opportunistic nature of the consultations regarding contraception with Chinese patients. They observed a preference for contraceptive methods that do not involve hormones among Chinese patients due to fear of hormonal side effects. They noted language being the major barrier to effective communication and as well as cultural barriers where Chinese women can be reluctant to discuss contraception.

Conclusions: The study results highlight the need for improved, linguistically and culturally appropriate contraceptive method decision support strategies for Chinese women. Future interventions could benefit from providing orientation to Australian healthcare systems, including the role of general practitioners and specialised sexual and reproductive health services, to recent arrivals from Chinese background. Also, there is a need to for Chinese language contraceptive choice decision aid tools which address contraceptive method attributes that Chinese women concerned about and there is also a need for a culturally sensitive communication guide for healthcare providers to open-up and guide the conversation with Chinese women when discussing contraceptive methods.

197 - Healthy Volunteers Role-play Helped Training of Patient Decision Aids (PDAs) Implementation in the Simulation of Shared Decision Making (SDM)

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Background and aim

Shared decision making is a new concept that the healthcare system in Taiwan has adopted since 2016. Patient engagement is a central part of designing and implementation of patient decision aids. Role-play is a method of simulation used commonly to teach communication skills. While recruiting real patients with specific health conditions are difficult, we invited healthy volunteers to participate as sim-patients in the SDM simulation training program in our hospital.

Methods

Thirty medical teams implemented department-based designed PDAs in 40-minutes simulation in OSCE center in August 2018. Volunteers were recruited and trained by a short curriculum of SDM. Volunteers were asked to role-play in the simulated clinical encounters of PDAs designed for, and the PDA topics were assigned based on their favor and life experiences. Questionnaires evaluated health literacy and collected the feedback to PDAs and the process of SDM of the volunteers. The anxiety of the volunteers to the PDA topics was assessed pre- and post-simulation. The performance of medical teams was rated by measurement adopted from Observer Option 5 Measure.

Summary of Results

Twelve healthy volunteers participated in the department-based simulation activities. Item 1 (alternate options) had the highest average score, while item 5 (integrating preference) had the lowest. Item 1 also had the highest rate of teams reached 7.5 indicating skilled effort in the simulation, while item 5 also had the lowest. Although the volunteers were sim-patients, the PDAs reduced their anxiety about the specific topics in the simulation. The average of satisfactory scores to PDAs and the SDM process were both high, regardless of the performance scores of the teams. The content of PDAs and the skills performing SDM by teams of different departments could be examined by adopted measurement efficiently in volunteer role-playing simulation.

Conclusion

The engagement of healthy volunteers by role-playing in the simulation of department-based clinical encounters with adequate assessment helped to identify the skills of medical teams and the fitness of content of PDAs in SDM.

199 - Increasing Percutaneous Endoscopic Gastrostomy (PEG) usage among oral surgery patients by Shared Decision-Making

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Background

PEG insertion remains useful in supporting nutritional needs for oral surgery patients but should only be performed when a need is certain and its usage is likely to exceed three weeks duration. Almost 25 percent patients (23/92) with oral surgery in our study could have had their nutrition needs met by a feeding tube over one month, however no patients acquired enough information could self-determined nasogastric tube or PEG during the period from January 1, 2017 to December 31, 2017 in a district hospital of southern Taiwan. In the patient-centered care, an individual's specific health needs, it was treating the person receiving the care in the way they want through Shared Decision-Making.

Purpose

The purpose of this study was to investigate the PEG usage by Shared Decision-Making process for patients with oral surgery.

Method

A quasi-experimental study implemented three steps as following: (a) To conduct a multidisciplinary team working; (b) Patient's needs assessment ; (c) To develop evidence-based Patient Decision Aids and carry out α and β test; (d) Apply and evaluate in clinical practice. Analysis of the data was carried out after collection of all information.

Setting and Participants

The participants who need tube feeding for one month with oral surgery were purposively selected from a district hospital of southern Taiwan. A total of seven patients who received oral surgery included in this study.

Results

There were two major findings of this study. First, we conducted the multidisciplinary team include doctors, clinical specialist to participated Shared Decision-Making process. Second, the findings showed all patients could self-determine their feeding tube, 14.3 % (1/7) of the patients chose nasogastric tube feeding, 85.7 % (6/7) of the patients chose through Shared Decision-Making. In addition, the mean length of placement, a feeding tube was 10.9 days fell to 4.6 days, physical restraint rate decreased from 63.0% to 15.4%, and the mean length of hospital stay decreased from 13.2 days to 9.4 days.

Conclusion

As the study result Shared Decision-Making can provide enough information to help patients understanding and self-determined suitable feeding tube after oral surgery. It achieved high-quality, efficient care for patients.

200 - The effectiveness of decision-making tools in the choosing of renal replacement therapies for end-stage renal disease patients

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Background

Patients with end-stage renal disease (ESRD) often suffer from emotional depression, helplessness and perplexity from decisional conflict between renal replacement therapies (RRT) when having to undergo long-term dialysis due to loss of kidney function.

Methods

From July to September 2017, according to the individualities of targeting patients in the fourth and fifth phases of ESRD, medical staff provided a variety tools to better assist the patients' medical decision-making processes. The tools include professional consultations, health promotion posters, flyers, simulation models, interactive videos, experience-sharing from other patients, and other diverse tools.

Results

A total of 19 patients were received, with a male-to-female ratio of 10:9, 74% of whom being under sixty years old, and 68% having received senior high-school or higher education. As shown from the survey results, the medical decision-making tools were able to help 84% of the patients make the most suitable medical choices. In addition, there are 79% of the patients have better understand the advantages and disadvantages of the various medical options; 84% of the patients learned the relevant knowledge of RPT; 89% of the patients acknowledged the effectiveness of the medical decision-making tools in access to information applicable to the medical decision making. Furthermore, the degree of anxiety in the face of current medical problems has improved with the use of medical decision-making tools.

Conclusion

Using medical decision-making tools with the three initial elements of knowledge, communication and respect, the patient-centered clinical procedures-- Shared Decision Making (SDM) is achieved. Subsequently, the medical staff and patients are able to reach consensus in clinical decision-making and support the patient in making the medical decision most suited to the patients' individuality through mutual engagement of the clinical specialists and patients in the medical care, while taking into account the results of current evidence-based practices, combined with the preferences and values of the patients, and decreasing patients' level of anxiety due to facing medical issues, all before making the medical decisions.

201 - Using Positive Feedbacks from Patients and Health Care Providers by Using Shared Decision-Making Model on Smoking Cessation

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Introduction

After advocating the sharing of medical treatments, the Medical Council will use the medical treatment sharing decision-making aid charts and using an appreciation's video to understand easily the advantages and disadvantages of cigarettes on physical harm and smoking cessation methods. Nicotine addiction, assist the case to participate in the smoking cessation team communication discussion, choose the most appropriate way to quit smoking; this is the purpose of the study.

Method

Fill in the questionnaires of the medical policy sharing decision-making to investigate the auxiliary effect, the feelings of medical staff and smoking cessation cases before and after using decision aids.

Result

The Decision Aids tool assists by making decisions through four steps to implement the feelings of the medical staff and smoking cessation cases. A total of 38 valid questionnaires were collected, including 8 medical staff and 30 smoking cessation cases. The questionnaire contains 11 questions, which are calculated using scales 0~4. The higher score will be the better benefit of using decision aids.

According to the results of the medical questionnaire analysis, it is found that it helps the case to understand and discuss and participate in decision-making. The results of the patient-based questionnaire analysis showed that the majority of people were male, with an average age of 40 to 49 years old, indicating that most of the co-decision-makers involved in smoking cessation medical treatment were followed by the children or their spouses. Using decision aids, the case is the most helpful in clarifying the level of involvement in the decision-making process and in clarifying physician issues.

Conclusions and recommendations

The theory of smoking cessation is similar to the principle of weight loss, and all need to be firm and persevering. Smoking behavior pattern belongs to learn; through the behavior Pattern the habits are developed. Using shared decision aids and shallow display some Easy-to-understand of videos deepen case impressions and work with smoking cessation teams. Participate in the discussion process and accompany the case to face the cessation of smoking, Let the case easily get rid of the ranks of addicts!

203 - Development and evaluation of a patient empowerment strategy to support shared decision-making in cancer care

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Background and aims:

Many cancer patients want active engagement in treatment decision-making. Strategies, which encourage patients to ask questions during clinical encounters, can strengthen their abilities to engage in the decision-making process. Ask 3 Questions was developed in Australia, and different versions were used in implementation programs around the globe. So far, Ask 3 Questions was not available in German. Thus, the aims of this study were to develop a German version of the strategy, to assess its feasibility and acceptance, and to evaluate its effects on question-asking of patients in routine cancer care.

Methods:

Seven English versions of the Ask 3 Questions strategy were translated into German following the translation protocol TRAPD (Translation, Review, Adjudication, Pretesting and Documentation). Comprehensibility and acceptance were tested via cognitive interviews with cancer patients (n=10). Feasibility of the German version will be assessed in focus groups with cancer patients, physicians, and nurses. Focus groups will be analyzed using qualitative content analysis. Additionally, effects of the intervention on patients' question-asking will be analyzed in audio-recordings of clinical encounters before and after implementation.

Preliminary results:

In cognitive interviews, cancer patients of different age (49.0 years \pm 11.27), gender (f=5, m=5), years with disease (4.8 years \pm 3.55), and health literacy levels participated. Comparison and testing of different versions of the three questions during cognitive interviews led to a revised version that was well understood and accepted by German cancer patients. So far, six focus groups with 42 participants have taken place and 72 audio-recordings were conducted. Results from the analyses of focus groups and audio-recordings will be presented at the conference.

Discussion:

This study provides a German version of the Ask 3 Questions strategy to be used in Germany. Preliminary results suggest that the Ask 3 Questions strategy could be a helpful instrument to empower patients in Germany to play an active role in the decision-making process. If evaluated positively in the following steps of this study, the German version of Ask 3 Questions could be used in various medical facilities, where patients have to make decisions regarding their health care.

213 - Advance care planning practices and billing habits of hospitalists: a multicenter qualitative study

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Background: Advance care planning (ACP) seeks to identify and document patients' goals, values, and preferences for their future medical care. By introducing ACP billing codes in 2016, the Centers for Medicare and Medicaid Services (CMS) sought to increase ACP among older adults. We explored facilitators of and barriers to ACP by hospitalists in a national acute-care physician practice with an ACP quality improvement (QI) initiative.

Methods: We conducted a qualitative analysis of semi-structured interviews with hospitalist chiefs from 158 U.S. hospitals. We purposively sampled chiefs from hospitals with high and low ACP billing rates in 2018 (billing rate calculated as the proportion of admissions over the age of 65 with at least one billing code (99497 [first 30 min]; 99498 [each additional 30 min]), adjusted for age, sex, DRG, and season). Hospitalist chiefs receive feedback on their team and individual provider rates monthly. Telephone interviews probed attitudes toward ACP and team norms. A multidisciplinary team thematically analyzed interview transcripts using the framework method.

Results: High-ACP billing hospitals (n=53) billed for 28.5% of admissions and low-ACP billing hospitals (n=52) billed for 3.7%. Among 4 high and 5 low billing site interviews completed to date, thematic differences between high and low ACP billing sites were: (1) the definition of ACP, (2) hospitalists' attitude toward ACP, (3) the presence of a clinical champion, and (4) team dynamics. Low-ACP sites' definitions of ACP were narrower and framed around code status, compared to high-ACP sites' longer conversations about broader end-of-life care needs. Low ACP-sites were less likely to identify a clinical champion for ACP and had higher turnover, documentation issues, and more locum providers. All sites reported the same barriers to ACP, such as time, documentation burden, compensation, patient preferences and the 16-minute time requirement to submit a bill.

Conclusions: In this sample of hospitalist chiefs from high and low-ACP sites in a national acute-care physician practice, differences in facilitators but not barriers explained differences in ACP billing rates. Differences in norms regarding the definition of ACP may be a fruitful target for interventions to increase ACP among hospitalized older adults.

215 - Shared-decision making tools to support collaborative deliberation in obesity management consultations: Exploring new processes

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New shared-decision making (SDM) tools are emerging to help patients and providers work together to uncover the unique patient circumstances, understand how they are affecting health, share information of value for each person, discuss possible alternatives, and determine what is best to address the health issues of this particular individual, in a specific socio-economic and emotional situation. The design of these new tools benefits from processes that constantly build understanding from reality. Being aware that reality is more complex than what one can conceive.

Obesity is a complex chronic disease. The complex pathophysiology of obesity, the socio-economic factors affecting health, and the need to understand the connection between all these aspects make the management of obesity challenging. To develop the new tools we used a participatory approach combining anthropology and human-centred design. The 5As Team Program (5AsT) conducted a qualitative study to better understand patient experience of obesity conversations in primary care.

Building upon this foundation, we used co-design, a process of engagement and participation, to develop four tools to help apply the best available evidence, while considering the patient's goals, needs, values, concerns; current mental, social, and physical health context; the patients journey with weight, their strengths and challenges during this journey, and their willingness and possibilities to create a personalized care plan. Once we arrived at a satisfactory toolkit prototype, we observed encounters to evaluate the tools' performance.

We observed that the tools create a common territory anchoring the conversation. The tools permit participants to focus not only on listening but also on shared understanding. They guide not only identification, but interpretation. The tools help to document, to choose and prioritize, to explore, to re-focus, to decide and to plan.

Design processes for shared decision-making tools cannot be prescriptive, they need to be designed depending on the context of applicability: certain groups of people, performing certain tasks, within a given setting, to achieve a certain goal.

Adopting co-design processes that build on understanding, learning, and discovering the needs of clinicians and patients navigating complex clinical situations is essential to support collaborative deliberation in obesity management consultations.

218 - Presenting time-based risks of stroke and death for patients facing carotid stenosis treatment options: patients prefer pie charts over icon arrays

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Background: The data is inconsistent, but there is evidence to support the use of icon arrays (as opposed to other graphical display formats like bar, line, and pie charts) to present time-dependent risk information to patients who may wish to make a preference-sensitive treatment decision (i.e. patients with carotid artery stenosis). However, it is unclear which format is *preferred* by patients weighing the risk of stroke or death.

Aim: To user-test graphical display formats in order to identify the preferred format to display time-dependent risk of stroke or death for the three treatments for carotid stenosis - carotid endarterectomy (CEA), carotid artery stenting (CAS), and medical therapy.

Methods: We conducted semi-structured interviews with patients diagnosed with carotid artery stenosis at an academic medical center. Patients provided feedback on factors that could influence preference for formats: the metric used to convey risk data (probabilities versus proportions), the timeframes (risk was presented in increments from 1 month to 5 years post-intervention), labels, and colors. We performed a thematic qualitative analysis, and based on feedback, we changed the formats at each iteration.

Results: A total of 27 patients (12 male and 15 female) were interviewed over four iterations. Of the 27 patients, 17 needed to decide between surgery and medication, and 10 had already undergone a procedure on the carotid artery. The time-series based icon arrays were consistently viewed as being visually confusing and were therefore dropped for the final iteration of interviews in favor of a line chart and bar chart. Out of the four graphical display formats presented, the pie charts were the preferred format to illustrate that the risk of stroke and death increases over time.

Conclusions: We were expecting to confirm the use of icon arrays, but we found that patients strongly preferred the use of pie charts to represent the change in risk over time.

Further investigation is needed using a diverse sample of patients to establish formats that are preferred and can help patients understand time-dependent risk information for different treatment options.

219 - Multi-component implementation of shared decision making (SDM) for uterine fibroids across socioeconomic strata (UPFRONT): a study protocol

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Background: Uterine fibroids are non-cancerous overgrowths of smooth muscle in the uterus. Approximately 50% of women of reproductive age have fibroids. At least half of those women have significant symptoms such as heavy menstrual bleeding, pelvic pain, discomfort during sexual intercourse, or difficulty becoming pregnant. Multiple treatment options are available; decisions are sensitive to individual preferences. Encounter patient decision aids (ePDAs), designed for use in clinical encounters, can facilitate shared decision making (SDM). Despite widespread patient and clinician interest in SDM, implementation of ePDAs in routine care remains difficult.

Aim: We aim to develop and implement uterine fibroids Option Grid™ PDAs (available in multiple formats: text, pictures, and online) to facilitate SDM at five clinical sites across the United States.

Methods: We will conduct a stepped-wedge multi-component SDM implementation strategy guided by the Consolidated Framework for Implementation Research (CFIR) and the Normalization Process Theory (NPT). The strategy includes: (1) assessment of organizational readiness for SDM using a team-based survey to develop a tailored strategy at each site addressing potential organizational barriers to implementation; (2) online or in-person introduction to SDM and the Option Grid tools; (3) clinician access to multiple formats of Option Grid ePDAs including text and picture-based versions (English and Spanish), online, and site specific Epic electronic health record integration of the online tool - clinicians will be asked to use the Option Grid during the clinical encounter; and (4) the integration of a suggested SDM approach and new evidence into existing clinical practice guidelines.

Outcomes: To assess exposure to the intervention, we will calculate the proportion of eligible patients reporting exposure to Option Grids (primary outcome measure). Secondary outcome measures will be assessed via survey and include patient-reported experience of clinician effort to achieve SDM, the proportion of intended/selected treatments reported as accomplished, patient-reported uterine fibroids symptoms, patient financial stress and total healthcare utilization. Surveys and interviews with staff (i.e. administrators, clinicians, nurses, etc.) at each site will assess the extent to which the intervention is used as intended and document adaptations to access, workflow or documentation requirements needed for sustained use.

222 - Effects of extended scope of practice in family physicians: a rapid review involving knowledge users

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Background: Family physicians play an important role in healthcare systems. Their scope of practice could range from clinical activities in primary care to the ones in hospitals (e.g., emergency, obstetrical care). However, the synthesis of evidence on the benefits of scope of practice in family physicians has not yet been explored.

Methods: We performed a rapid literature review of peer-reviewed studies that met the following criteria: *Population:* family physicians; *Intervention/Exposure:* Scope of practice defined as an extension of family physicians' activities in two or more of fields mentioned above. *Comparator:* another level of the scope of practice; *Outcome:* any outcome related to the family physician (performance, psychosocial outcomes, clinical status); *Study design:* experimental and observational studies. Three bibliographic databases were consulted from January 1966 to August 2018. Since this review aimed to inform health system managers, we have restricted the results over the past five years.

Results: Four studies, including three cross-sectional and one cohort study, were selected for a total of 13,205 participants. The methodological quality of the studies was generally acceptable. The ability of family physicians to place or remove intrauterine devices or long-acting contraceptive devices appears to be enhanced by a scope of practice including prenatal care with or without delivery (Odds Ratio (OR): 3.37 95%CI[1.99 ; 5.69]), and the insertion or removal of implants (OR : 9.04 95%IC [5.93; 13.43]). Similarly, a broad scope of practice for family physicians appears to have a protective effect on the occurrence of burnout when the practice includes hospital medicine (OR: 0.70 95%CI [0.56; 0.87]) or obstetrical care (OR: 0.64 95%CI 95 [0.47; 0.88]). In contrast, working in both a hospital and primary care compared to working only in primary care did not appear to influence the quality of antibiotic prescribing among family physicians (OR: 0.76 95%CI [0.39; 1.49]).

Conclusion: This review based on studies conducted over the past five years found that there are many definitions of the scope of practice around clinical activities and some characteristics of clinical practice settings. The majority of the associations studied support the encouragement of a broad scope of practice among family physicians.

223 - Amputation Shared Decision-Making Patient Decision Aid for Bone Cancer in the Lower Extremity: Which Option is Best for My Child - Amputation, Rotationplasty, or Limb Salvage Surgery?

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Background and Aims

Osteosarcoma is primarily a pediatric cancer diagnosis with bony tumors occurring around the knee joint during periods of rapid bone growth. While a standard of chemotherapy is required for survival, there is no single objective choice for local control that increases those odds. Three surgical options include amputation, limb salvage surgery, or rotationplasty in which the foot and ankle are amputated and rotated 180 degrees with the ankle becoming the knee joint. All three options have radically different appearances and functional outcomes with varying risks and benefits.

Decision aids are most often used for preference-sensitive decisions, or decisions in which the clinical evidence does not indicate one best option over another. Making decisions based on long-term quality-of-life goals can be a burdensome for patients and families who need to consider complicated medical information in conjunction with personal values. A patient decision aid that clearly details each option as well as real-world patient stories is paramount to understanding the lifelong impact of the surgical decision. The purpose of this study is twofold: to identify knowledge gaps in the patient population and to develop a tool to reduce decisional conflict and increase decisional satisfaction.

Methods

In year one, a qualitative inquiry of questions posed in social media by patients as well as in depth interviews with patients identifies knowledge gaps for decision-making. Years 2-3 develop and test a complex interactive decision aid that includes patient narratives in video form with orthopedic surgeons, pediatric oncologists, and patient/family stakeholders. Years 4-5 beta test and revise the final model in a pre/post design with decision conflict and decision satisfaction scales and qualitative interviews. This patient decision aid is stakeholder driven by patients/families as well as clinicians from Johns Hopkins, Cleveland Clinic, Indiana University, University of Utah, University of Missouri, Texas Children's Hospital, and Harvard University. Decision satisfaction outcomes are tracked longitudinally over time.

Results

This is a five funded study with the Amputee Coalition and the Administration for Community Living; the National Limb Loss Resource Center will house the decision aid. Preliminary results will be available at the time of ISDM 2019.

224 - Cost Conversations in Shared Decision Making Encounters Regarding Anticoagulants

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Background and Aims: Chronic Atrial Fibrillation is a common health condition imposing considerable medication cost burdens on patients. The Anticoagulation Choice Decision Aid (DA) provides comparative costs, among other issues reflecting treatment burden, deemed important for choosing between treatment alternatives. Using a sequential exploratory mixed methods design, we sought to examine if DA usage, clinician characteristics (e.g., gender, training, years of experience), or contextual factors (inpatient or outpatient visit) impacted cost conversation frequency and thematic content of encounters.

Methods:

Using a sample of 93 videos from a single site of the Atrial Fibrillation Choice Trial, we conducted inductive content analysis to summarize the substance of cost conversations in recorded encounters. We then used Chi-Square tests to determine the association between clinician and context characteristics and encounter content. Results from the single center analysis will be augmented with further analyses from other sites (i.e., different practice cultures, resources, workflow, safety net status) by the time of the meeting.

Results:

Cost conversations were significantly associated with the DA use over usual care (85% versus 50% respectively; $p < 0.001$), consultant physicians over residents (62% versus 33% respectively; $p < 0.05$) and inpatient over outpatient setting (83% versus 60% respectively; $p < 0.05$). No association was found with type of clinician (MD versus Nurse Practitioner) or clinicians' gender. Conversational quality ranged widely from noting importance to active problem solving and pointers to additional resources. Patients' initiation of cost conversation was associated with better conversational quality. Costs were one of the major drivers of medication choice. However lack of cost transparency (related to insurance and co-pays) at time of visit hindered immediate medication choice or changes. Complex medical issues took precedence when time was limited.

Conclusions: At this stage, themes associated with inclusion, centrality or neglect of cost discussions point to the significant role played by clinicians and DA use. Barriers to cost conversations centered on clinician DA exposure, lack of cost transparency, and conflicting priorities in limited patient visits. These may suggest targets for interventions to promote better cost conversations to assess patient treatment burden for decision making in routine practice.

225 - Use of a newsletter in knowledge translation: a descriptive longitudinal study

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Background: The Knowledge Translation Component of the Strategy for Patient-Oriented Research (SPOR) Quebec SUPPORT Unit is tasked with identifying knowledge translation resources and ensuring their dissemination. It therefore set up an information monitoring system to produce bi-monthly newsletters in knowledge translation published in French and English.

Methods: We performed a descriptive longitudinal study of the newsletter which is divided into four sections: News, Events, Resources, and Papers. Our newsletters cover the topics of knowledge gaps (misuse of healthcare resources, evidence quality), knowledge creation (patient engagement in research, knowledge synthesis, patient-oriented research) and knowledge dissemination activities (shared-decision making, end-of-grant activities). We considered subscriber data generated by Mailchimp in the period from May 2017 to December 2018 for of subscribers who enrolled by purchasing a list of emails from a previous information monitoring in knowledge translation in May 2017. We performed a descriptive analysis of these data using R version 3.5.1.

Results: In total, 504 subscribers enrolled in May 2017 (340 to the French version and 164 to the English). The main types of affiliation reported by subscribers were universities (44%) and hospitals (21%). The number of people who subsequently unsubscribed number was 34 (7%). They were mainly in research centres (N=9) and hospitals (N=9). On average, 53% of the newsletters were opened at least once. The rate of opening varied from 45% to 60% (Median= 54). Among those who opened the newsletters, 69% clicked on at least one hyperlink. The most consulted sections were in the French version were Resources (Median=16 clicks/hyperlink) and News (Median=9 clicks/hyperlink), and in the English version, Resources (Median=8 clicks/hyperlink) and Papers (Median=6 clicks/hyperlink).

Conclusion: Overall, a high percentage of people remained subscribed with the newsletter openings showing the maintainance of their interest during our study period. More especially, people read the sections on Resources and News more than others showing their willingness to inform themselves on the concrete application of theories in knowledge translation. In the future, we will use these information to better understand the interests and the motivations of our subscribers.

228 - Measuring clinician attitudes to shared decision making: developing **toleRATE**

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Background and Aims

Most clinicians agree that decisions should be shared with patients and report they engage in shared decision making (SDM). But many studies indicate a gap between perceived practice and objective assessments of SDM. Clinicians often cite barriers to SDM such as a lack of time and patient resistance. Such attitudes influence practice, and we lack good measurement tools. The aim of this study was to 1) develop a new measure, called **toleRATE**, of attitudes about SDM, and 2) evaluate the relationship between attitudes and other clinician characteristics.

Methods

Development and testing occurred in 3 phases (P1-3). P1 involved construct selection. P2 involved 3 rounds of cognitive interviews with clinicians at an academic medical center in New Hampshire. P3 involved testing **toleRATE** with an online, clinician panel in the US. Clinicians indicated agreement or disagreement with statements representing attitudes about SDM on a visual scale. We analyzed mean scores, ranges, correlations, and conducted an exploratory principal component (PC) analysis.

Results

In P1, we created an 8 item measure with opposing statements concerning SDM necessity, patient receptivity, use of time, skill confidence, relationship to evidence-based guidance, patient assessment of performance, and respect for patient autonomy. In P2, we conducted 40 cognitive interviews (60% senior/40% junior clinicians) and identified the following themes: clinician discomfort with patient autonomy and resistance to evaluation. In P3, we tested the measure with 253 clinicians (50 internal medicine, 52 medical specialists, 51 surgeons, 50 gynecologists, and 50 psychiatrists). Clinicians reported positive views about the broad concept of SDM (PC1; mean=78%) but were not comfortable if patient choices differed from their own recommendations (PC3; mean=48%), and were hesitant about evaluation (PC2; mean=57%). **toleRATE** discriminated between clinicians based on attitudes about key aspects of SDM, but scores did not vary by age, gender, years of experience, or provider specialty.

Conclusions

toleRATE may be helpful for organizations interested in advancing a culture of SDM by identifying the attitudes of health professionals. Our findings suggest clinicians have generally positive attitudes about SDM, but not when patients disagree with their recommendations.

229 - Facilitating effective shared decision-making with surrogates of dying patients to manage or avoid potential conflicts

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Background and Aims: Conflict with families and substitute decision-makers of dying patients can occur more frequently than is ideal in end-of-life care. Understanding how to best manage these conflicts may improve relationships between physicians, and families or surrogates of patients, reduce stress, improve shared decision-making, and ultimately improve the care of dying patients.

Methods: To gain insight, we explored the experiences of Canadian family physicians who had encountered conflict with a substitute decision-maker of a dying patient. We employed Grounded Theory methodology with in-depth, semi-structured, audiotaped interviews about recent experiences of conflict. Purposeful sampling sought a maximum sample variation for physician participants. The verbatim transcripts, field notes and project memos were analyzed using an iterative process involving the constant-comparative method to identify emerging key themes and concepts.

Results: Our study found reflections of conflict experiences focused on the physicians' main concern for the patient: to have a death free from avoidable distress, and in accordance with the patient's wishes. A framework for effective shared decision-making to achieve a "good death" through finding Common Ground is described in working with families and surrogates of patients. This process involves: 1) building trust through clarifying roles, bringing key players together and delivering small bits of information at a time; 2) understanding through active listening, to finally enable 3) informed shared decision-making with the families and surrogates involved. We also describe barriers to achieving Common Ground and what to do when an impasse occurs.

Conclusions: This presentation will describe a framework for shared decision-making to develop Common Ground between Family Physicians and substitute decision-makers to assist in achieving a "good death". We will share how this study has informed education initiatives for medical students, residents and practicing physicians locally. This presentation, based on our findings, may help physicians, allied healthcare professionals, learners, patients and their families, improve end-of-life decision-making and healthcare communication more broadly in different settings.

232 - Providing Nursing Care to Tracheostomy Patients with Shared Decision Making

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The patients included those who were mechanically ventilated for more than 2 week and were indicated for tracheostomy due to anticipated prolonged weaning process in the RCC. The patients and their family were then enrolled.

The standardized health education intervention included the following steps:

1. Arrange a family meeting to discuss with every important family member. Explain the advantage and disadvantage of prolonged intubation and tracheostomy. Facilitate mutual communication and shared decision making.

2. A set of PDAs was utilized: In addition to the documentation, the APP (supplementary material 5) is also provided to reward physicians with the results of family or patient decisions.

- A. During family meeting, a real endotracheal tube, tracheostomy tube and a human respiratory system model (supplementary material 1) were used to virtually demonstrate the effect and side effect of intubation and tracheostomy.

- B. After family meeting, an educational document (supplementary material 2) was provided to disseminate essential knowledge about tracheostomy in addition to oral explanation. A specific questionnaire was attached at the end of the document to clarify family's preference and assist in making the decision about tracheostomy or not.

- C. Meanwhile, an educational video (supplementary material 3) which was available online by scanning the QR code in the educational document was provided to answer frequently asked questions about tracheostomy and demonstrate the interview of patients who had received tracheostomy in the RCC. The advantage of comfort and the ability to eat by mouth and talk with a speaking valve were also shown in the video.

3. After family had made the final decision about tracheostomy or not, another specific questionnaire (supplementary material 4) was provided for each family member to evaluate the degree of helpfulness in 5 domains by employing the model of SDM.

234 - Assessing the relevance and implementation of patient-centeredness from the patients' perspective in Germany: Results of a Delphi study

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Background and Aims:

Patient-centeredness (PC) has been widely discussed over the past years and there has been much research on its conceptualization. However, conceptual work neglected the patients' perspective. Thus, it remains unclear which dimensions of PC matter most to patients. This study aims to assess relevance and current degree of implementation of PC from the perspective of chronically ill patients in Germany.

Methods

We conducted a Delphi study and recruited patients throughout Germany using community-based strategies (e.g. newspapers and support groups). The survey was built on the 2014 Integrative Model of Patient-Centeredness, which consists of 15 dimensions of PC (essential characteristics of clinician, clinician-patient relationship, clinician-patient communication, patient as unique person, biopsychosocial perspective, patient information, patient involvement in care, involvement of family and friends, patient empowerment, physical support, emotional support, integration of medical and non-medical care, teamwork and teambuilding, access to care, coordination and continuity of care). In round one, patients rated relevance and implementation of 15 dimensions of PC anonymously. In round two, patients received results of round one and were asked to re-rate their own results.

Results

226 patients participated in round one, 214 patients in round two. In both rounds, each of the 15 dimensions was rated highly relevant, but currently less well implemented. Mean scores regarding relevance were above 7 (on scale from 0-9) for all dimensions except "involvement of family and friends". Mean scores for implementation ranged from 4.6 to 5.6 (on scale from 0-9) There were no major differences between subgroups (e.g. age groups, single disease vs. multi-morbidity).

Conclusion

This is the first study assessing patient-centeredness from patients' perspective in Germany. Our results can be used to foster patient-centered health care delivery and to develop a patient-reported experience measure to assess patient-centeredness of health care delivery in Germany.

235 - Adaptation of a decision guide to jointly support hospitalized frail patients and their caregivers in the decision-making process about location on discharge

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Background: Most hospitalized older adults living with frailty and cognitive impairment want to return home. Frail older adults, their caregivers and clinicians are often confronted to a difficult decision about location of care on discharge (e.g., home with/without assistance, care facilities). There are often different points of view and conflicting values/preferences. An interprofessional approach to shared decision making (IPSDM) could help clinicians to engage frail older adults and caregivers in this difficult decision. Previous studies conducted in home care settings showed that caregivers supported by trained teams in the IPSDM approach had a better match between their preferred and assumed role in the decision-making process and felt more engaged. However, this approach has not yet been used with frail older adults and their caregivers for acute hospital discharge (AHD).

Objective: We will adapt the IPSDM approach including its decision guide to jointly support frail patients and their caregivers in the decision-making process about location of care in the context of AHD.

Methods: Inspired by the Knowledge-to-Action framework, content adaptation will be under the leadership of an Expert Advisory Committee, including 6 researchers, 2 key stakeholders, 2 clinicians, 4 frail older adults and 4 caregiver representatives (all familiar with discharge issues). First, an evidence generation (rapid review) and a consensus building (one-day workshop) will be performed to address potential recommendations/challenges relating to both the content and format of the current decision guide and IPSDM approach. The existing guide will then be modified to produce a new preliminary version for AHD location of care decisions with frail older adults and their caregivers. To enhance content validity, a web-based E-Delphi process will be conducted with 48 members of multidisciplinary hospital-based teams and 12 frail older adults/caregiver representatives from users' and residents' committees. The study is currently underway.

Conclusion: By providing an adapted decision guide and related IPSDM approach, this study will support frail patients with complex needs and their caregivers facing difficult decisions about location on discharge following AHD. Findings will help to evaluate the relevance of implementing this tool in hospital care and to create a more integrated vision of care transitions.

236 - Création d'une exposition interactive en prévention des cancers avec et pour les jeunes : un outil pédagogique pour sensibiliser sur les moyens d'agir en prévention

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Contexte et objectifs

Le Centre de lutte contre le cancer Léon Bérard a des activités de prévention, dépistage, soins, enseignement, recherche et innovation pluridisciplinaire en cancérologie. Au sein de ce centre, le département Cancer Environnement produit une expertise basée sur les données probantes et des outils d'informations et aides à la décision en prévention. Alors que 40% des cancers seraient évitables en favorisant l'adoption de comportements réduisant les risques de cancer, les usagers sont demandeurs d'informations claires, compréhensibles et adaptées à leurs attentes pour leur permettre d'agir sur leur santé. L'exposition a pour objectifs de sensibiliser prioritairement les jeunes (15-25 ans) à la prévention des cancers, tester leurs idées-reçues et perceptions vis-à-vis de la prévention des cancers et des moyens d'agir.

Méthodes

Les contenus de l'exposition reposent sur une adaptation des informations evidence-based produites par l'équipe au sein du portail d'information francophone de référence www.cancer-environnement.fr. Les supports et visuels ont été sélectionnés par l'équipe en lien avec une agence spécialisée dans les outils pédagogiques en santé, et relus et commentés, sur la forme et sur le fond, par un groupe test de jeunes (collégiens, lycéens, étudiants) de la région Auvergne-Rhône-Alpes. Les contenus ont été également relus et validés par des professionnels de santé.

Résultats

Cette exposition a impliqué une équipe projet pluridisciplinaire composée de quatre représentants associatifs de la Ligue contre le cancer du Rhône, une quinzaine de jeunes, cinq professionnels de santé référents thématiques, et trois spécialistes de la communication en santé. Les thèmes retenus sont en phase avec les recommandations actuelles. Les supports retenus ont été des panneaux d'exposition mobiles comprenant des textes courts, des infographies colorées, et quatre applications sur écran tactiles.

Discussions et Perspectives

Cette exposition est un support attractif et interactif en phase avec les préférences des jeunes en matière d'accès à des informations en santé. Elle aborde la prévention de manière globale et interroge les perceptions sur des questions socialement vives (pollutions, vaccinations...). Elle sera accueillie dans des établissements scolaires en 2019/2020 et évaluée au sein des parcours éducatifs de santé des élèves ; elle a reçu le soutien de la Région Auvergne-Rhône-Alpes.

238 - Améliorer l'accès des Français à une information en santé de référence, facile à comprendre, pertinente et géolocalisée : le Service Public d'Information en Santé (SPIS)

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Contexte

L'information représente un enjeu majeur de la qualité des soins, de la performance du système de santé et de la démocratie sanitaire. Les inégalités d'accès à l'information sont déterminantes en matière de décision de santé car elles influent directement sur les comportements à risque, l'orientation dans le système de santé et l'efficacité de l'accompagnement des usagers. En France, les usagers recherchent régulièrement des informations sur leur santé et souhaitent prendre part dans les décisions de santé. Le SPIS, prévu par la Loi de modernisation du système de santé (article 88) est une réponse de l'Etat pour mieux informer et accompagner les citoyens dans leurs choix de santé en améliorant la coordination des émetteurs, les stratégies et les outils.

Objectif

Améliorer l'accès à une information en santé de référence, compréhensible et accessible en fournissant aux usagers une information exhaustive et adaptée à leurs besoins en fonction de leur lieu de vie sur l'ensemble du territoire français.

Méthode

Le SPIS s'appuie sur une méthodologie participative innovante qui associe toutes les institutions et agences publiques missionnées dans les champs de la santé, ainsi que des acteurs institutionnels à but non lucratifs (associations, ordres professionnels, sociétés savantes, universités...). Cette démarche repose sur 3 instances complémentaires : comité stratégique pluridisciplinaire, collègues thématiques et comité éditorial.

Résultats

Une charte d'engagement des parties prenantes au SPIS a été co-construite et validée. Un moteur de recherche santé.fr a été développé (site internet et application mobile), ainsi qu'un espace de recueil d'idées et retours d'expériences des usagers (lelab.santé.fr). Plus de 5000 contenus éditoriaux, 250 000 professionnels, établissements et services de santé, sont déjà indexés, tous issus de sources labellisées par la puissance publique. Ces informations couvrent un large périmètre : préventions, informations sur les pathologies, alertes sanitaires, annuaires des professionnels... Les données de toutes les régions françaises figureront sur Santé.fr (d'ici fin 2019).

Discussions

Cette méthodologie assure une cohérence et cohésion des actions menées en faveur de la qualité de l'information en santé et l'aide à la décision en santé autour d'une vision partagée qui tire parti des avancées technologiques et s'adapte aux nouveaux usages du numérique.

239 - Implementation of a program based on adapted physical activity and recommendations for second cancers prevention for adolescents and young adults with cancer: PREVAPAJA study

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Background/Objectives:

About 700 adolescents and young adults (AYAs; 15 to 25 years) are diagnosed annually with cancer in the French Auvergne-Rhône-Alpes region. While their long term survival is about 80%, they are six times more likely to develop a second primary cancer (SPC) compared to their peers. This risk is multifactorial and depends on the type of first cancer, treatment received and prevalence of risk factors (smoking, overweight, sedentary lifestyle, environmental exposures...). PREVAPAJA aims to implement a clinical program based on physical activity (PA) and cancer prevention recommendations for AYAs with cancer at Centre Léon Bérard-AYAs Department.

Design/Methods:

AYAs attended PA sessions during the active treatment period (4-6 months) and participated to individual information meetings on SPC risk prevention. Physical activity (IPAQ, 6MWT), sedentary, anthropometrics (BMI), quality of life (QLQ-C30) and fatigue (VAS) were assessed at baseline (T1) and at the end of treatment (T2). They participated to a final meeting by phone 1 year after T1 (T3) to assess their level of physical activity (IPAQ) and intention of changes in health behaviors.

Results:

63 AYAs (39 boys, 24 girls; median age=18 years) participated in the study. PA level increased between 360 MET-min/week at T1, 1059 MET-min/week at T2 and 1116 MET-min/week at T3. Sedentary time decreased from 56 h/week at T1, 40 h/week at T2 to 30h/week at T3. Fatigue assessed decreased between T1 and T2 ($p<0.01$) and overall quality of life improved statistically significantly between T1 and T2 ($p<0.001$). Information meetings showed important differences in consideration for cancer risk factors.

Conclusions:

This study showed the feasibility of implementing a clinical program based on PA intervention and cancer prevention recommendations for AYAs with cancer. It responded to AYAs' needs for support and discussions regarding physical activity recommendations and ways to prevent SPC. Beneficial outcomes of this program should encourage to systematically proposing PA intervention in combination with information exchanges with AYAs with cancer to strengthen the shared decision-making process.

242 - Should mastectomy and BCT rates be used as a quality indicator?

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Background: For early stage breast cancer (ESBC), it is well established that breast conservation therapy (BCT) and mastectomy offer equal survival and are considered equivalent treatments. Treatment for ESBC can therefore be viewed as preference sensitive care, where decision-making between treatment options should vary based on underlying patient preferences. However, the use of mastectomy or BCT rates have repeatedly been utilized as performance and quality indicators at breast units. In Canada, the 2012 Canadian Partnership Against Cancer report on Breast Cancer Control specifically utilizes mastectomy versus BCT rates as the first set of breast cancer treatment indicators in their report. We pose the question whether mastectomy and BCT rates should continue to be used as quality indicator?

Methods: We have reviewed various literature and guidelines and present a narrative summary highlighting historical context, current controversies, and evolving trends.

Results: The use of BCT rates as a quality indicator stems from the seminal National Institute of Health Consensus Conference on the treatment of ESBC in 1991. Specifically, they recommend BCT as a 'preferable' treatment because of superior cosmetic outcomes. The wording of this recommendation has propagated innumerable studies evaluating influences of mastectomy versus BCT treatment and guidelines regarding BCT rates as a quality indicator. For example, the European Society of Breast Cancer Specialists has published multiple guidelines recommending a minimum BCT rate of 70%. However, as more understanding is gained of how complex and varied individual decision-making can be, there is also an increasing recognition and advocacy in the literature against the use of mastectomy or BCT rates as a quality indicator.

Conclusions: Through this review and with an improving understanding of the complexities behind patient therapy choice, we would advocate the use of mastectomy or BCT rates should be discontinued. If the decision-making between mastectomy versus BCT in ESBC is still to be used as a quality indicator, there needs to be a shift to align the quality indicators with modern treatment goals. This could be in the form of measuring if patients are being offered treatment choices and if the treatment they receive is in line with their wishes.

243 - Development of a decision aid for adults newly diagnosed with ADHD

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Introduction

Attention deficit hyperactive disorder (ADHD) is defined as a chronic neuro-developmental disorder and diagnosed when the following behavioural symptoms manifest themselves: inattention, hyperactivity, and impulsivity. Although ADHD has been thought of as a childhood disorder for a long time, in the last few decades, research has shown that ADHD persists into adulthood. Regarding the pharmacological treatment of adults with ADHD, there are two medication options available in Japan: atomoxetine and methylphenidate. However, unlike other countries, where clinical guidelines for adult ADHD already exist, to date no treatment guideline for adult ADHD has been established in Japan. The current study aimed to develop a decision aid for adults in Japan who are newly diagnosed with ADHD.

Methods

Part I. For the needs assessment, 12 adults diagnosed with ADHD during adulthood were recruited. Semi-structured interviews were conducted, and data were analysed with a modified grounded theory approach.

Part II. We used the results of Part I and the International Patient Decision Aid Standards instrument to develop a decision aid prototype for adult ADHD. The prototype included the options watchful waiting and pharmacological treatment, which consisted of atomoxetine or methylphenidate. Then, the prototype was presented both to adults with ADHD and to healthcare professionals in semi-structured interviews. We adopted their feedback to revise the prototype.

Part III. We will evaluate the feasibility and acceptability of the decision aid intervention in an outpatient setting using a mixed method approach.

Results

Part I. Although facing stigma related to ADHD, almost all adults with ADHD asked for information regarding ADHD and wanted to participate in treatment decision-making.

Part II. Constructive feedback for the length of sentences and the font size was obtained. There was still room for improvement in selection of illustrations and colours.

Part III. This part is currently in progress.

Conclusion

By using a systematic patient participatory approach, a decision aid for adult ADHD was successfully developed. Insights were obtained on requirements for implementation. Further research to evaluate the feasibility of the decision aid is now ongoing. Findings will be presented at the conference.

246 - Advance Care Planning and Shared Decision Making for Patients with Advanced Chronic Kidney Disease

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Background. Shared decision making (SDM) has been considered as an important element of well adopted to disease status in patients with advanced chronic kidney disease (CKD) while facing to the choice of Renal Replacement Therapy (RRT) or conservative treatment.

Aims. We developed and deployed SDM program in PreESRD project since 2016, and would like to share our clinical experiences on initiating and optimizing the SDM program for RRT or conservative treatment in patients with advanced CKD.

Methods. Based on the flowchart, the steps of this program include team consensus development, facilitator cultivation, teach-back enhancement, development of decision support tools with multiple applications, care model adoption, and care process optimization. Length of decision making and satisfaction survey were done in patients, family members, and medical staffs.

Results. Among 161 patients with advanced CKD enrolled in the SDM program, the average time from the date of SDM institution to the date of vascular access creation was 76.8 ± 87.1 days. All medical staffs, patient families, and patients participating in this program satisfied with the whole processes based on the survey results.

Conclusion. Our successful experiences suggest that patients with advanced CKD should start SDM program 3 to 6 months in advance before the initiation of dialysis. Developing patient-friendly decision support tool based on current medical evidences, such as plain text, figure, movie, forum, and scenario practice supported by informatics technology, could enhance the efficiency of SDM and assist patient to make a more suitable decision for RRT or conservative treatment.

Keyword: chronic kidney disease, shared decision making, renal replacement therapy

247 - The impacts and associated factors of decision preferences in shared decision making in patients with advanced chronic kidney disease

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Background. Shared Decision-Making (SDM) was promoted clinically in Taiwan since 2016. However, study on patient participation in SDM, preference type, and final decision choice of renal replacement therapy (RRT) in patients with chronic kidney disease (CKD) were lack.

Aims. The aim of study was to explore the relationship between preferences and clinical decision making in patients with advanced CKD and its associated factors.

Methods. A cross-sectional study was conducted in a medical center at Kaohsiung, Taiwan. We invited non-dialysis advanced CKD outpatients to participate in this study from August 1, to December 31, 2018. All participants were requested to complete the questionnaire of control preference scale (CPS), which divided patients into three preferred decisional roles (active role, collaborative role, and passive role) according to the scores. We also collected the demographic characteristics and clinical decision making of RRT. All statistical analyses were conducted using SAS 9.4.

Results. The roles of preferences in 72 advanced CKD patients were 20.8% active, 52.8% collaborative, and 26.4% passive. Among those who preferred collaborative role, most were men (60.5%), educational level in college (55.3%) or aged between 45 and 65 years (50.0%). Three preferred decisional roles were not statistically significant in gender, education level, and age among three groups. Thirty participants have made RRT decisions (41.7%). The length of time for consideration arranged in order were 94.4±96.4 day in collaborative role (n=15), 58.4±17.6 days in passive role (n=7), and 48.6±43.7days in active role (n=8). Interestingly, the results were comparable to the percentages of pre-implantation of dialysis access (collaborative role 62.5%, passive role 25.0%, and active role 12.5%). However, the period of consideration for choice of the modality of RRT (p=0.3058) or the percentages of pre-implantation of dialysis access (p=0.5795) were not statistically significant among three groups of preferred decisional roles.

Conclusion. Our study showed near half of the participants with advanced CKD preferred to have a collaborative relationship with the medical team. This highlights the needs for incorporation of shared decision making process into treatment plans of RRT regardless of their decision preferences.

Keywords: Decision preference, shared decision making, chronic kidney disease, renal replacement therapy

248 - Brief illness perception and shared decision making in patients with advanced chronic kidney disease--A pilot study

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Background. Patients with good disease perception could take action to respond to the disease and then decide treatment options. Few studies have focused on the impact of disease perception in patients with chronic kidney disease (CKD) on shared decision-making (SDM) for choice of renal replacement therapy (RRT). The purpose of this study was to investigate the association between disease perception and SDM of RRT in patients with advanced CKD.

Methods. We conducted a cross-sectional study to enroll out-patients with CKD stage 5 who involved in the SDM program in a medical center at Kaohsiung, Taiwan. We collected the data including demographic characteristics, Brief Illness Perception Questionnaire (BIPQ) and period of clinical decision time of RRT. There were eight items in BIPQ and the score of the BIPQ was from zero to ten. Higher scores indicated better disease perception.

Results. There were 30 patients participated in our study from August 1 to December 31, 2018. The mean age of the participants was 63.0 (± 11.9) years old. The average score of BIPQ was 6.1 (± 1.0) and average time to make a decision of RRT was 73.8 (± 72.7) days. The average score of BIPQ was not related to age, gender, education level and decision type ($p > 0.05$). However, the average score of BIPQ of the patients without jobs (7.1 ± 1.1) was statistically higher than the score of the patients with jobs (6.3 ± 0.9) ($p = 0.02$). The correlation of the average time to make a decision of RRT and BIPQ score was not statistically significant ($r = 0.186$, $p = 0.326$).

Conclusion. The results of this study indicate that patients without jobs might pay more attention to their disease than patients with jobs. The relationship between the disease perception and the time to make a decision of RRT in patients with advanced CKD might not be strong. We suggest that the SDM strategies should be fully deployed among the patients with CKD stage 5 regardless of their disease perception. More studies in the future are necessary to build the reference of SDM clinical practice.

Keywords: Illness perception, shared decision making, chronic kidney disease, renal replacement therapy

250 - Enhancing patient satisfaction by strategic implementation of shared decision making in a tertiary hospital

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Background:

With the advance of patient awareness and easy access to medical information, patient-centered care and shared decision-making (SDM) has become increasingly important in health care. The purpose of this study is to evaluate the process and outcome of implementing SDM in a tertiary hospital.

Methods:

Starting from Jan 2017, we formulated the framework of leadership (vice-superintendent), infrastructure (physicians, nurses, information technology personnels, and quality control staff), and practice (enrolling inpatients/outpatients and outcome assessment). The program consists of the following strategies: (a) making policy to encourage implementation of SDM in each clinical specialty, (b) individual coaching and training for physicians and nurses, (c) providing evidence-based PDA (patient decision aids) of printouts or videos (d) revision of PDAs after pilot use by the patients and their family (e) team meetings to critically assess the outcome of the multi- and inter-disciplinary approach.

Results:

From Jan 2017 to Jun 2018, a total of 37 training courses or campaigns was organized, including SDM implementation, PDA design, and SDM coaching/troubleshooting. There were 2,318 participants with a satisfactory rate ranging from 86.5%~100.0%. Demonstration of practice outcome was held twice a year, with 28 programs presented and 28 guidelines formulated. For the 517 patient enrollments, the SURE test showed that 84.93% of patients/family considered SDM a helpful tool fulfilling their expectation of treatment outcome. Furthermore, the overall satisfaction of outpatients improved from 88.09% in June 2017 to 92.05% in Dec 2018. Specifically in the domain of medical care, the satisfaction improved from 92.31% to 93.72%.

Conclusion:

In the past 2 years, the adoption of SDM through the abovementioned program has successfully empowered our healthcare providers with awareness, knowledge, and ways of implementation. The enhanced satisfaction has proved SDM a useful tool in patient-centered care and in creating a more harmonious patient-doctor relationship.

254 - Validation of the SURE-test for screening decisional conflict among parents making decisions for their child

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Background: The 4-item SURE-test screens for decisional conflict in clinical settings. Although valid in adults, validity data for parents in pediatric clinical practice is lacking. We aimed to validate the SURE-test for use with parents in pediatric practice.

Methods: We conducted a secondary analysis of randomized trial data that evaluated a shared decision-making intervention for parents deciding about antibiotic use for their child. We compared parents' scores on the SURE-test and Decisional Conflict Scale (DCS; gold standard for assessing decisional conflict). A Spearman correlation coefficient was used to describe the association between the scores and linear regression to determine the variance in the DCS explained by the SURE-test. Using clinically significant cut-offs, we dichotomized each measure to calculate sensitivity, specificity, and positive and negative likelihood ratios for the SURE-test. The Kuder-Richardson 20 was used to measure internal consistency between dichotomized measures. We evaluated the presence of effect modification by sex using an interaction term in our linear regression model, followed by sex-specific calculation of validation statistics.

Results: We analysed data from 201 parents (67% female). The average parent age was 36 years (*SD* 6); average child age was 5 years (*SD* 4). Mean total scores were 14.2/100 (*SD* 14.3) for the DCS and 3.8/4 (*SD* 0.7) for the SURE test, which were significantly correlated ($\rho = -0.36$, $P < 0.0001$). The SURE-test explained 34% of the variance in DCS scores. SURE-test sensitivity and specificity for identifying decisional conflict was 82% and 93% respectively; the positive likelihood ratio was 11.9 and negative likelihood ratio 0.2. Internal consistency was moderate at 0.56 ($P < 0.0001$). The SURE-test and DCS total score correlation was higher for females than males (-0.37 vs. -0.21; $P = 0.008$ for the interaction).

Conclusions: The SURE-test demonstrated moderate correlation and reliability with the DCS for parents making a pediatric health decision. As a decisional conflict screening test, SURE-test performance is strong and valid in screening for the presence of decisional conflict, but moderate for ruling it out. The SURE-test performed differently for males and females, suggesting sex-based differences exist in screening for decisional conflict. Our analyses were limited by a low prevalence of decisional conflict.

259 - An overview of systematic reviews of interventions to improve patient-centred approaches to healthcare decision-making to inform the design of a novel intervention incorporating core information sets for informed consent to surgery

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Background and Aims

Patient-centred care is a major paradigm in modern healthcare. Models including shared decision-making (SDM) - considered the cornerstone of patient-centred care - have been prioritised for focussed, collaborative developmental work. A major legal ruling in the United Kingdom recently aligned informed consent with SDM for the first time in law. The ruling has subsequently been incorporated into professional guidance from regulatory bodies including the Royal College of Surgeons and the UK General Medical Council.

There remain, however, barriers to the implementation of this model of care. Reasons include poorly designed interventions, uncertainty about which level (e.g. patient, healthcare professional, or system) should be the target(s) for intervention, and the existence of overlapping constructs. There are, additionally, issues around heterogeneity in outcome definition, measurement, and reporting meaning that synthesising evidence about which type(s) of intervention are most effective is difficult.

Overviews of systematic reviews are a relatively new approach to synthesising multiple systematic reviews to provide a single synthesis of relevant evidence. Our hypothesis is that there will be significant overlap in the types of patient-centred interventions delivered, and the broad categories of outcomes measured, but with heterogeneity in definition and measurement. The overall aim of this overview of reviews is to summarise the evidence about interventions aimed at improving patient-centred clinical decision-making.

Methods

Searches will be undertaken in relevant databases. Included systematic reviews of studies (randomised controlled trials, non-randomised trials, controlled before-and-after studies, and interrupted time series analyses) of interventions to improve patient-centred decision-making. Results will be tabulated and non-quantitative data presented narratively. The presentation of results will be in line with the guidelines in the Cochrane Handbook of Systematic Reviews of Interventions, and the Preferred Reporting Items for Systematic Reviews and Meta-Analysis statement.

Results and conclusion

At the time of writing, the overview of reviews is ongoing. The results will be ready for presentation at the conference.

263 - Humanistic communication in the evaluation of shared decision making: A systematic review

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Background/Aims:

Shared decision making (SDM) research and implementation has had a strong focus on 'technically correct' SDM: taking the right steps, in the correct sequence, at the right time. It is unclear whether the distinction between 'technical' and 'humanistic' aspects of SDM conversations has been drawn in empirical SDM research. The aim of this systematic review was to assess how often and in what manner studies evaluating SDM quality also consider the extent and quality of humanistic communication (i.e., respect, compassion, empathy).

Methods:

We systematically searched Web of Science and Scopus for prospective studies published between 2012 and February 2018 that evaluated SDM in actual clinical decisions using validated SDM measures. Two reviewers working independently and in duplicate extracted all statements from eligible studies and all items from SDM measurement instruments that referred to humanistic patient-clinician communication.

Results:

Of the 154 eligible studies, 14 (9%) included ≥ 1 statements regarding humanistic communication, either in framing the study (N = 2), measuring impact (e.g., empathy, respect, interpersonal skills; N = 9), as patients'/clinicians' accounts of SDM (N = 2), in interpreting study results (N = 3), and in discussing implications of study findings (N = 3). Of the 192 items within the 11 SDM measurement instruments deployed in the included studies, 7 (3.6%) items assessed humanistic communication.

Conclusion:

Assessments of the quality of SDM focus narrowly on SDM technique and rarely assess humanistic aspects of patient-clinician communication. Considering SDM as merely a technique may reduce SDM's patient-centeredness and undermine its' contribution to patient care.

264 - Performing Shared Decision Making: Using Traditional Indian Dance Choreography to Understand ICU Patient-Provider Communication

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Background and Aims: Shared decision making is increasingly recognized as an effective strategy for delivering patient-centered medicine; however, it can prove to be challenging in the setting of the intensive care unit. An integral principle of shared-decision making is open lines of communication of values and priorities between patient and provider. However, in the setting of an ICU, where communication is often compromised by illness circumstances, providers must rely on family, friends, and previous documentation about wishes when patients reach a cross-roads during end of life care. Traditional Indian Dance, such as Kuchipudi and Bharatanatyam, are performed to narrate stories using intricate hand gestures, footwork, and facial expressions. In this project, we looked at using traditional dance to enact shared decision making through performance and then assessed impact on improving physicians-in-training's understanding of the challenges in shared decision making in the ICU.

Methods: A story-line was constructed utilizing a composite of de-identified patient experiences. This story-line was then translated into traditional dance with the purpose of allowing the performers, all physicians-in-training, to discuss points of communication and shared values between patient and provider.

Results: Through choreography, performance, and post-performance discussions, the performers noted increased awareness of shared decision making as a tool in modern medicine and improved awareness of the extant nonverbal communication in the ICU between patients and providers. Results are ongoing and will be updated.

Conclusion: Performing physician and patient roles in shared decision-making scenarios using the narrative, expressive style of traditional Indian dance can improve trainee's understanding of nonverbal communication and reveal shared values of both physician and patient in end of life decision making.

266 - Experiment Outcome Indicators. Outcome transparency for shared decision making.

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Background and aims

Existing forms of shared decision often make use of information on treatment outcomes. However, the data used is regularly based on international data that either does not fit the Dutch situation, is outdated, uses averages for the entire patient population instead of patient-specific information, or is even incomplete or lacking. The objective of the Experiment Outcome Indicators is to provide patients with personalized, up to date information based on the outcomes of care delivery within the hospital in which the patient is treated. For that purpose, we will develop and implement an effective approach for the use of outcome data in shared decision making and aim to gain insight in the degree to which better patient information and shared decision making lead to different treatment choices and increased patient satisfaction.

A brief description of methods

The program will be conducted within Santeon; a Dutch group of seven teaching hospitals that uses the value-based healthcare framework as its guiding principle. Santeon measures and compares outcomes, costs and turnaround times per medical condition in a structured, standardized manner. Within the program we will use the collected outcome data on individual patient level. The program focuses on three patient groups: patients with breast cancer (oncological/elective condition), stroke (cardiovascular/(sub)acute condition) and chronic renal failure (chronic condition). Essential in our approach is the involvement of key stakeholders (patients and health care professionals), the use of continuous evaluation cycles and intertwinement between development, implementation and evaluation. Approaches and tools will continuously be evaluated, adapted, and improved over the course of the project. The study can therefore best be classified as action research. In addition, pre- and post-implementation measurements will be conducted. We discern three lines of evaluation: one per patient group. Evaluation methods are standardized, allowing for evaluation within and across these lines.

A summary of results to support conclusions

The study is ongoing and results will be updated.

A conclusion

We aim to provide insight into the value of transparency of outcomes relevant to patients and to identify best practices to disclose these outcomes and use these for shared decision making.

269 - Offering patients a choice for colorectal cancer screening: a quality improvement pilot study in a quality circle of primary care physicians

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Introduction Colorectal cancer (CRC) screening guidelines recommend offering a choice of colonoscopy and fecal immunochemical test (FIT). Patients offered both tests divide almost evenly between them, but in Switzerland, only a minority of patients are screened for CRC, and most with colonoscopy. We trained primary care physicians (PCPs) in shared decision-making (SDM) within a quality circle (QC) to increase the likelihood they would offer CRC screening and FIT along with colonoscopy as a screening option. This quality improvement pilot study systematically assessed CRC screening status of eligible 50-75 y.o. patients and determined if SDM implemented within a QC increased the proportion of patients offered a choice of CRC screening and which test patients chose.

Methods: Working through 4 Plan-Do-Study-Act (PDSA) cycles in their QC, 9 PCPs adapted tools for SDM, implemented them in their practice, and surmounted organizational barriers by involving practice assistants (PAs). In the first data collection, each PCP included 20 consecutive 50-75 y.o. patients; in the second, they included 40. For each round, they reported CRC status, the proportion of eligible patients with whom they could discuss CRC screening, and their patients' decisions.

Results: Qualitative results indicated that participating PCPs found it easier to use SDM communication tools for CRC screening than they had anticipated. PAs helped PCPs note patients' CRC screening status in the electronic medical record, and CRC screening was implemented in daily routine for eligible patients, thus increasing their chance to be offered screening; 176 patients were included in the first data collection and 320 in the second. CRC screening rates trended upwards over the course of a year, from 37% to 40%; FIT use increased from 2% to 7% ($p=0.008$). Initially, 7/9 PCPs had no patients ever tested with FIT, but after the intervention the proportion dropped to 2/8.

Conclusions: PCPs in a QC systematically collected data on CRC screening status, made significant organizational changes, and implemented SDM tools in their daily routine after participating in a series of data-driven PDSA cycles. The intervention increased the proportion of patients who received a screening discussion who chose FIT.

276 - Barriers and facilitators to implement shared decision making: the views of Chilean primary healthcare providers

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Background and aim

In Chile, since 2012 Health Participation (HP) has been promoted by Family and Community Integral Attention Model in Primary Health Centers. However, now a days not been possible for total implementation. Shared Decision Making (SDM) it is delivery model principle for operationalized HP. National context studies only have patient's perspective, therefor the aspects that promote and hinder it use in clinical meetings have not been explored by health professional.

Objective: to identify barriers and facilitators for the implementation of SDM perceived by primary healthcare providers in one Family Health Center in Chile.

Methods

A qualitative study was conducted in one Family Healthcare Center in Santiago, Chile. Health providers were invited to participate in one focus group. Key informants were selected to participate in one interview and one day of their clinical practices were observed by the researcher using the OPTION scale and SDM-Q.

Results

One focus group was conducted with eight health professionals. Three participants were required for the personal interview and the non-participant observation (a total of 16 consultations were observed). After the analysis three main factors were identified as key elements to implement SDM in Chile: professionals' attitude, patients' expectations and the health system. Participants identified mostly barriers for the implementation, with the "paternalistic approach" as the main obstacle for professionals. However, their willingness to kindly treat patients could support SDM. As for patients, the passive attitude emerged as the main limitation, but health policy that promoted patient empowerment gives hope for a more participative approach, as it could provide a framework for the training of patients and professionals.

Conclusion

Health providers perceived larger barriers to SDM implementation. However, the current healthcare policy is a major facilitator and must be consider in different strategies to prepare both patients and professionals for a more horizontal and participative encounter.

280 - Evaluating two decision aids for Australian men to support informed decisions about prostate cancer screening

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Background and aims: While internationally, few independent agencies support population screening for prostate cancer, Australian clinicians are advised to 'offer evidence-based decisional support to men considering whether or not to have a PSA test'. There is little evidence of widespread adoption of decision aids (DA) in primary care. This study aimed to determine the acceptability of two new decision aids (one full length, one abbreviated) to inform how best to support men to make informed choices about PSA screening.

Methods: Almost 3000 Australian males aged 45-60 years, not previously diagnosed with prostate cancer, were recruited via an online panel and randomised to view one of two online decision aids and then completed a questionnaire.

Results: Both decision aids were rated highly on acceptability. Most men found the DAs clear and easy to understand (80% and 83% in long and short DA respectively), and helpful in making a decision. About 50% of each group found the DAs completely balanced, about a third considered them slanted towards, and 15% slanted away from screening. A significantly higher proportion of men in the long DA group (38%) made an informed choice than men who received the shorter DA (33%) (4.7% more; 95% CI 1.1% to 8.2%; $p=0.008$). Men allocated to the long DA were less likely to intend to have a PSA test in the future (53%) compared with men in the short DA group (59%). In contrast the shorter DA was more likely to be read in full and was more likely to be rated as about the right length than the longer DA. The DAs were equally effective and similarly rated in higher and lower educated groups of men.

Conclusion: Both decision aids were useful and acceptable to men regardless of education level and both supported informed decision making. The long version resulted in slightly higher levels of knowledge. A long decision aid may serve to provide additional information for those men whose informational needs are not satisfied by the brief information in the short version.

281 - Harmonizing Theory, Teaching and Measurement: The SHARE TO CARE model of Shared Decision Making

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Background and aims

Most communication methods developed to teach clinicians, while they may have relevance for SDM, are not designed to teach SDM specifically. In addition, models of instruction may not align with existing measures of SDM. Wording of measures and definitions, in turn, is often not applicable to clinicians.

The aim of this work was to develop and implement a model for training clinicians in SDM that is both easy to understand and adheres to existing SDM theory and measurement.

Methods

Incorporating prior training experience, we developed a model to teach clinicians to engage in SDM with patients that corresponds to the Makoul and Clayman Essential Elements and the MAPPIN'SDM coding scheme.

Results

We defined the SHARE TO CARE model of SDM, which is taught as a chronological sequence of six steps:

As preliminary feedback from trained physicians suggests, the 6-step model of SDM makes sense to them logically, and is easy to understand, even by novices. Clinicians being taught by use of this model still do not regard SDM as easy, but as simple.

Systematic evaluation data are currently being collected, as the SHARE TO CARE model is used in two connected large-scale implementation projects addressing entire hospitals in Germany (University Medical Center Schleswig-Holstein, Kiel) and Norway (University Hospital of North Norway, Tromsø). All employed intervention modules (online training; face-to-face training for physicians and decision coaches) and attempts to optimize clinical pathways in these hospitals refer to the 6-step model.

Conclusion

Applicable steps for teaching SDM should and can be in alignment with theoretical models and validated tools to measure SDM, such as the Essential Elements of SDM and MAPPIN'SDM. This enhances theoretical coherence of implementation projects, credibility of the training, content validity of the employed measures, and the likelihood that the improvement of SDM behavior induced by the training will be detected.

282 - Conflict resolution: An experimental study of users' perceptions of and responses to conflict of interest disclosure statements in patient decision aids

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Background and Aims: Conflicts of interests have potential to undermine the usefulness of patient decision aids for enabling informed, values-concordant health decisions. Prevailing quality standards attempt to counteract the potential bias introduced by conflicts of interests by advocating disclosure. However, we know little about how decision aid users perceive and respond to conflict of interest disclosure statements and thus, whether this management strategy is adequate. This study aims to address this evidence gap.

Methods: We will conduct a 2 (conflicts of interest: absent, present) x 2 (disclosure statement: basic, enhanced) x 2 (delivery mode: doctor, online) between-subjects fractional factorial experiment. Approximately 360 English-speaking adults in the United States will be recruited using a commercial panel service with oversampling of participants with limited health literacy. Participants will be instructed to imagine they have been diagnosed with an illness, will be presented with a fictional one-page decision aid on treatment options, and will be advised either that they were given the decision aid by a doctor or found it online. The decision aid presented will feature one of four competing interest disclosure statements: basic–conflicts absent, basic–conflicts present, enhanced–conflicts absent, enhanced–conflicts present. The basic statements will be simple and brief, reflecting those typically present in existing decision aids. The enhanced statements will provide more detailed information, incorporate a pictogram representing the presence or absence of conflicts, and include a brief educational statement about possible effects of conflicts of interest. We will assess study outcomes (i.e., perceived decision aid credibility, decision aid acceptability, treatment choice, perceived values concordance of treatment choice, perceptions of disclosure statement) and administer a manipulation check immediately after decision aid exposure. Analyses examining the effects of conflicts of interest, disclosure statement, and delivery mode on study outcomes, along with relevant interactions, will be conducted separately by health literacy group.

Results and Conclusions: This study is ongoing and complete results will be available at the time of presentation. Study findings are critically for informing our understanding of the adequacy of current approaches to managing conflicts of interests related to patient decision aids.

286 - Evaluation of a Novel Information Technology Solution for Pediatric Asthma Shared Decision Making and Decision Support

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Background: Asthma is a chronic disease with significant morbidity and cost with currently over 6 million children diagnosed. 1 in 6 children will visit an Emergency Department (ED) for asthma and 1 in 20 will be admitted for an inpatient stay. Asthma is a condition with marked disparities in prevalence, quality of care, and outcomes. Asthma exacerbations can be attributable to knowledge gaps, lapses in medication adherence and increases risk for poor outcomes. While adherence to asthma treatment guidelines can improve symptoms and decrease exacerbations, unfortunately most patients receive care that is not guideline-based. Shared Decision Making (SDM) is a patient-centered process in which doctors and patients work together to make treatment decisions. New approaches that incorporate SDM and health information technology (IT) are needed to positively impact asthma management. We created an interactive, web-based application called Carolinas Asthma Coach that incorporates SDM principles through an animated character “Coach McLungs” to elicit patient information, including goals and preferences, and provides health literate, tailored education with specific, guideline-based recommendations for patients and their providers.

Objective: We piloted and evaluated Carolinas Asthma Coach in a large healthcare system. The real-world pediatric practice settings included primary and emergency care. The study evaluated the feasibility and efficacy of the application.

Design: Quasi-experimental, pre-post study design. Prospective series with convenience sampling of pediatric patients 7-17 years old and their caregivers (n=62). Pre and post asthma knowledge, participant perceptions of SDM, and satisfaction surveys were collected.

Results: Feasibility of use was demonstrated across all settings. Improved asthma knowledge was demonstrated with both patients (n=31) and caregivers (n=31) where patient knowledge scores improved on average from 52% to 77% (p<0.001) and caregiver scores improved on average from 68% to 84% (p<0.001). 90% reported the treatment decision was shared (mostly patient, mostly provider, or equally). 100% reported satisfaction with use of the coach.

Conclusions: The web-based application was successfully piloted across all settings. Health IT solutions like Carolinas Asthma Coach may facilitate more widespread use of SDM and empower patient-provider collaboration in the treatment plan, ultimately having the potential to improve outcomes for asthma patients.

287 - The practical experience of introducing shared decision making in Taiwan regional teaching hospital

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"Shared Decision Making (SDM) " is a process in which the medical team and the patient choose the options for medical diagnosis or treatment through communication and dialogue, emphasizing the interaction between the two parties and the input of opinions to achieve the purpose of decision-making. The Shared Decision Making has been promoted abroad for many years, but it has only been promoted in Taiwan in the past three years. In the already busy medical environment, it is still a considerable challenge to promote Shared Decision Making. Therefore, the teams of various departments will be invited by encouragement to participate the "Shared Decision Making".

A introducing Team consisted of members from the Center of Quality Management and Department of Development and Planning planned the activity schedule using Gantt chart. Through holding 4 Shared Decision Making course, including Key Performance Indicators (KPI) of Balanced Scorecard (BSC) in the department, and providing Patient Decision Aid (PDA) with a bonus of NT10,000 per piece, and holding the final prizes, the winning team will be awarded at the whole hospital meeting.

In 2018, a total of 23 Patient Decision Aid (PDA) were completed, the topic including Tracheostomy, Dialysis fistula, AIDS drugs, hospice, Pediatric urinary tract infection, etc. The Questionnaires were used to understand the experience of the medical team and patients. The satisfaction rates were 97% and 92%, respectively. It is still going on in 2019, and it is hoped that patient safety and quality will continue to improve.

289 - Revue de portée sur la collaboration entre chercheurs fondamentaux et cliniciens dans un contexte de recherche axée sur le patient en première ligne : protocole.

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INTRODUCTION: Les réseaux de recherche en médecine fondamentale et ceux orienté vers les applications cliniques travaillent de façon indépendante et sans engager les patients dans la recherche. Nous déterminerons quels sont les facteurs associés à la collaboration entre les chercheurs en science fondamentale et les cliniciens dans un contexte de recherche axée sur le patient en première ligne ainsi que les impacts.

MÉTHODE : Notre démarche repose sur une collaboration avec l'unité SOUTIEN du Québec de la Stratégie de Recherche Axée sur le Patient. Notre équipe de projet inclut des patients partenaires et des représentants des diverses parties prenantes. Inspirés par la démarche proposée par Arksey (2005) et adaptée par Levac (2010), nous réalisons une revue de portée. Cette synthèse exploratoire et reproductible permet un survol de l'état des données probantes dans un domaine donné et d'identifier des lacunes dans la recherche. Elle exige une phase de consultation visant à compléter la littérature manquante publiée ou non ainsi que certains éléments contextuels. **Étape 1 :** Se familiariser avec la littérature et déterminer les questions de recherche. **Étape 2 :** Élaborer une stratégie de recherche dans différentes bases de données incluant la littérature grise. Cette recherche est développée avec une spécialiste de l'information afin d'identifier les mots-clés. **Étape 3 :** Sélection des articles et documents basée sur des critères d'inclusion en lien avec les questions de recherche. **Étape 4 :** Extraire les données. La grille d'extraction et le guide de codification sont développés à partir des éléments de cadres théoriques expliquant les déterminants de l'implantation du modèle et son évaluation. Elle inclut les caractéristiques de l'engagement des patients dans la recherche et les impacts potentiels dont la participation des patients aux décisions. **Étape 5 :** Traiter les données et faire leur synthèse. **Étape 6 :** Consulter les parties prenantes incluant les chercheurs fondamentaux, chercheurs-cliniciens, cliniciens et patients partenaires.

RÉSULTATS : Travaux en cours. 4316 références identifiées, 3675 références uniques (sans doublons).

CONCLUSION : Nos résultats renforceront la collaboration entre les chercheurs en science fondamentale et les cliniciens dans un contexte de recherche axée sur le patient en première ligne.

291 - Développement d'un protocole d'implantation en clinique de première ligne d'un modèle de collaboration interprofessionnelle axée sur le patient et fondée sur les meilleures pratiques en matière de prévention et de prise en charge de l'obésité et des problèmes de santé associés.

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Introduction :

L'obésité est un phénomène mondial touchant le quart de la population canadienne. Les services publics ne parviennent toujours pas à offrir une prise en charge de l'obésité adéquate. Effectivement, les services offerts sont souvent axés sur les objectifs du clinicien et visent la perte de poids, alors que la recherche nous indique qu'il vaut mieux viser des objectifs réalistes et centrer les soins sur la santé générale du patient et son mode de vie. Dans le présent projet nous avons développé une clinique de 1^{ère} ligne spécialisée en obésité et en santé métabolique dans le cadre de la bourse de développement de RESEAU-1 Québec au GMF-U de Saint-Charles-Borromée (GMF-U SCB).

MÉTHODE :

Nous avons effectué une revue de la littérature pour identifier les données probantes soutenant la prise en charge de l'obésité. L'équipe de recherche composée d'une patiente partenaire et des intervenants du terrain (infirmières, médecins, pharmacien, nutritionniste, psychologue, agent d'amélioration de la Qualité, gestionnaire) s'est rencontrée à trois reprises et un consensus a été établi quant à la réorganisation des soins sous forme de clinique spécialisée en première ligne.

RÉSUMÉ DES RÉSULTATS

Les conclusions sont basées sur les données de la littérature et sur le vécu expérientiel de la patiente partenaire et de l'équipe de terrain. Les objectifs de la clinique sont : 1) volet clinique : offrir des meilleurs soins aux patients; 2) volet pédagogique : enseignement aux résidents de la médecine centrée sur le patient et de la collaboration interprofessionnelle; 3) volet recherche : laboratoire vivant pour développer des innovations en lien avec l'obésité et la santé métabolique. Les faits saillants sont : 1) un suivi régulier est essentiel et ce peu importe l'intervenant; 3) objectifs du patient et non du médecin; 4) infirmière pivot pour coordination des soins; 5) outil de communication à développer.

CONCLUSION

La bourse de développement du Réseau-1 Québec et l'aide du RRAPPL-UL a permis aux intervenants du GMF-U SCB d'organiser une équipe de recherche comprenant une patiente partenaire et les intervenants du terrain. Celle-ci a développé une clinique spécialisée en obésité et santé métabolique centrée sur le patient

292 - Shared decision making in primary care consultations around medical leaves of absence for mental disorders

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Background and aims: Family physicians and nurse practitioners (NP) commonly encounter people experiencing distress or mental illness that request a leave of absence from work. However, these professionals receive little training in this area and have little guidance available to them on how to effectively manage medical leaves and engage their patients in work-related decisions. This presentation will describe a clinical interview guide that has been developed to support a more patient-centered management of mental health-related medical leaves in primary care.

Methods: This was a user-centered design study involving two family physicians, one psychologist, one patient partner, and two researchers. This interdisciplinary team met regularly between January and August 2018 to co-design the clinical interview guide. The physicians, psychologist and patient partner shared their experiences related to medical leaves and the research team drafted a prototype version of the guide. This was followed by two more design cycles, where professionals provided feedback on prototype versions of the guide and researchers refined the tool based on their feedback and guidance from the literature.

Results: The guide is approximately two pages in length and includes the main elements that should be covered by the physician or NP during consultations involving discussions around medical leaves. This includes the patient's current problems (e.g. needs, symptoms, history), employment status (e.g. type of work, stressors, relation between health problems and work functioning), and treatment plan. The guide also promotes shared decision making for two key decisions: whether or not to take a medical leave, and what treatment should be selected. The guide prompts professionals to explore preferences, explain risks and benefits, and make informed, shared decisions with their patients.

Conclusions: This clinical interview guide was co-designed to be used by primary care professionals to support management and decision-making related to mental health-related medical leaves. This innovative tool is brief, integrates easily into the workflow of clinicians, and has the potential to enhance patient involvement and patient-centeredness at the point-of-care

294 - SOINS Diabète

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Le Projet SOINS est un nouveau modèle d'organisation des soins pour le suivi des patients atteints de maladies chroniques qui s'appuie sur les composantes définies par le Chronic care Model (CCM) : 1) la promotion de l'autogestion, 2) le suivi du plan de traitement des patients par une infirmière clinicienne, 3) l'éducation des patients, 4) l'accès à des professionnels spécialisés, 5) une communication améliorée entre le patient et son équipe de soins, 6) l'utilisation d'un registre électronique de patients et d'outils d'aide à la prise de décision intégrée au dossier médical électronique et 7) l'implication de patients partenaires et des services communautaires.

L'implantation de cette Trajectoire de Soins sera effectuée en se basant sur le Model for Improvement intégrant la pratique réflexive et la mise en œuvre progressive de cycles Plan-Do-Study-Act (PDSA).

Les patients diabétiques seront ciblés pour la première phase d'implantation et d'utilisation du modèle. **Le but de ce projet sera de documenter l'implantation progressive et les effets du Projet SOINS Diabète au sein de 2 GMF-U et 2 GMF, afin de développer un guide d'implantation pour l'ensemble du Québec.**

Pour ce faire, notre équipe utilisera le RE-AIM pour étudier la portée, l'efficacité, l'impact d'une intervention sur les résultats, l'adoption, la mise en œuvre et le maintien de la TdeS. La portée et la mise en œuvre seront documentées par les données des DMÉ. L'efficacité du projet sera documenté par les indicateurs de l'INESSS, les niveaux d'autogestion et de détresse liée au diabète et les coûts associés. L'évaluation des changements sera documentée par les données disponibles dans les DMÉ. L'évaluation du modèle sera documenté par des entrevues et un sondage auprès des professionnels et des patients diabétiques. Finalement, le processus d'implantation sera documenté par l'utilisation d'outils de suivi et de la description détaillée des cycles PDSA.

Le projet permettra d'implanter et d'évaluer un modèle d'organisation des soins pour les patients diabétiques où les compétences de tous les professionnels sont reconnues et valorisées. Les patients auront un accès accru au soutien nécessaire en temps opportun, avec le bon professionnel de la santé.

296 - The eTRIO trial: Novel online education programs to facilitate effective involvement of family carers in oncology

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Background and aims: Family carers are at the core of patient cancer care, yet they frequently report feeling disempowered, excluded and ill-equipped to support patients. Clinicians value carer involvement, however report a need for educational/training opportunities to help them effectively navigate clinician-family interactions. Our group published evidence-based TRIO Guidelines to improve clinician engagement with carers and management of challenging situations involving family. To facilitate implementation of TRIO Guidelines into clinical practice, we have developed two novel online education modules: i) for oncology clinicians and ii) for cancer patients and carers. This presentation will describe the modules' development and the eTRIO RCT protocol.

Methods: The eTRIO learning modules were rigorously developed, based on: i) our groups Guidelines, and iii) two additional systematic reviews of interventions/advice targeting carer communication and involvement in consultations. The draft modules' content and interactive learning activities were iteratively reviewed by an expert advisory group involving academic/clinical experts (n=7) and consumers (n=5). The functionality of both online modules was tested using the co-design methodology involving workshops with the research, design and development teams, as well as potential end-users.

Results: The eTRIO online programs utilise the latest interactive web-technology to promote learners' effective engagement throughout the module, and uptake of key skills and strategies. The modules integrate 11 professionally produced short films (with embedded trigger activities) which model effective behaviours in clinical scenarios (e.g. clinician dealing with conflicting patient-family treatment preferences, family carer advocating for a patient's needs). Experiential content is provided via video-messages from consumers and clinicians. A national RCT will evaluate the effectiveness of the combined modules (versus an attentional control) in: increasing carer involvement in consultations, improving clinician/patient/carers self-efficacy in triadic communication, improving patient/carers psychosocial outcomes, and lowering health care costs.

Conclusion: The eTRIO online education training modules are designed to increase clinicians' confidence and skills in interacting with a patient's loved ones and enhance carer involvement in cancer consultations and decision-making. These interventions have the potential to shift the status of informal carers from an underserved, vulnerable, and ill-equipped population to being confident, engaged, informed, and supported partners in consultations and patient care.

300 - The Applicability of a Patient Decision Aid in App Format for Patients with Chronic Kidney Disease

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Background: The Dialysis Guide (DG) is a patient decision aid (PDA) in app format developed for smartphones for patients with chronic kidney disease facing the decision about dialysis modality.

The aim of the study was to examine whether the app, the DG, is applicable as a PDA for patients with chronic kidney disease to decide on dialysis modality.

Method: The respondents completed a questionnaire before and after using the DG. The respondents' decisional conflicts were examined using the Decisional Conflict Scale (DCS), and the usability was examined using the System Usability Scale (SUS). The change in decisional conflict was determined with a paired t-test.

Results: Twenty-two respondents participated and the mean age was 65.05 years; 90.91% had attended a patient school for kidney disease, and 59.09% had participated in a conversation about dialysis choice with a health professional. After using the DG, the respondents' decisional conflicts were reduced, though not statistically significantly ($p = 0.49$). The mean value (SD) of the SUS score was 66.82 (14.54), corresponding to low usability.

Conclusion: The DG does not significantly reduce the decisional conflict, though the results indicate that it helped the respondents to decide on dialysis modality. Attending a patient school and having a conversation about dialysis choice with a health professional is assumed to have had an impact on the decisional conflict before using the DG. The usability of the DG was not found to be sufficient, which might be caused by the respondents' average age. Thus, the applicability of the DG cannot be definitively determined.

306 - Typologie des attitudes et des croyances stigmatisantes des étudiants en sciences infirmières du Québec envers la clientèle autochtone - Une étude descriptive

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La prestation de soins de qualité et équitable auprès de l'ensemble des clientèles est au cœur des pratiques infirmières. Toutefois, les pratiques reflètent une disparité entre l'offre de traitement et les besoins de certaines clientèles vulnérables, telles que la clientèle autochtone. Les Autochtones y sont particulièrement vulnérables en raison du cumul de risques apporté par le colonialisme et la complexité de leur état de santé. De plus, des barrières à l'accès aux soins existent dans les interactions entre professionnels et patients. En effet, plusieurs études mettent en évidence des interactions marquées par la stigmatisation, la discrimination avec les prestataires de soins. Si l'expérience des Autochtones est relativement bien documentée dans la littérature, les attitudes et les comportements des infirmières le sont beaucoup moins. L'étude proposée vise précisément à pallier cette lacune avec une approche collaborative impliquant des patients partenaires autochtones. **But.** L'étude vise à dresser un portrait des attitudes et des croyances stigmatisantes des étudiants en sciences infirmières envers la clientèle autochtone. **Objectifs.** Nous souhaitons : 1-Décrire les attitudes et les croyances stigmatisantes des étudiants envers la clientèle autochtone et 2- Définir des profils (typologie) d'attitudes et de croyances stigmatisantes envers la clientèle autochtone chez les étudiants en sciences infirmières. **Méthodes.** Cette étude s'inscrit dans un projet de recherche plus large et axé sur le patient, qui vise à développer *un instrument de mesure de la stigmatisation des professionnels de la santé envers la clientèle autochtone*. Notre étude, qui s'inscrit dans ce contexte général, utilisera un devis descriptif quantitatif transversal et une approche collaborative avec des patients partenaires autochtones. L'échantillon (n=100) sera recruté sur une base volontaire. Les données seront colligées au moyen d'un questionnaire en ligne (Limesurvey) et transférées dans une base de données SPSS. Les analyses seront menées en deux temps : 1- Des analyses descriptives décriront l'échantillon ainsi que les attitudes et les croyances stigmatisantes des participants, 2- Une analyse typologie permettra de définir les différents profils en regard de la stigmatisation. **Résultats.** À venir.

307 - Elicitation of preference and shared decision making in cancer breast screening programs

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Background

Breast Cancer (BC) screening programs has been expanded in Spain during the 1990s based on scientific evidence that screening significantly reduce breast cancer mortality.

Gotzsche, with its systematic review, introduced the debate about screening benefits and harms. Nowadays it is known that screening may cause harms, such as overdiagnosis, false positives and false negatives. However, heterogeneous opinions and different recommendations have been used by professionals and scientific societies about BC screening.

The principal lines on BC screening research are: (1) to analyze the risk-based screening; and (2) to carry-out shared decision making (SDM).

Our research group has obtained results on cost-effectiveness and harm-benefit, and preferences and acceptability for a personalized program on women. In addition, we could observe opposition and disagreement from some health professionals to use SDM.

Global Aim for our proposal research (2019-2021)

To evaluate the health professional's acceptability and preferences about SDM and the opportunity of introducing it in BC Early Detection Programs.

Specific objectives and Methods

To perform:

1. A literature systematic review about the professionals' disposition to accept the SDM model.
2. A DELPHI model involving health professionals to identify barriers and facilitators to create a SDM tool in BC screening.
3. A decision aids, in order to propose an alternative organization including SDM model in the BC screening program.
4. A cost-benefit analysis in order to compare the SDM alternative with the current scenario and estimate the budgetary impact.

Expected results

Ensuring a broad participation of health professionals aiming to do a reform of the BC screening program more viable, resulting in an improved cost-benefit ratio.

*This study is on implementation process, it has not results.

309 - Service design for improving the implementation of SDM in cancer treatment

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Background **and** **aims**

Shared Decision Making (SDM) achieves benefits for patients and oncologists, but implementation of SDM in oncology is limited. A promising approach to implementation is service design. In service design, not only the consultation, but the entire patient journey is considered as a service - including many moments of decision-making. Those involved encounter many so-called 'touch points', such as medical devices, websites, letters, instruction leaflets, sign posts, etc. All these touch points need to be considered to become parts of a consistent support system (the service), helping patients and clinicians to make the best decisions. The aim of our study is to define which touch points in a cancer treatment trajectory (for locally advanced pancreatic cancer, LAPC) can affect knowledge and empowerment of patients, their significant others, and clinicians participating in SDM.

Method

We started with an analytical auto-ethnography capturing the rich details of the experience of a patient with LAPC and his wife (IG, also a service designer) This was followed by an exploratory qualitative study with other patients with LAPC and their significant others, to corroborate and extend the findings of the auto-ethnography. In qualitative interviews we investigate the perspective of patients, their significant others and clinicians on relevant touch points. Interviews are audiotaped, transcribed, coded and analysed using a framework approach. Interviews are adapted, based on the analysis of earlier interviews.

Results

From the first results it becomes clear that patients and caregivers continuously need to adapt by, to meet stressful changes during the journey. Flexible teamwork and a flexible service are facilitators of SDM, but are not always present.

Conclusion

The analytical auto-ethnography contains important areas to improve the implementation of SDM in oncology with service design. The semi-structured interviews are currently taking place and results will be updated.

310 - Using eHealth Technology to Improve Shared Decision-Making in Asthma Care

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Background

Asthma is the most common chronic respiratory disease in adults, yet >50% of Canadian asthma patients remain poorly controlled. Patient-physician communication is suboptimal, and although a majority of asthma patients prefer an active and collaborative role in asthma management, they are less involved in their care than they would like to be. Hence a role for shared decision-making, SDM.

SDM improves adherence to beneficial but underused treatments and clinical outcomes in asthma patients, but is not yet routinely implemented. Several barriers to SDM uptake have been reported, and although DAs are effective in overcoming these barriers, implementation of SDM and DAs has been challenging.

As mobile applications could present a novel vehicle to drive SDM through use of DAs in routine care, we are now integrating an asthma decision aid (DA) that fulfills International Patient Decision Aid Standards within an existing asthma eHealth tool [a patient-facing mobile application and a clinician-facing computerized decision support system (CDSS)] to determine its effects on real-world SDM between asthma patients and clinicians at the point of care.

Objectives

We aim to assess whether this novel system (DAs embedded into an existing eHealth tool) enables real-world use of DAs and whether it drives SDM in asthma.

Methods

The system will be tested in a 6-month pilot prospective cohort study enrolling prescribers (~10) and adult patients with asthma (~800) from a primary care setting in Ontario, Canada.

We will measure:

- 1) Uptake of DAs** (patient and clinician weekly access frequency, duration of access, and proportion of visits during which the tool was accessed and completed; through system audit, Google Analytics and e-chart review);
- 2) Quality of resulting SDM** (through the validated Shared Decision Making Questionnaire).

Perspectives

SDM holds much promise, but uptake remains limited. Our novel approach seeks to engage patients and clinicians in SDM by leveraging technology to address known barriers to SDM uptake. In this pilot context, our extensive process evaluation will enable a deep understanding of how this intervention functions. Accordingly, we believe that our results will contribute to the science of knowledge translation and prove useful to SDM scientists across diseases.

311 - Comparative effectiveness of encounter decision aids for early-stage breast cancer across socioeconomic strata

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Background and aims

Breast cancer is the most commonly diagnosed malignancy in women. Both breast-conserving surgery (BCS) with radiation and mastectomy are options for patients with stages I-III breast cancer. Each option has distinct risks and benefits, but no difference in terms of survival. Women of lower socioeconomic status (SES) with early-stage breast cancer often experience poorer clinician-patient communication, lower satisfaction with surgery and decision-making, and higher decision regret compared to women of higher SES. They often play a passive role in decision-making, are less likely to undergo BCS and may face higher mortality. We aimed to 1) evaluate the comparative effectiveness of two encounter decision aids against usual care; and 2) explore the effect of a picture-based encounter decision aid on socioeconomic disparities in decision-making and treatment choice.

Methods

We conducted a block-randomized controlled superiority trial with blocking by SES, randomization at the clinician level, and three arms: (1) Picture Option Grid, (2) Option Grid, and (3) Usual Care. The target sample size was 600 patients of higher and lower SES from four large cancer centers in the US. We included women at least 18 years old with stages I-III breast cancer and a basic command of English, Spanish, or Mandarin Chinese. Our primary outcome measure was the revised 19-item Decision Quality Instrument. We collected data at baseline (before the surgical consultation), during the consultation, at 1-week, 12-weeks and 1-year post surgery.

Results

Recruitment ended in February 2019. Fifteen surgeons were randomized to one of three arms. As of January 2019, we have recruited 585 women. Our consent rate across study sites is 76%. We are currently analyzing data using standard hierarchical regression and the similarly-specified models

represented within a mediation analysis framework. We are also performing heterogeneity of treatment effects analyses by SES, age, ethnicity, race, literacy, language, and study site. Full results available in July 2019.

Conclusion

This study promotes the involvement of women of lower SES in breast cancer treatment decisions to address disparities in this area. We hope to identify solutions that effectively improve outcomes across socioeconomic strata and reduce disparities in quality of care.

316 - Self-reported screening practices of family physicians participating in the colorectal cancer screening program of Canton Vaud: a cross-sectional study

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Background: An organized colorectal cancer (CRC) screening program was implemented in the Canton of Vaud in Switzerland in 2015, offering the choice of the fecal immunochemical test (FIT) or colonoscopy via a visit with a family physician (FP). Given the central role of FPs in the program, this study aimed to compare FP's preventive practices with the objectives of the program, namely "informing patients of the program" and "presenting the choice of colonoscopy and FIT", and to raise factors associated with FPs presenting the choice of colonoscopy and FIT.

Methods: This was a mixed-methods study using an online survey and semi-structured interviews. Participants were FP from the canton of Vaud who had included at least one patient in the screening program. Multivariate logistic regression was used to compare physicians who offered primarily colonoscopy to those who offered a choice of tests.

Results: The participation rate was 40% (177 respondents / 443 eligible). The majority of physicians (68%) reported informing more than 75% of their eligible patients about the CRC screening program. Regarding the screening method offered by FP, 20% (n=36) of physicians prescribed only colonoscopy, 13% (n=23) only FIT, 35% (n=62) both while indicating their preferred test, 21% (n=37) both screening methods on an equal basis and 9% (n=16) both methods using a decision support tool. Lack of time (n=86, 33%) was the principal reason cited for not informing patients. Predictors of offering only colonoscopy rather than a choice of screening tests included: first, FP choosing colonoscopy for his or her own screening (OR 0.12 (0.02 – 0.54)**); second, having more than 20 years of experience (OR 0.21 (0.05 – 0.76)*); and third, seeing 300 or more patients per month (OR 0.33 (0.13 – 0.81)*). When asked what could improve the program, 17% (n=31) wrote that patients should be informed in advance about the program by postal mail and large-scale communication campaign.

Conclusion: The majority of FPs reported CRC screening practices consistent with the objectives of the program. However, in order to obtain equal information and to gain time, patients should be informed in advance.

320 - Making SDM a reality: Methods for large-scale production of evidence based patient decision aids (EbPDAs) Part 1: Which of the methods in evidence based medicine and health technology assessment can be applied to developing decision aids, and where do we have to develop new procedures?

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Background

Evidence based patient decision aids should be available and affordable for many different medical decisions. In order to make SDM a comprehensive reality in hospital or ambulatory care, several high-quality (evidence-based) decision aids must be produced simultaneously. Therefore, we must develop from costly single unit research projects to serial assembly.

This requires an effective and unified method for serial production, allowing the application of generic processes to different clinical contexts, languages and health care systems. The presentations in this workshop aim to encourage discussions about core methodological standards and processes for effective production of decision aids.

Methods

Within our German-Norwegian SDM cooperation project, 30 topics for in-hospital decision aids were up-to-now generated in close cooperation with patients and physicians. The evidence for relevant treatment options was searched systematically, appraised and synthesised in cooperation with review specialists. Evidence was transferred to easily comprehensible patient-information.

Results

A range of issues arising throughout information retrieval, critical appraisal/synthesis of evidence and producing patient-understandable point of care information will be discussed. Risk communication, which is also a huge challenge in this field, will not be part of this cluster. The presentations should be seen as interactive work in progress or as a collection of challenges we are still facing in our project.

Conclusion

One major prerequisite for large-scale implementation of SDM is a uniform and rigorous process of generating relevant information for evidence based patient decision aids. Exchange and agreement on methods will enable to share decision aids across different working groups and countries.

321 - Measuring shared decision making in oncology: Psychometric properties of the iSHAREpatient and iSHAREphysician questionnaires

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Aim:

Questionnaires to assess shared decision making (SDM) often focus on physician behaviour, but SDM requires patient behaviour as well. Moreover, strong ceiling effects are seen. Further, definitions of what SDM should entail differ per healthcare setting. We developed the iSHARE questionnaires to assess SDM in oncology, which include both physician and patient behaviours. These behaviours relate to several domains, e.g., *the physician provides benefits/risks of the treatment options, the patient considers what is most important to him in context of treatment options*. The present validation study aims to determine 1) construct validity (iSHAREpatient and iSHAREphysician), 2) test-retest reliability (iSHAREpatient), and 3) correlation between the iSHAREpatient and iSHAREphysician.

Methods:

Physicians from different departments in five Dutch hospitals asked several cancer patients for participation, following a decision consultation. Physicians completed the iSHAREphysician, the Control Preferences Scale (CPS), and the SDM-Q-Doc for each of these consultations, and the Ideal Patient Autonomy Scale (IPAS) once at the start of the study. Participating patients completed the iSHAREpatient, the SDM-Q-9, the CPS, the Decisional Conflict Scale (DCS), the Combined outcome measure for risk communication and treatment decision making effectiveness (COMRADE), the Trust in Oncologist Scale (TiOS), the Patient Satisfaction Questionnaire (PSQ), the Perceived Efficacy in Patient-Physician Interactions (PEPPI-5), and age, gender and education. Patients were further asked to complete the iSHAREpatient again one to two weeks after the first assessment. We formulated a priori hypotheses at total and domain score level. E.g., we expected the iSHAREphysician to correlate >.40 with the SDM-Q-Doc, the iSHARE domain 'Consider Treatment Options' in patients to correlate >.60 with the DCS 'Values Clarity'-subscale, and the scores on the iSHAREpatient to be higher in younger, in female, and in highly educated patients. Finally, we determined the correlation between the iSHARE questionnaires.

Results:

Data collection is ongoing. Currently, 40 physicians rated 119 consultations using the iSHAREphysician and 82 patients completed the iSHAREpatient. We expect to present results on >100 completed iSHAREpatient questionnaires.

Conclusions:

The results will provide information about the psychometric properties of the iSHARE questionnaires and will show to what extent these questionnaires are a valuable addition to instruments currently available.

324 - Participatory approach with a citizen advisory group: an iterative evaluation and adaptation of patient decision aids

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Introduction

Guidelines for the development of patient decision aids (DAs) recommend involving the target population throughout the creative process. We are developing cancer screening decision aids (DAs) for colorectal, prostate, and lung cancer. We wanted a pool of citizens who could participate in repeated meetings and contribute to the iterative, user-centered evaluation and adaptation of DAs. However, it can be challenging to recruit asymptomatic citizens aged 50 to 75 years, our target population. Further, there is little literature reporting on methods for the creation and maintenance of such groups.

Methods

We recruited a participatory group of citizens without previous cancer diagnoses using contacts with: a consumer association, a state association for elderly people, patients from our academic practice, and standardized patients from the medical school. We planned two qualitative evaluation cycles for each DA, each time with two in-person meetings of 10 people lasting 2 hours, and an evaluation by mailed questionnaire to remaining group members.

Results

We successfully recruited 50 citizens, though we had to adapt and intensify our communication strategy. For the DA on colorectal cancer screening, we have had 2 meetings with 8 and 9 of 10 people invited attending. Twenty-three of 28 participants mailed the questionnaire responded. We found that simultaneous in-person meetings and questionnaires provided complementary information and allowed us to reach more participants. For the prostate cancer DA, we had one meeting with 4 of We are beginning development of the DA for lung cancer screening. Participants were very appreciative our participative approach. We have made numerous changes to our processes along the way, like optimizing the timing and length of questionnaires.

Conclusion

Our participative approach with a citizen group to evaluate patient DAs has provided us with valuable information and been evaluated positively by participants. The involvement of citizens on a volunteer basis has required extensive personalized communication. The creation of an initial pool of available people has resulted in a high participation rate. These results could help other research groups perform participative research in a way that is informative and feasible.

330 - Design, Accrual, and Experience Fielding Two Decision Aid Trials for Localized Prostate Cancer Targeting Minority Men in the US

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Background and Aims: Prostate cancer is a prevalent condition whose treatments carry disputed comparative benefits and important quality of life tradeoffs. Though decision aids for prostate cancer treatment are among the most common conditions in the decision aid literature, no studies to our knowledge have tested the comparative role of both in-visit and pre-visit decision aids nor have any specifically over-sample minority men in the US at risk for worse outcomes. The aim of this study was to test the comparative effectiveness of two kinds of decision aids – in-visit and pre-visit – alone and in combination to improve patient knowledge, symptom burden 1 year after initial treatment.

Methods: We designed and implemented two trials -- a four-arm, cluster-randomized trial of two different decision aids along and in combination among sites capable of oversampling minority men with a diagnosis of early stage prostate cancer from urology practices within the Alliance NCORP Research Base. In parallel we conducted a three-arm patient-level randomized trial comparing pre-visit and in-visit decision aids. Both trials will assess knowledge immediately post-consultation. Both trials have been open since late summer 2017. The first trial has accrued 140/172 proposed patients at 16 sites. The second has accrued 90+/100 patients at 4 sites.

Results: At ISDM we will present accrual and associated patient demographics for these trials and outline experiences in their respective implementation. We will summarize our experience and speculate on the implications of conducting trials with similar designs as well as future dissemination and implementation opportunities.

Conclusions: Recruiting minority to men to prostate cancer decision aid trials if feasible. Whether in-visit or pre-visit modes of delivery are equally effective or superior will be ascertained in future analyses.

331 - Factors associated with decisional regret among caregivers of cognitively impaired seniors who have faced the decision to move or not: a secondary analysis of a randomized cluster trial.

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Background and aims: Decision regret is associated with an increased rate of adverse events and poor quality of life. Identifying people at high risk of developing decision regret is a first step in building risk-mitigation strategies. We aimed to identify the factors associated with decisional regret among caregivers of cognitively impaired seniors who have faced housing decision.

Methods: We performed a secondary analysis of data collected in a two-arm multicenter cluster randomized trial. The purpose of the trial was to evaluate the effect of training interprofessional home care teams in shared decision-making on seniors who have faced a housing decision and on their caregivers. A total of 16 primary healthcare and social service centres in the Province of Quebec Canada participated in the study and were randomised to the intervention arm (training programme) or the control arm (usual care). Data was collected using self-administered questionnaires. Decisional regret was assessed using the decisional regret scale. Our identification of independent variables to be included in the data analysis was informed by the Conceptual Model and Approach to Measuring Serious Illness Communication and its impact. This conceptual framework provides a theoretical description of the communication between clinicians and patients or their caregivers. Factors influencing regret in caregivers is classified as follows: a) communication quality and processes, b) patient experience, c) shared decision making, d) patient-surrogate communication, e) advance directive completion and f) goal-concordance care. Descriptive and appropriate bivariate and multivariate analyses will be used.

Results: Among 296 caregivers, 221 (74%) were women. The average age (\pm SD) was 62 (\pm 11.73) years. The mean \pm SD of decisional regret score was 12.43 ± 18.12 . Overall, 157 (50.81%) caregivers experience regret and they were older than those who did not (mean age (\pm SD), 63.46 (\pm 11.75) vs 60.87 (\pm 11.61) years). These are preliminary results, bivariate and multi-variate analysis will be forthcoming.

Conclusions: Our results will help identifying people at high risk of developing decision regret and allow risk-mitigation strategies.

332 - How much shared decision making do Canadians experience when facing healthcare decisions? A web-based population survey.

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Introduction: We know little on SDM implementation in clinical practice from a population-based perspective. We aimed to assess how much SDM was experienced by Canadians in 2017-2018.

Methods: In collaboration with a survey firm and informed by the reporting guidelines CHERRIES, we conducted a pan-Canadian cross-sectional online survey in January 2018 on a representative Web-panel of Canadian citizens. SDM was measured using five questions focusing on participants' healthcare experiences over the past 12 months. Regarding the decisions they had had to make about a care/treatment choice during the past 12 months, participants were asked how often their health professional: 1) mentioned they had a choice, 2) presented advantages and disadvantages of the available options, 3) asked about their opinion and preferences, 4) asked which option they preferred and 5) if their actual level of participation in decision-making matches their preferred level of participation. We computed an average SDM score (1(never) to 5(always)). We weighted data for age, sex, region and language based on distributions reported by the 2016 Statistics Canada census. We explored variations across socio-demographic factors, jurisdictions, geographical area and care setting (homecare or not) using multivariate weighted regressions.

Results: Considering all potentially eligible participants who clicked on the link to visit the survey as unique survey visitors, the view rate was 17.3% (1,725/10,000) and the participation rate was 92.2% (1,591/1,725). Of the 1,591 participants surveyed, 1,010 received healthcare services during the past 12 months (58.3% were women and 23.6% were aged ≥ 65 years old). Average SDM score (mean \pm -SD) was 2.3 \pm 1.2; 42.8% of respondents reported their health professional always or often discussed choices, 45.4% reported pro/cons of options were presented, 38.7% reported they were asked for their opinion, 40.2% reported they were asked about preferred option, and 54.2% reported a match between preferred and actual level of participation. Increasing age, rural setting, living in Quebec province and not being Caucasian significantly decreased SDM experienced. Elderly respondents receiving homecare reported the least SDM (mean score \pm -SD 1.7 \pm 0.5).

Conclusion: Canadians experienced a low degree of SDM in 2017-2018, with variations across age, ethnicity, jurisdictions, care settings and geographical areas.

333 - Methods for large-scale production of evidence based patient decision aids (EbPDAs) Part 4: From scaled evidence based clinician-oriented systems to evidence based patient decision aids.

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Background

Large-scale production of evidence based content has not been fully established for patient decision aids but it has been fully established for clinician-oriented point of care references. The most likely route to achieving this state for patient decision aids will be adaptation of methods and systems for clinician-oriented tools with special attention to the specific needs for high-quality patient decision aids

Methods

We are actively involved in the development of teams, processes and systems for large-scale production of evidence based patient decision aids. Following achievement of this state for clinician-oriented systems we are developing systems for at least three different styles of patient decision aids: HealthDecision (image-based format with icon arrays), Option Grid (tabular format for easy reading), and an investigative project for German patient decision aids.

Results

We will present the common methodologies (standards) developed and implemented for these three different styles of patient decision aids. We will also summarize differences that are necessary compared to processes and systems for clinician-oriented content. For example, patient-relevant questions such as duration of surgery-induced pain may not be readily covered in conventional research, systematic reviews, guidelines or other clinician-oriented sources. Another example is that comparison frame is a more critical consideration for use of a patient decision aid than for clinician-oriented resources.

Conclusion

Establishing standards, methods and systems for large-scale production of evidence based patient decision aids is necessary to reach the potential of shared decision making in real-world settings. In 2019 we are reaching the transition point from shared decision making as an academic endeavour to a practice expectation during clinical practice.

334 - Evaluating a shared decision-making e-learning program for healthcare professionals caring for older adults living with neurocognitive disorders

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Purpose: Our aims were (1) to study the processes to implement a training program with an e-learning activity on shared decision-making (SDM) and five Decision Boxes aimed at people with neurocognitive disorders and their caregivers; and (2) to measure the program's impacts in terms of participants' knowledge, understanding, and intention to adopt SDM.

Methods: We performed a convergent mixed method study. Participants were healthcare professionals working at family medicine clinics and in homecare settings in the Quebec City area who signed up for the training as a continuing professional development activity. We conducted telephone interviews with a sample of cases where half had completed the training and the other half had not. The participants also completed a questionnaire before and after the training, to assess their knowledge, understanding, and intention to adopt SDM. Three researchers conducted an independent thematic analysis of the interview transcripts, as per the theory of planned behaviour. We performed bivariate analyses with data from questionnaires.

Results: Of the 47 participants who signed up, 31 (66%) completed at least one part of the training. Of those, 10 (32%) completed the online activity in its entirety, and 26 (84%) opened at least one Decision box. The factors that influenced participation in the training program were divided into five themes: 1) pros and cons of participating; 2) ability to participate; 3) ability to adopt SDM; 4) training program characteristics; and 5) issues surrounding implementation of the tools. Following training, we observed an improvement in participant knowledge about risk communication ($p=0.02$) and three of the five clinical themes ($p=0.0004/0.0005/0.001$). The intention of participants to adopt SDM was high before the training, and remained high thereafter (average pre= 5.6 ± 1.0 / post= 5.9 ± 0.9 , on a scale of 1 to 7, where 7 is high).

Conclusion: Our results suggest that, to improve participation rates, the training could be condensed and tailored to the specific needs of each type of professional. The results of this study will allow us to modify the training course in order to improve participation rates and, ultimately, uptake of meaningful SDM with patients.

335 - Implantation en routine de la prise de décision partagée dans le cancer du sein au stade initial : Analyse longitudinale du point de vue des patientes

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Contexte : La prise de décision partagée dans la chirurgie du cancer du sein au stade initial est utilisée en routine au sein du département sénologie du Centre régional de lutte contre le cancer Léon Bérard (Lyon, France) depuis 2007 par 3 chirurgiens.

Objectifs : Analyser de façon longitudinale le vécu par les patientes de ce processus décisionnel.

Méthodes : Triangulation méthodologique basée sur deux périodes d'analyse utilisant des observations de consultations, des questionnaires et des entretiens individuels semi-directifs avec les patientes.

Résultats : Période 1 : 2009/2011. Réalisation de 47 entretiens auprès de 14 patientes, recueil de 132 questionnaires et observations de 26 consultations. Période 2 : 2016/2017. Observation de 15 consultations et réalisation de 12 entretiens auprès de patientes dont nous avons observé la consultation de prise de décision partagée.

La dimension longitudinale des données en lien avec la complémentarité des recueils s'avère particulièrement intéressante en ce qu'elle permet :

- D'évaluer les évolutions et la variabilité des attitudes des patientes entre les deux périodes de relevés des données : histoire du dispositif de prise de décision partagée, évolution du positionnement des médecins.
- De dégager plus explicitement les conditions interactives et les négociations entre médecins et patients ainsi que les facteurs relevant du psychique et du social qui s'avèrent les plus influents sur la possibilité (ou l'impossibilité) d'être, de se sentir et de se définir comme étant véritablement engagées dans la prise de décision : relation avec le médecin et attentes de la médecine, représentations de la maladie et des soins, sentiment de sécurité et rapport à l'information, conceptions et vécus de l'autonomie, construction de la notion de responsabilité.

Discussion : Cette analyse originale dans le temps d'un processus de prise de décision partagée ancré dans les pratiques permet de prendre la mesure de l'évolution des positions des patientes. Le processus permet aux patientes de faire part aux médecins de leurs représentations, de révéler leurs préférences et d'accompagner leur vécu de l'incertitude.

339 - Impact of Shared Decision-Making in Patients with advanced kidney disease in Taiwan

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Advanced kidney disease is a high prevalence and critical disease in the world. End stage renal failure needs renal replacement therapy for life saving which influences economic and health systems in majority of countries. However, patients and their family show their anxiety, worry, and helplessness when they face this condition and multiple medical choices, and it always leads to worsen doctor-patient relationship. In Taiwan, even though we have well-recognized National Health Insurance for people to lower threshold for medical support, there are still more and more legal problem occurred daily in Taiwan. Comprehensive communication and understanding patients' viewpoints are crucial keys to solve this situation.

After introducing shared decision-making in Taiwan, we also recruited 72 patients with renal disease enrolling shared decision-making program in 2018. In these patients, 26 patients (36.1%) were female with average age 67.4-year-old and 46 patients (63.9%) were male with average age 60.0-year-old, and average age was 63.9-year-old. Furthermore, 12 patients (16.7%) underwent shared decision-making during their hospitalization and 60 patients (83.3%) received coaching at outpatient department. Comparison with anxiety level of patients with renal disease without and with shared decision-making program, we found the decline of anxiety level showing 7.3% (70.8% à 65.6%). On the other hand, after interviewing with doctors or nurses by shared decision-making method, almost half of these patients could make their own further renal replacement therapy strategies at the first time successfully (43.1% v.s 56.9%). Finally, after one-year-course shared decision-making program performed in nephrology department, significant increase of choosing peritoneal dialysis was also noticed (41.9% v.s 51.6%).

In conclusion, discussing about renal replacement treatment issue with patients suffering renal disease is difficult, sensitive, and easily to worsen doctor-patient relationship. Shared decision-making successfully help patients to participate and think about their own future management and life quality. It not only lowers medical personnel's pressure but also let patients receive correct and lifesaving treatment timely. Good communication tools and patients' involvement of their diseases will significantly improve patients' compliance.

341 - Modèle structurant pour développer et implanter une pratique de pointe au CIUSSS de la Capitale-Nationale : étude de cas portant sur la collaboration interprofessionnelle à la décision partagée.

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Introduction et objectif

Il existe des lacunes quant aux stratégies efficaces permettant le développement d'une pratique de pointe en santé et services sociaux. Notre objectif est de décrire le modèle et les stratégies du Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale (CIUSSS-CN) dans le cadre du développement et de l'implantation de la collaboration interprofessionnelle à la décision partagée.

Méthodes

Inspiré par l'étude de cas, notre équipe a porté son attention sur le contexte du CIUSSS-CN et sur le cas que représente le développement et l'implantation de la collaboration interprofessionnelle à la décision partagée auprès des aînés. Le CIUSSS-CN est un organisme public chargé de prodiguer les soins et les services sociaux dans la région de Québec (population : 730 000). Dans le cadre de sa mission universitaire, il doit développer et implanter des pratiques de pointe ayant un potentiel d'améliorer significativement les soins et services aux usagers. Un modèle et des stratégies pour structurer le développement, l'implantation et le rayonnement des pratiques de pointe dans tous ces services a donc été élaboré. Depuis 2017, la direction Soutien aux personnes âgées, la direction des services multidisciplinaires, le Réseau de collaboration sur les pratiques interprofessionnelles en santé et services sociaux, la Chaire de recherche du Canada sur la décision partagée et l'application des connaissances et la direction de l'enseignement et des affaires universitaires est à développer la pratique de pointe : « Pratique de collaboration interprofessionnelle d'aide à la prise de décision partagée avec la personne âgée à domicile ». À l'aide du modèle de développement de pratiques de pointe, nous colligeons les données portant sur son actualisation dans le développement de ce projet (e.g. structure du processus et du travail, maillage entre les acteurs, transfert de connaissances, actions menées dans l'établissement) et les leçons apprises.

Résultats

À venir.

Conclusion

Le modèle de développement de pratiques de pointe du CIUSSS-CN est un processus rigoureux qui permet de s'assurer que les organisations de santé et services sociaux puissent implanter efficacement des pratiques de pointe telles que celle de la collaboration interprofessionnelle à la décision partagée.

342 - Which information can and should we use when informing patients with chronic limb-threatening ischemia about treatment benefits and risks?

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Background and aims

Patients with chronic limb-threatening ischemia (CLTI) present with pain and wounds, and carry a high risk of losing their affected limb. International guidelines advise to treat these patients with revascularization. However, invasive treatment carries substantial risks, while benefits can vary among patients. Therefore, there is a need for relevant and accurate information about the benefits and risks of invasive treatments in order to engage patients in shared decision-making. We studied what the best source would be from which to obtain these data.

Methods

Semi-quantitative, comparative study on the reported benefits and harms of treatment options of CLTI as provided by international (North-American, European) and national guidelines, recent systematic reviews, national (Swedish, Dutch) registries and the local hospital database of a Dutch tertiary-care university medical center. Beneficial outcomes of interest were overall and amputation-free survival (AFS). Possible treatment risks were major cardiovascular complications, amputation and mortality rates, and reoperations.

Results

International guidelines typically presented recommendations on the preferred treatment, but rarely exact numbers on the benefits or risks of available treatment options. Recent systematic reviews and RCTs provided results for both benefits and risks. However, some of the studies included in reviews were up to thirty years old. Swedish and Dutch registries provided diverging data on amputation rates (15% vs. 10%, respectively) and mortality rates (21% vs. 10%, respectively) after invasive treatment, but hardly any data on complication or reoperation rates. Local results from the university hospital also differed from other sources (AFS 67%, mortality 23% after invasive treatment), and were labour-intensive to retrieve.

Conclusion

The various sources of evidence about benefits and risks of available treatment options for patients with CLTI show contrasting results and differences in comprehensiveness. Thus, providing unequivocal and patient-specific information to foster shared decision-making remains a challenge. Reviews and RCTs seem to provide the most detailed information, but may not be in agreement with local performance.

344 - Bridging the Age Gap in Breast Cancer: Cluster Randomised trial to evaluate the clinical benefits of decision support interventions for older women with operable breast cancer

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Background

Older women with breast cancer are often treated in a non-standard manner for their early breast cancer. Outcomes in this age group are inferior to those in younger women which may reflect this differential management. This cluster randomised trial sought to evaluate the impact of two “complex” decision-support interventions (DESI) for older patients with breast cancer facing a treatment choice of:

The DESIs each consist of an online decision tool, a brief decision aid and a booklet. The primary aims of the study were to assess the impact of the DESIs on patient quality of life, treatment allocation, and measures of decision quality and regret.

Methods

A UK wide cluster randomised trial recruited women aged 70 years and over with operable breast cancer. Sites were randomly allocated to usual care or the use of two DESIs specifically developed to support the above treatment choices in this age group. Training in the use of the DESIs was provided. The primary outcome was global quality of life measured using the EORTC QLQ C30 tool. Treatment allocation was recorded for each patient. Shared decision making (collaboRATE) and decision quality (knowledge, preference and readiness to decide) were assessed at baseline. Decision regret (decision regret scale) and anxiety (Spielberger short form State Trait Anxiety Inventory) were assessed at six weeks and six months after treatment decision. Analysis is by both intention to treat and per protocol using SPSS and R.

Results

The main trial included 1321 participants recruited across 46 UK breast units between December 2015 and June 2018. The trial achieved its powered recruitment target. Analysis is underway and results will be presented alongside a discussion of the efficacy and utility of the DESI for routine clinical care in this age group of women.

Discussion

The implications of the findings will be discussed and recommendations about introducing the DESI components into clinical care will be presented.

345 - Engaging Patients and Families as Stakeholders in a Rapid Realist Review

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The involvement of patient and family advisors may guide researchers to more relevant questions, improve their data collection methods, and enhance data interpretation. Knowledge translation, a fundamental aspect of the research process, could also be enriched. Based on these potentials, patient-oriented research (POR) has gained momentum among researchers and significant institutional support.

To better understand how, why, and for whom POR impacts the health care system, a group of patient and family advisors (PFAs), researchers, clinicians and policy makers have embarked on a realist examination of the patient-oriented research literature. Following an established protocol for rapid realist review, the stakeholders, including PFAs will actively participate in shaping the project scope, developing the specific research questions, and identifying how the findings will be used. Patient and family advisors' role in determining the review products will be a key element of the review. All stakeholders will have the opportunity to contribute documents (published and grey literature) which will assist the search strategy. While the data extraction and analysis phases of the review will be conducted independently of the stakeholders, the stakeholders will be involved regularly to ensure the analysis coincides with the intent of the review. Once initial program theories are generated, the stakeholder group will review and modify as necessary. As rapid realist review is driven by policy recommendations, application of the findings will be determined by PFA stakeholders.

In this presentation, we will describe our experience working alongside a stakeholder group with PFAs who are informing a process about patient-oriented research. The rapid realist review method provides a unique opportunity to have stakeholders contribute directly to theory development regarding patient-oriented research.

346 - Let's talk about it? A provincial initiative to encourage shared decision making during the clinical encounter

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Background and aims : INESSS's mission is to promote clinical excellence and the optimal use of technologies, medications and interventions in health and social services in the province of Quebec. Aligned with its mission, INESSS aims to increase clinician awareness on how to discuss evidence-based health-related options with patients using a shared decision making (SDM) approach.

Methods : This initiative consists in developing and disseminating a) context-specific, decision aids (DA) for guiding clinicians to use a SDM approach during clinical encounters; and b) video vignette illustrating SDM key elements and DA use in clinical practice. These materials are under development using an interactive, three-phase, user-centered design involving patients, clinicians and representatives of professional associations as end-users.

Decision Aids - Phase 1 : decisional needs assessment consulting key informant and existing literature related to INESSS ongoing projects; development of the first prototype. Phase 2 : input from end-users; adaptation of prototype. Phase 3 : final input from end-users and INESSS scientific directors; graphic designer. **Video vignette** - Phase 1 : SDM content elements selection; true-to-life clinical scenario approval; draft script. Phase 2 : input from SDM experts and end-users; script adaptation. Phase 3 : final input from SDM experts, end-users and INESSS scientific directors; video production.

Results : Decision Aids - Phase 1 : We identified health-related decisions that should be discussed using a SDM approach in three distinct ongoing projects under INESSS responsibility : 1) antibiotic prophylaxis for Lyme disease, 2) use of implantable cardiac defibrillators, and 3) self-monitoring for long-term warfarin-treated patients. We drafted a first standard prototype guided by the Ottawa Decision Support Framework. Phase 2 : overall, end-users were positive about DA first prototype. Among suggestions for improving clarity and usability in clinical practice, end-users indicated a preference for using a binary response (important/not important) to each pro or con in DA's values clarification section. Phase 3 and video vignette development are currently ongoing and results will be updated.

Conclusion : This provincial initiative may help increase clinician awareness about SDM process in clinical practice and patient participation during the decision-making process.

352 - Māmawōhkamātowin (Working Together) – Co-Evaluation of a Co-Designed Program to Enhance Health and Wellness

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Background and aims:

When environmental tobacco smoke (ETS) is combined with other home-based exposures such as mould, dampness, and crowding, the risks to respiratory health are dramatically increased. Currently, 50% (119/238) of the homes at Sturgeon Lake First Nation are smoke-free.

The aims of this co-designed project were: to investigate whether or not the Green Light Program was improving health and wellness with Sturgeon Lake First Nation; and, to determine whether or not mould growth was different between houses that were smoke-free and those that were not.

Methods:

The overall co-design of the study was informed by the integration of community-based participatory research and transformative action research. This approach facilitates the process of identifying an issue of concern with the community, utilizing the strengths and contributions of the community and its members; as well as, involving all partners equally in the initiative. Each home in the community had a dust sample vacuumed from a two square meter of the floor most often utilized which was assessed for measures of endotoxin, mould and environmental tobacco smoke.

Summary of the Results:

The community-based survey was co-created with members of the community and the data collection done by peer researchers in the community. The initial summary of the results were as follows: participation rate was 100% (238/238) of the homes; “Satisfactory, Good or Very Good” was indicated by 91.3% (210/230) of those answering the question related to Self-Reported Health Status. The study is ongoing and the results of the dust samples will be returned to the community before being presented at the conference.

Conclusion:

Building on strengths and celebrating the small changes provides an environment in which meaningful change can be made.

355 - Contribution des services d'éducation prénatale de groupe et en ligne à l'implication des pères dans le choix et le soutien à l'allaitement : protocole d'une étude de cas

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Certains pères se disent peu concernés quant au choix du mode d'alimentation de leur bébé alors que d'autres ne se considèrent pas suffisamment préparés à soutenir leur conjointe qui allaite et se sentent « inutiles », voire « impuissants » face aux difficultés d'allaitement. Il a été démontré que les services d'éducation prénatale de groupe (ÉPG) peuvent contribuer à une prise décision informée des femmes en matière d'allaitement. Rares sont toutefois les études qui se sont intéressés à l'apport de l'ÉPG auprès des pères. Alors que certains établissements intégrés de santé et de services sociaux (ÉISS) recommandent maintenant des services d'éducation prénatale en ligne (ÉPL), tout en continuant l'offre d'ÉPG, il importe de bien situer leur apport respectif quant à l'implication des pères en matière d'allaitement. **But** : Expliquer en quoi les services d'ÉPG et d'ÉPL contribuent à l'implication des pères dans le choix et le soutien de l'allaitement. **Méthode** : Le présent projet s'intègre à une étude élargie de laquelle seront tirées les données requises à la poursuite d'une étude de cas unique à niveaux d'analyse imbriqués quant aux services d'ÉPG et d'ÉPL dispensés par un ÉISS québécois. Il y aura intégration complémentaire de deux sources de données : 1) entretiens semi-structurés auprès de mères et de pères (n=10) ayant eu recours aux services d'ÉPG et/ou d'ÉPL visés; 2) sources documentaires permettant de documenter le contexte de prestation, ainsi que l'organisation, le format et le contenu de ces services d'ÉPG et d'ÉPL. Les entretiens individuels et les sources documentaires feront l'objet d'une analyse de contenu directive. **Résultats attendus** : Les résultats situeront la contribution distinctive et complémentaire des modalités d'ÉPG et d'ÉPL, au profit d'approches maximisant l'inclusion des pères en matière d'allaitement. S'intégrant à une optique de prise de décision interprofessionnelle partagée, ces résultats seront porteurs du rôle que peuvent avoir les pères dans les premiers choix d'alimentation de leur bébé. **Conclusion** : Les services d'ÉPG et d'ÉPL ont le potentiel d'impliquer les pères et de mieux répondre aux besoins de ceux-ci. L'apport de ces services mérite aussi l'attention des décideurs et des différents professionnels de la santé.

357 - Implementation of intensified team-based program for the development of shared decision making: experience from a medical center in Taiwan

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Background and aims

Shared decision making (SDM) serves as a bridge between evidence-based medicine (EBM) and clinical practice. There are several barriers in constructing patient decision aid (PDA) and implementation of SDM, including lack of knowledge of EBM, unfamiliar with the format of PDA, and insufficient practice of coaching. EBM center of Taipei Veterans General Hospital was established in 2017, which facilitated the improvement of quality of care among different divisions. EBM center held several programs for alleviating the barriers in the development of SDM.

Methods

EBM center promoted the development of SDM through intensified team-based program. The program was composed of one-day intensive course for PDA construction with coaching training, and monthly discussion with supervisor of each small group. All members of a group should receive basic EBM learning program through online video provided by EBM center. The quality and progress of PDA was also audited by supervisor monthly with detailed check-list. The application report of each group would be presented in the annual conference.

Results

Total 6 groups joined this program in 2018 and successfully developed their own PDA with well-trained coaching. In 2019, there were around 20 groups joined this program. Through the intensified training program, members had good satisfaction (>90%) with our training course and agreed with the efficient knowledge-transfer way through discussion with the supervisor. Through presentations of application result, the peer pressure augmented the motivation of different group, which enhanced the coherence of SDM in clinical practice. The training program of this year is currently ongoing.

Conclusions

SDM had many barriers for beginners, and EBM center helped members conquer the difficulties through intensified team-based training program.

359 - Development and validation of coopeRATE, a brief patient-reported measure of collaborative goal setting

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Background and Aims

Collaborative goal setting involves patients and providers working together to incorporate goals that are meaningful to patients in care planning. This process is closely aligned with shared decision-making but is particularly relevant for people with long-term health conditions. Due to limitations in existing measurement tools, this study aimed to develop and validate the 'coopeRATE Measure', a brief patient-reported measure of collaborative goal setting.

Methods

Development and validation of the coopeRATE Measure is taking place across two, consecutive studies. In the development study, an initial set of items were drafted based on concepts of collaborative goal setting described in current literature. Initial items were refined over rounds of patient interviews, in-clinic pilot testing, and stakeholder consultation. Participating patients were adults in the United States, who have one or more long-term conditions and had a health care visit in the past year. Stakeholders included clinicians, experts in patient-reported measurement, and others. In the validation study, the final coopeRATE Measure is being tested in 10 cystic fibrosis care settings in the United States. Participants are 300 adult patients attending a health care visit, who are asked to complete the measure and additional questions, immediately following their visit. Convergent validity will be assessed by comparing coopeRATE scores to measures of other related constructs, including shared decision-making, clinician interpersonal and communication skills, and self-efficacy for managing chronic disease. Clinic-level variation, associations with patient characteristics, and different scoring approaches will also be assessed.

Results

The coopeRATE Measure development study is ongoing and results will be updated. The subsequent validation study is expected to be complete by late 2019.

Conclusions

The coopeRATE Measure of collaborative goal setting will fill a gap in existing measurement tools and have potential to be implemented broadly, across different health contexts. Results from the in-clinic validation study will provide further evidence of the suitability of the measure for routine use.

361 - Clinician-Patient Shared Decision Making to the Decision-Making of Indwelling Urethral Catheter Placement in a Patient with Dysuria Requiring Catheter Removal

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In the past, home care patients have less access to resources than hospitalized patients. As the preferences of the patients and their families affected the form of catheterization, they are conservative in their choice of the placement of urinary catheters, and are likely to select indwelling urethral catheterization, which can be attributed to the lack of medical knowledge and the absence of detailed instructions on how to operate catheters.

The first challenge that the medical team encountered was clinician-patient information asymmetry. To improve efficiency of communication and reduce the knowledge gap between the medical team and the family of the patient regarding indwelling urethral catheterization and intermittent catheterization, the medical team made tutorial videos to facilitate technique acquisition and to reduce learning anxiety. The medical team also built a SDM platform (with QR code links to the clinician-patient SDM platform of the hospital). The team also prepared clinician-patient SDM manuals specifically designed to guide relevant parties through the catheter placement decision making process.

Telephone questionnaire follow-up surveys were administered following the initiation of SDM in order to track the satisfaction rate and the result of each decisions made. The medical team completed 30 clinician-patient SDM assisted catheter placement decision-making cases in six months. Compared to previous data, the satisfaction rate rose from 56% to 95%, and the percentage of respondents with no regret following the decision reached 100%. Among these, 40% chose indwelling urethral catheterization, 50% chose intermittent catheterization, and 10% completed successful catheter removals. In addition, the re-hospitalization rate of home patients due to urinary tract infection dropped from 70% to 30%. There is also a drop in the average expenditure for tubing sets and disposables from 43,100 NTD to 35,600 NTD.

Clinician-patient SDM provides home patients with the wherewithal to understand the choice and goal of therapy; it empowers the patient. Caregiving becomes patient-centered, and there is more mutual respect and communication between clinicians and patients. When we provide assistive tools for making medical decisions that address bladder and urinary tract issues, home patients and family members receive better guidance on how to approach catheter care management.

365 - Taxonomy of Behavior Change Techniques in Shared Decision Making: A Secondary Analysis of a Systematic Review

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Background: A variety of interventions exist for changing the behaviour of health professionals and patients regarding shared decision making (SDM). While some of them are based on theory, there is currently no information about the Behaviour Change Techniques (BCTs) used to develop these SDM interventions. Therefore, we sought to identify BCTs used for SDM implementation interventions.

Method: This study is a secondary analysis of the third update of the Cochrane review entitled "Interventions for increasing the use of shared decision making by healthcare professionals." This review aimed to determine the effectiveness of interventions for increasing the use of SDM by healthcare professionals. It considered interventions targeting patients, interventions targeting healthcare professionals, and interventions targeting both. Eligible studies were sought using CENTRAL, MEDLINE, Embase and five other databases on 15 June 2017, two clinical trials registries and proceedings of relevant conferences. Reference lists were checked and study authors were contacted. Eligible study design included: randomized and non-randomized trials, controlled before-after studies and interrupted time series studies. This review included 87 eligible trials. Based on the methods for designing behaviour change interventions proposed by Michie et al. (2014), we codified the interventions (functions and BCTs). Three coders experienced in SDM and intervention design individually codified the interventions included in all 87 trials. Coders then cross-checked codifications and discussed any discrepancy until consensus was reached. Data extracted includes: name of first author, year, target population, target behaviour, type of intervention, content of intervention, its functions (e.g. education, persuasion) and BCTs (e.g. instruction on how to perform the behavior, problem solving) used to achieve them. We used descriptive statistics to report on functions and BCTs found in SDM interventions that were associated with positive effects.

Results: Data analysis is ongoing and results of the current study are forthcoming.

Conclusion: Our results will guide the development of future theory informed implementation interventions in SDM.

367 - Patient-provider perceptions about criteria for patient prioritization in rehabilitation programs

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Background. Shared-decision making extend over clinical treatment to modify policies and organizational practices. This extend to patient prioritization, that aims patients with the greatest needs to be treated first and patients' wait times should be determined objectively on the basis of explicit criteria. Designing criteria becomes a complex task because it is important to analyse converging or diverging opinions of concerned stakeholders regarding this healthcare decision. The aim of this study is to compare service users' and service providers' perspective about patient prioritization criteria within two rehabilitation programs. **Methods.** We conducted a multiple cases study in two rehabilitation programs in Quebec City (Canada), a driving evaluation program (DEP) and a compression garment-manufacturing program (CGMP). We sent a web-based survey that brings two groups (patients and providers) of informed stakeholders to individually produce a set of criteria. We conducted an inductive thematic analysis, where individual answers of each group were coded and combined in a single set of criteria. **Results.** Stakeholders from DEP identified a total of 22 criteria to prioritize patients, whereas those from CGMP list 27 criteria. Providers shared 76% of criteria mentioned by patients. Criteria, such as age, occupation, functional level, pain, absence of a caregiver and time since referral are considered important from both stakeholders in both programs. **Conclusion.** Patients and providers tend to have a converging opinion about a majority of criteria to prioritize waitlist patients. There is a tendency that patients and providers can base their choices on different types of knowledge and values, explaining some differences noticed. Considering all concerned stakeholders' opinions about prioritization criteria is an important part of the decision making process, based on a multiple-constituency approach.

368 - The Participatory Research to Action Framework: Guiding design, embedding processes, and lessons learned in shared decision making - Part 1: Introduction to the PR2A framework

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Background: There is a desire across the health care system to better engage patients and caregivers in the design and delivery of health services. As researchers and service designers adapt to this, methods of co-design, engagement, and participatory research have become more commonly implemented. This presentation will report on the (removed for blind review) approach to co-design using the Participatory Research to Action (PR2A) Framework, an action focused approach to patient-oriented shared decision making research.

Methods: The PR2A has been designed through collaboration with a large, diverse, stakeholder group. The framework combines the creativity of human-centered design and the rigour of scientific research. This is a six phase framework which guides design processes from conceptualization to evaluation and embeds working in partnership with stakeholders at every stage throughout. The framework offers a structured, yet flexible approach which allows a variety of data collection methods to be employed to answer research questions.

Results: Use of this framework facilitates meaningful opportunities for engagement with diverse stakeholders at multiple points in design processes. We have used this framework successfully in a variety of research projects (to be reported on in following presentations) in community and healthcare settings.

Conclusion: Our goal is to meaningfully engage with stakeholders representing all of the voices of Canada to continue to co-develop the PR2A framework in order to achieve a seamless cycle of problem finding to research to innovation and action that prioritizes lived experience and creates measurable, replicable impact for all Canadians. Our work contributes an action focused approach to the growing science of patient-oriented shared decision making research.

371 - The Participatory Research to Action Framework: Guiding design, embedding processes, and lessons learned in shared decision making - Part 4: Lessons learnt through developmental evaluation

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Background: A growing recognition of the complexity of both the health care system and implementation of shared decision making processes supports the relevance of complexity theory to guide health care research and evaluation. We share our lessons learned in applying this approach to a variety of shared decision making projects.

Methods: Across a variety of health services research projects we have used a Developmental Evaluation approach (Patton, 2010) with overall data collection and analysis following a mixed methods design guided by the Participatory Research to Action Framework (Reference removed for blind review). This design allows for the use of multiple data sources, collected in an ongoing iterative process and the meaningful engagement of stakeholders throughout. In collaboration with these stakeholders we have employed Developmental Evaluation to generate evidence to inform action by embedding rapid cycles of evaluation to enable real-time iteration and testing.

Results: Within the complex health care system, our approach has resulted in desired co-designed outcomes to support shared decision making. Developmental Evaluation encourages data collection to be ongoing and iterative, continually feeding into design processes. The researchers engaged in Developmental Evaluation play multiple roles, acting as expert advisors in the design processes, providing critical feedback on progress, and serving as 'guardians' of the principles which are meant to be adhered to. This presentation will report on our experiences of using participatory action methods within a developmental evaluation framework, highlighting the challenges and opportunities inherent when a research team plays multiple roles in a constantly evolving process.

Conclusion: Developmental evaluation has different aims to traditional impact or process evaluations. Our experience with this approach to complexity science has been informative, at times challenging, and influential on the outcomes of our shared decision making work. Results will be of interest to stakeholders across the healthcare system challenged by the complexities inherent in their work towards patient-oriented shared decision making research.

372 - Adapting AHRQ's SHARE Approach for Purposeful Shared Decision Making

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Background/Aims: AHRQ's SHARE Approach is a general five step approach to conducting shared decision making (SDM) when patients and clinicians are choosing between treatment options in light of patient preferences and values. However, there are many other situations in which patients and clinicians make decisions together that don't principally focus on choosing an option. For example, a patient struggling to find ways to care for his multiple chronic conditions while his wife is dying of cancer, or a patient wrestling with the change of identity that she is experiencing as she considers moving from a longstanding family home into an assisted living facility. In these instances, the issue isn't which option is the best, rather solving problems regarding emotional and practical matters, and integrating change within a patient's life story respectively. Here, patients, clinicians, and caregivers are making decisions together in different ways and pursuing different resolutions and purposes through SDM. Purposeful SDM is a schema describes four kinds of problems and situations for which patients and clinicians need to make decisions together and the purpose that SDM pursues in each.

Methods: We created a matrix relating the four *particular* kinds of Purposeful SDM to the five *general* steps of the SHARE Approach framework for SDM, adapting each SHARE step to each kind of Purposeful SDM. We used the matrix to test the theoretical applicability of SHARE Approach to different patient problems as a tool to guide clinicians in SDM. We considered the SHARE Approach tools that provide actionable guidance, tips, and conversation starters for each step to determine how they may be used or adapted for scenarios representing each mode of SDM.

Results: The five steps of the SHARE Approach are applicable with adaptation to each of the four purposeful modes of SDM respectively, but actionable guidance, tips, and conversation starters need to be further developed to fit the different situations and purposes of SDM.

Conclusions: Although originally developed under a traditional SDM model, the five steps of AHRQ's SHARE Approach are general and adaptable to help guide clinicians through the various problems and situations requiring SDM.

373 - SHARE TO CARE: A scalable international implementation program to transform hospitals into full-blown shared decision making organizations

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Background and aims

Shared decision-making (SDM) has been implemented sporadically within every sector of healthcare. Typically, SDM is to be induced by either training of physicians, by empowering patients, or by providing decision aids. Rarely, different interventions are combined. However, transforming any given hospital sustainably into a full-blown SDM organization requires a different approach, both in terms of measures and scale. Therefore, the SHARE TO CARE implementation program was developed and is currently implemented at the University Medical Center Schleswig-Holstein in Kiel, Germany, and the University Hospital of North Norway in Tromsø. The implementation strategy and first experiences will be presented.

Methods

The SHARE TO CARE program in Kiel combines 1) training of every physician (web-based and in person; N=850) 2) empowerment of every patient (N>250.000 per year), 3) training of decision coaches (N=150) and 4) web-based decision aids (N=83). These 4 modules are embedded into a comprehensive implementation strategy focusing on the organizational level and clinical processes. Primary outcome is the implementation success in terms of SDM level (based on patient questionnaires and video recordings). Secondary outcomes are quality and costs of healthcare in Kiel compared to all other German hospitals (based on data from a health insurance company).

In the long run, the same implementation strategy will be applied in Tromsø. Learnings from Kiel will be integrated.

Results

This is ongoing work. In Kiel, currently, 8 (of 27) departments are enrolled. 27 (of 83) decision aids are produced or in production. The training module for physicians is being applied (web-based and in person). Training of decision coaches is about to start.

In Tromsø, 13 decision aids are produced or in production. The web-based training component is in production.

Conclusion

The SHARE TO CARE implementation program is unique as it integrates different interventions that have each proven effective. As it is designed to fit into different national healthcare systems and employs easily scalable web-based intervention modules, chances of generalizability to other hospitals are high. However, fine-tuning is necessary to meet the needs of every newly enrolled department with its operating procedures, its health care professionals and patients.

375 - Reporting of interventions in Shared Decision Making: A Secondary Analysis of a Systematic Review

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Background: Many interventions to change health professional (HP) behaviour exist. However, they are often poorly described in publications and thus difficult to replicate. We aimed to assess the reporting of SDM implementation interventions.

Method: This study is a secondary analysis of a Cochrane review that aimed to determine the effectiveness of interventions for increasing the use of SDM by healthcare professionals. It considered interventions targeting patients, interventions targeting healthcare professionals, and interventions targeting both. Eligible studies were sought using CENTRAL, MEDLINE, Embase and five other databases on 15 June 2017, two clinical trials registries and proceedings of relevant conferences. Reference lists were checked and study authors were contacted. Eligible study design included: randomized and non-randomized trials, controlled before-after studies and interrupted time series studies. This review included 87 eligible trials. For quantitative data, we used the 12 items of the TIDieR (e.g. reporting of rationale, procedures, materials) to assess the reporting of SDM interventions. For qualitative data we extracted representative quotes. Two researchers performed extractions separately. Discrepancies were resolved by consensus. SAS 9.4 was used to analyze quantitative data; quotes were analyzed quantitatively.

Results: Out of 87 studies, the intervention name was included in all 87 (100%), intervention procedures were reported in 83 studies (95.4%), location in 73 studies (83.9%), mode of delivery in 56 studies (64.3%), informational materials in 29 studies (33.3%), intervention providers in 21 studies (24.1%), when and how much the intervention was delivered in 17 studies (19.5%), adherence or fidelity in 13 studies (14.9%), tailoring (where applicable) in 12 studies (13.8%), rationale in 11 studies (12.6%), and modifications made to the intervention in 3 studies (3.5%). For interventions targeting HPs, 41.1% of items were reported; for interventions targeting patients, 45.8% of items were reported; and for interventions targeting both, 30.1% of items were reported. Overall reporting of elements of the interventions was 40%.

Conclusion: In general, the reporting level was low. Interventions targeting patients seem to be better described than those targeting HPs or both patients and HPs. Faithful scaling up of useful interventions will require improved reporting of neglected items.

377 - How do German oncologists perform in shared-decision making? Baseline data of an intervention study to enhance SDM in routine care.

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Background

Cancer patients often feel left out of important treatment decisions. However, when physicians engage them in shared decision-making (SDM), patients and physicians benefit in many ways. There is limited data on the SDM performance of oncologists. Aim of this study was to evaluate the ability of oncologists to conduct a treatment decision consultation following the SDM approach.

Methods/Design

We report the baseline data of a three-armed randomized controlled trial evaluating two strategies to train oncologists in SDM: A face-to-face-training vs. a web-based training vs. a control group. Physicians involved in the treatment of breast cancer or colon cancer treatment were asked to conduct a consultation with a simulation patient regarding a defined treatment decision. This consultation was followed by a questionnaire including SDM-Q-9 / SDM-Q-Doc and Patient Preference Scale (PPS) filled out by both physician and simulation patient as well as an objective rating with OPTION-12 of the videotaped consultation.

Results

Data from 143 consultations were analysed. 62.2% of the physicians were female and 86.2% worked in inpatient care. The average work experience of the physicians (4.9% resident physicians, 40.6% medical specialists, 8% head physicians) was M=11.54 years (SD=10.1). On the PPS 58.2% of the physicians rated that the decision was made by the patient with physician input, 22.4% rated it a shared decision. Of the patients 59.2% rated it a decision made by the patient with physician input, 31.1% rated it as a shared decision. Physicians rated their consultations on the SDM-Q-Doc as M=47.7 (SD=12.3) on a scale from 0-100; similarly, patients rated the consultations as M=47.1 (SD=11.5) on a scale from 0-100. The OPTION-12 rating of the consultation was M=36.4 (SD=12.8) on average. There were no significant differences between the sexes.

Discussion

Patients perceived the consultation as a shared decision more often than the physicians on the PPS, but rated it similar to the physicians on the SDM-Q-9. The objective rating with the OPTION-12 showed a rather good performance compared to other studies. Limitation could be a sample or rating bias or the fact that the consultation was simulated.

378 - Informing a Research Agenda to Advance the Field of Shared Decision Making: An Analysis of the Agency for Healthcare Research and Quality's Shared Decision Making Research Investments

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Background and aim: As a major funder of shared decision making (SDM) health services research in the U.S., the Agency for Healthcare Research and Quality (AHRQ) can help lead the SDM field by funding projects that address key needs of patients, clinicians, and the healthcare system. AHRQ has propelled the field by previously supporting SDM projects that developed and tested tools, methods, and measures, and studied outcomes. The SDM research field is diverse and growing, creating an opportunity to strategically build a solid evidence base that fully gains the clinician and policymaker support needed for SDM to become commonplace in practice. A retrospective review and analysis of AHRQ's past and current SDM investments will help the Agency develop a forward-looking SDM research agenda that takes into account continually evolving technology, expectations, needs, and priorities as they relate to the SDM field.

Methods: We collected data from internal sources, including databases, project reports and files, and discussions with AHRQ project officers most knowledgeable about relevant projects, to capture major attributes of SDM grants and contracts funded over a twenty year period. Examples of attributes include, but are not limited to, project/study type, aims, intervention target audiences and outcomes, location, care setting, time period, and dollars expended. Populating the attributes in a spreadsheet, performing quality checks on the data, and using descriptive statistics, we analyzed the Agency's investments in SDM research.

Results: This analysis is ongoing and results will be provided.

Conclusion: AHRQ's early investments in SDM were responsive to general health services research grant announcements or specific contract requirements. These investments helped move the field forward but left important gaps. As a core funder of SDM research, AHRQ aims to develop a more focused and impactful SDM research agenda that is not only informed by our past activities and associated impacts/outcomes but is responsive to the needs of the health care system, patients, and the communities where they reside.

381 - A Pilot Study of SDM Implementation and Measurement in Safety Net Clinics.

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Background and aims

Implementation of SDM throughout a healthcare system is a difficult challenge. How to best evaluate pragmatic implementation of shared decision making adds a layer of complexity to implementation. ACCESS, a network of 35 health centers that serves roughly 180,000 unique patients a year in a population of mostly poor (85% < 200 percent of the federal poverty level) and ethnic-minority patients, conducted trainings and a pilot study of SDM implementation.

Methods

As part of a comprehensive plan to implement SDM, a group of 15 regional medical directors and nurse-practitioner mentors attended an introductory lecture on SDM and then received additional small-group training on using decision aids. Evaluation of the training included a feasibility study incorporating collection of CollaboRATE scores, interviews with trained providers, and documentation in the electronic health record (EHR). EHR options included “did not use SDM,” “used SDM with a decision aid,” or “used SDM without a decision aid.”

Results

During the two-week pilot period, 892 CollaborRATE surveys were collected on 14 providers. Average CollaborRATE scores for the 12 providers with at least 25 valid surveys ranged from 51-97%, using “top-line” scoring.

Overall, providers were pleased with the training. Concerns that have been noted elsewhere, including time constraints, were also named by providers. Some providers felt they were already doing SDM, and the training was validating for them.

In the EHR, these 15 providers documented SDM use with 1595 unique patients, of which 123 included decision aid use.

Conclusions

Measuring SDM implementation in a busy clinic setting is feasible, but several types of measurement are likely necessary to gain a rounded picture.

386 - Difficult conversations about systemic anti-cancer treatment in advanced lung cancer. Results from a prospective, multi-centre, multi-methods, five-stage, qualitative study (The PACT study)

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Most non-small cell lung cancer (NSCL) patients that present with metastatic disease are unsuitable for curative treatment and many receive chemotherapy for symptom control. Many of these patients will die on, or within 30 days, of chemotherapy.

The PACT study was a five stage, multi site qualitative study (n=85) using multiple methodologies to observe how decisions around treatment in NSCLC are made. Observations of multidisciplinary team (MDT) meetings, patient consultations, and interviews with patients and oncologists tracked the treatment decision-making process.

At MDT meetings, discussed in the patients' absence, MDT members constructed treatment recommendations around patient pathology, clinical information and imaging. Situating the patient in the context of their real life was rare and varied between sites.

Information on the priorities and preferences of patients was not formally integrated into the oncology consultation, Oncologists were concerned with establishing rapport, were aware of the consultation length, and followed their own established structure. With a rapid disease trajectory, the oncologist often had to re-evaluate the patient in terms of fitness for chemotherapy. Where the health of the patient had changed significantly this placed additional stress on the consultation, with the potential need to consider a different treatment option to that suggested at the MDT. Key issues for the oncologist were managing uncertainty, maintaining hope, and bearing witness to what the patient was experiencing.

Patients did not understand the decision-making purpose of the oncology consultation and focused on relationships, placing their disease in the context of everyday life. For the patient, the treatment context was focused on external priorities, such as being able to attend a special family event, prior understanding and experience of particular treatments, and existing relationships with health professionals, such as the chest physician.

The NHS seeks to place patients' needs, wishes and preferences at the heart of clinical decision-making; however, the current pathway for NSCLC patients focuses on clinical management at the expense of patient-centred care.

Future work will test the feasibility of applying a patient-held communication tool at the different stages of the patient pathway.

388 - Dissemination of research results in the public libraries network: an integrated knowledge transfer project

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Background: There are relatively few strategies for actively disseminating health research results to the public, which is the primary beneficiary of health cares. The Bibliothèques2 project is a knowledge transfer project, which aims to evaluate the effectiveness of outreach conferences to disseminate research results to the general public through public libraries.

Methods: Fitting into a participatory research approach, the project is led by a multidisciplinary committee of 13 people (4 experts in patient involvement/patient partner, 2 public library network officials representing the general public, 6 physicians/researchers and 1 science communication specialist). All committee members are equally involved from the beginning at all critical stages of the project, from research design to conferences content development. Results to be disseminated during the conferences were identified following a call to all primary care research teams in Quebec and applications were exclusively evaluated by the patient and the public representatives on the project's committee. A 1.5 hour interactive conference will be presented in public libraries. We will conduct a pre-post evaluation study targeting participants in the audience. Data on participants' sociodemographics, perceptions and satisfaction concerning the conferences as well as pre and post levels of knowledge on the subject debated, will be collected. Facilitators will hold a post-conference focus group to qualitatively assess satisfaction and impact. A mixed-method analysis will be done to assess dimensions of effectiveness.

Preliminary results: Five primary care research teams across the province of Quebec submitted their results and the selected results address the high prevalence of potentially inappropriate medicines (PIM) among people over 65 years of age. Seventeen libraries in Montreal and ten in Quebec City agreed to host the conferences on next spring for their clientele. Other results are to come.

Conclusions: At the end of the project, we hope to raise public awareness and reach people not yet exposed to PIM through libraries. We ultimately hope to contribute to the empowerment of the vulnerable elderly clientele and thus, to enable it to share decision-making. This project is also distinctive for its strong involvement of end users, not only limited to patients, but also encompassing the general public.

389 - Quality of reporting of scaling up strategies for evidence-based practices

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Background

Findings from studies assessing scaling-up strategies need to be reported adequately to facilitate their use in scaling up trials of shared decision making. We sought to examine the reporting quality of studies included in a review of scaling-up strategies.

Methods

We conducted a secondary analysis of a recently published systematic review of scaling-up strategies for evidence-based practices (EBPs) in primary care. Sources of data consisted of all studies included in the review. We extracted characteristics of studies (e.g. publication year, country of origin). Three guidelines informed our data extraction. We compiled a list of key elements of implementation and scaling up under seven headings: title, abstract, introduction (background, aim), methods (18 elements such as theoretical framework, core components and assessment of scaling up potential of the EBP), results (8 elements such as effectiveness of EBP, quantitative metrics of scaling up success, cost, fidelity, sustainability), discussion (4 elements such as implications) and other information (funding source and conflict of interest). The list of 37 elements was refined through discussion by the members of the research team and each element defined. Two reviewers independently evaluated the studies included in the review against each element as follows: reported, not reported, unclear. We performed a descriptive analysis (number and percentage) of key elements assessed.

Results

A total of 14 studies were included. They were published between 2003 and 2016 in ten different countries. The implementation and scaling up elements the least reported were found under the following headings: methods and results. In the methods, none of the studies identified the core components of EBPs versus their modifiable components, nor the assessment of scaling up potential of the EBPs; and only one study used a theoretical framework. The least reported elements for results included fidelity (1/14), sustainability (1/14), quantitative metrics on the success of the scaling up intervention (2/14), cost (2/14), and effectiveness of EBP i.e. effect size and its confidence intervals (2/14).

Conclusion

Our results will inform the development of a reporting guideline for studies assessing the impact of scaling-up strategies and help the future scaling up of shared decision making in health care.

391 - Assessing the usefulness and acceptability of a decision aid on prenatal screening choices among pregnant women

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Background: During their pregnancy, pregnant women have to make a decision about Down syndrome (DS) prenatal screening tests that can be difficult. However, we developed two versions of Patient decision aids (PtDA) to help pregnant women and their partners to make a decision about prenatal screening. We aim to assess the feasibility, usability and acceptability of the recently developed PtDAs among pregnant women and their partners.

Method: This is a qualitative descriptive study. We conducted interviews with quantitative data collection before and after PtDA consultation (Knowledge, Decision Self-Efficacy Scale, self-confidence or belief in one's abilities in decision making, Preparation for Decision Making scale, Acceptability, Decision Regret, Helpfulness). We plan to recruit a purposive sample of 40 pregnant women and their partners (dyads) and/or pregnant women at three clinical sites: Maison des naissances de la Capitale Nationale (a birthing centre), the Family Medicine Unit at Maizeret and the Obstetrics and Gynecology Department at the CHU de Québec. To be eligible to participate, pregnant women must: (a) Be aged at least 18 years old; (b) Be more than 16 weeks pregnant; (c) Be able to speak and write in French and/or English; (d) Be able to give informed consent. Partners should also give their consent to participate to the study. Interviews will be audio and video recorded and we will perform content analysis of the transcribed verbatim interviews. We will perform verbatims analysis by using N'vivo software and quantitative analysis using SAS 9.4.

Result: Till today, we have recruited 66 participants in two clinical sites, birthing center and family medicine Unit, and conducted 26 interviews. We are still pursuing the recruitment on the Obstetrics and Gynecology Department. Data analysis is ongoing and results of the current study are forthcoming.

Conclusion: Results of this study will inform the feasibility, usability and acceptability of the recently developed PtDAs among pregnant women and their partners in the context of DS syndrome prenatal screening.

392 - Does pictorial health information improve health behaviors and outcomes?: A systematic review and meta-analysis

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Background and aims

Most health information is delivered by words, yet words alone may not be the most effective way to communicate, especially for individuals with lower textual and health literacy. Pictures have been shown to increase comprehension, recall, adherence, and attention. No review exists that systematically evaluates how pictorial information affects patient and consumer health behaviors and outcomes in controlled contexts. We aimed to 1) assess the effect of pictorial health information on patient and consumer health behaviors and outcomes, 2) differentially evaluate these effects on individuals with lower health literacy, and 3) examine the attributes of the pictorial health interventions.

Methods

We searched MEDLINE (Ovid), CINAHL, Web of Science, Cochrane, PsycINFO, and ERIC databases from inception until August 2018, including the reference and cited by lists of included articles, gray literature, Google Scholar, and clinical trial registries. We included randomized controlled trials (RCTs) in all languages that assessed the effect of pictorial health information on patients' and consumers' health behaviors and outcomes. Two independent reviewers conducted the primary screening of articles, data extraction with the TIDieR checklist, and quality assessment using the Cochrane Risk of Bias tool. We conducted the meta-analysis in RevMan.

Results

From 4,160 unique records, we included 54 RCTs in our analysis. Our three main outcomes were patient knowledge/understanding, recall, and adherence. Pictorial health interventions significantly improved knowledge/understanding [SMD=0.43; 95% CI 0.15, 0.72] [OR=0.53; 95% CI 0.36, 0.78] and recall [SMD=-0.31; 95% CI -0.54, -0.07] [OR=0.18; 95% CI 0.02, 1.92], but not adherence, with substantial heterogeneity. Differential analysis among individuals of lower health literacy, narrative synthesis, and descriptions of the pictorial interventions results will be available by March 2019.

Discussion

Pictorial health information increases knowledge/understanding and recall. Our results strongly suggest including pictorial information in health communication to improve patient outcomes. Future research should assess patient and consumer pictorial information preferences.

393 - Demonstrating Shared Decision-Making in the Planning of Youth Psychotherapy: A Case Study

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Decision making in youth psychotherapy is complex, requiring consideration of research, clinician expertise, and patient characteristics/preferences. Current evidence-based practices offer little guidance on how to incorporate youths and families in treatment planning. The current presentation provides details of the SDM process (e.g., activity to teach SDM concepts, discussion of possible treatment targets, consideration of practice elements starting with the most research-supported options) in the context of planning treatment for a 8-year-old Caucasian female diagnosed with Generalized Anxiety, Separation Anxiety, and Social Anxiety.

The one-session SDM protocol guides clinicians, parents, and youth through a collaborative treatment planning process that addresses: 1) target problem(s), 2) treatment participants, and 3) practice elements to be included in treatment (using the Modular Approach to Therapy for Children). The initial assessment included youth and parent completed measures related to treatment (motivation, preferences, outcome expectations), decision making (self-efficacy, conflict, satisfaction), and symptoms. A similar assessment was completed after each SDM discussion throughout treatment.

The SDM protocol resulted in a clear treatment plan agreed upon by youth, parents, and clinician. Mother (M), father (F), and youth (Y) were favorable to the SDM session, reporting low scores on decisional conflict (Y=25, M=1, F=32.81; 0=none, 100=extremely high), high satisfaction with decisions (Y=4, M=4.5, F=4.16; 5=highest satisfaction), and increased treatment outcome expectations (Ypre=80, YpostSDM=87.67; Mpre=75, MpostSDM=83.33; 0=no change expected, 100=change expected). Target problems decided upon were consistent with the problems individually identified by parents and youth. The practice elements selected were consistent with the MATCH algorithm and clinician preferences. If accepted, this poster will incorporate additional quantitative and qualitative results on the use of SDM at the beginning and throughout the treatment course.

This case study supports the feasibility and acceptability of using an SDM protocol for planning psychotherapy for youth emotional disorders. The current protocol was helpful in navigating common challenges in youth psychotherapy including disagreements about the treatment plan, issues creating a developmentally appropriate treatment, and difficulties explaining novel psychotherapeutic concepts. After engaging in the SDM protocol, the current youth and her family completed a full treatment course resulting in significant symptom reduction.

394 - Barriers and facilitators to shared decision making in medical school: a multinational qualitative study

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Background and aims

Shared decision making (SDM) training is not universally embedded in medical school curricula. Strategies to improve SDM acceptance and skills among medical students are not well known. We aimed to determine: (1) when and how to best deliver SDM training to medical students and (2) the ideal characteristics of SDM training in undergraduate medical school.

Methods

We conducted semi-structured interviews with students and curriculum stakeholders at selected medical schools across Canada, the Netherlands, the UK, and the US. We used thematic analysis on verbatim transcripts to develop a codebook that two independent researchers applied. We updated the codebook iteratively if new codes or themes emerged during analysis.

Results

We interviewed 34 students and 12 curriculum stakeholders across 20 medical schools from March to December 2017. The majority of the students were female (23/34) and spanned all years of undergraduate medical education (range 1 to 6). We asked each interviewee their definition of SDM and found that accurately defining SDM was a challenge in the medical school community and a universal language for this term seemed to be missing. Four major themes emerged from our interviews. Students and curriculum stakeholders believed that: (1) perceived barriers to SDM integration included time, an already busy and rigorous curriculum, limited resources available for SDM training, and institutional culture, (2) SDM training should be introduced early and taught frequently throughout medical school with preceptors who can demonstrate the utility of SDM, (3) the ideal approach to learning SDM is through application (e.g., standardized patients or group discussions), and (4) SDM is a facilitator for strong physician-patient relationships.

Conclusion

Participants reported that SDM was not currently integrated or taught in medical school curricula. They highlighted the importance of early and frequent trainings and outlined optimal features of SDM training. Further work is needed to design SDM training programs that address some of the cited barriers currently hindering routine integration into undergraduate medical school curricula.

395 - Engaging the public for high value care

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Background: Public engagement is core component of high value care. However, the best way to engage the public for high value care remains unknown.

Methods: To supplement the Reaching for High Value Care toolkit, we conducted a scoping review on engaging the public. We searched Medline, Google, and 13 key journals for systematic reviews, meta-analyses, scoping reviews, or expert consensus documents on public engagement or deliberative methods for health service delivery or policy; we also searched for national surveys of deliberative methods. We then supplemented these searches with Google Scholar searches of two key articles. A single reviewer reviewed titles, abstracts, and articles for inclusion. Included articles a) addressed key questions to inform practice (e.g. definitions, process, barriers, interventions, national or international competencies, and rates of delivery).

Results: We found 18 reviews on public engagement, including 4 on definitions, 9 on processes, 4 on barriers, and 1 on interventions. We found no competencies or national surveys of engagement rates. Reviews of the definition of public engagement indicate that engagement includes a spectrum of involvement (from information receipt to partnership) in activities related to community health promotion, organizational design and governance, research, and health policy. Frameworks of partnership (e.g. deliberative methods) for health service delivery and policy define a process including choice of an appropriate decision, involvement of a representative public, creation of a safe and participatory environment with clear rules of engagement, provision of understandable evidence, consideration of values, decision-making, and communication of impact. Identified barriers occur at multiple levels (e.g. public, system, policy). At present, there is scant evidence to support effectiveness. However, many potential benefits were enumerated, including empowerment and more effective services.

Conclusions: There is currently no shared vision for how to create value through public engagement and evidence of effect is limited. Additional work is needed to elucidate the effectiveness of public engagement and the features that drive effectiveness in various situations (e.g. net benefit, equipoise, net harm).

399 - An encounter decision aid can prompt discussions about breast cancer surgery costs: Analysis of recorded surgeon-patient consultations

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Background and aims

Clinicians often miss opportunities to address care costs. Although costs often impact cancer patients' treatment decisions, they are not routinely included in patient decision aids or education materials. We examined whether surgeons and patients discussed breast cancer care costs during their surgical consultation and whether an encounter decision aid plus brief training influenced cost discussions.

Methods

We randomized 13 breast surgeons to one of three arms as part of a randomized controlled trial of encounter decision aids at four cancer centers in the US: (1) Picture Option Grid that includes a prompt to discuss relative treatment cost information, (2) text-only Option Grid without cost information, or (3) usual care. We transcribed and analyzed audio recordings of encounters between surgeons and patients with stage I-IIIa breast cancer. We gave surgeons feedback on their fidelity to the study protocol at 3, 6, and 12-month study check-ins. We adapted a checklist from previous literature to assess cost discussion attributes and code the surgeon-patient conversations. We collected self-reported demographic data.

Results

Researchers recorded 267 patient encounters (123 in the Picture Option Grid group, 33 in the Option Grid group, and 110 in usual care). Surgeons and patients discussed costs in 110/267 (41.2%) encounters. Most cost discussions occurred in the Picture Option Grid group versus other groups (66.4% versus 33.6%; $p < .001$), directly prompted by the Picture Option Grid cost information in 60.3% of encounters. In the other groups, surgeons rarely mentioned surgery costs (24.3%); instead, insurance or employment questions often prompted patients to ask about costs (51.4%). The surgeons initiated the cost discussions in 87.7% of encounters in the Picture Option Grid group vs. 35.1% in the other study groups. Cost discussions lasted about 47 seconds when they occurred. This study is ongoing; final results will be updated.

Conclusions

Encounter decision aids containing cost information, along with training, can trigger cost discussions. Additional support should help surgeons navigate cost discussions.

402 - Patient Engagement in the What Matters Most Trial: Experiences and Future Implications for Research

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Background and aims

Engaging patients in conducting research has shown to improve patient enrollment, decrease attrition, and assist in making dissemination more meaningful. In the What Matters Most (WMM) trial on breast cancer decision aids, breast cancer survivors participate as patient partners (n=3) and associates (n=4) who join monthly calls and provide guidance on study design, documents, recruitment, management, and dissemination. Unique to WMM, each patient associate also recruits, consents, and conducts assessments with participants, furthering their involvement in the study. Our aim was to deeply understand the patient partner and associate experiences participating in the study and its implications for future research.

Methods

An external researcher interviewed WMM's patient associates midway and at the end of the 18-month recruitment period. The interview guide assessed the patient associate's feelings about research and their involvement with the research team, recruiting patients, challenges they face, and their thoughts about the involvement of patient associates in future research. Patient associates also sent reflections and notes intermittently. Further, WMM patient partners will be interviewed about their participation in the study. We are also collecting perspectives from clinical teams and participants about the patient associate role using process evaluation semi-structured interviews. We will use an inductive thematic analysis approach.

Results

Patient associates found their roles impacted participants and the research process. Patient associates, who all received study onset research training, felt well-suited for their role in the trial. Challenges included toggling identities as both a researcher and survivor, connecting to participants with their shared experience without bias, and working with a clinic's flow and complexities. All patient associates agree that their role is important to future research and creates a connection for patients they approach. We will update patient partner and associate interview results after April 2019.

Discussion

Designing WMM to meaningfully engage patients has enriched and impacted the course of the study. We recommend meaningfully engaging patient partners and associates so they fundamentally shape clinical research, rather than superficially involving patients to meet research funding requirements. Additional research in patient involvement in study design, data collection, and analysis is warranted.

404 - Will shared decision-making result in economic outcomes? A literature review

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Background and aim

The basic principle in economics is that society should be organized in a way such that overall welfare is maximized. The principal-agent relationship can be seen to operate in the context of the relationship between the clinicians and patients for playing different roles in medical decision-making. Economic evaluation can be defined as a comparison of alternatives options in terms of their costs and consequences. There are different types of economic evaluation: cost-consequence analysis, cost-minimization analysis, cost-effectiveness analysis, cost-utility analysis, and cost-benefit analysis. All methods of economic evaluation involve the comparison between alternatives interventions, treatment, or programs. The aim of our study is to explore for the status quo of the published literature on shared decision-making (SDM) and economic evaluation in the health care settings.

Methods

We have searched in the database powered by EBSCO for the literature on SDM and economics. We created a search strategy involving keywords: “shared decision making” and “economics” and “economic evaluation” and “health care”. We retrieved articles by focusing on the peer-reviewed academic journal articles in the language of English. No age, gender and time restrictions were imposed.

Results

From 1972 to 2019, a total of 251 studies were identified from the literature research. After removing the duplicated citations, and screened the citations by title and abstract for irrelevant to SDM, we excluded 235 citations. For the methods of the 17 unique citations, 3 were systematic reviews, 8 were quantitative researches (included 1 for cost study and 1 for cost-effectiveness analysis), 5 were qualitative researches, 1 were mixed methods.

Conclusion

The emergence of SDM can be seen as a tentative vital topic for health economists because it is aligned with basic economic theory about individual’s preferences. Meanwhile, the practice of SDM may imply that doctors spend more time on eliciting patient’s preferences and discussing alternative diagnostic and therapeutic options. Increasingly, the society expect that doctors consider opportunity cost, allocate scarce medical resources, maximize patients’ preference and irrespective to the service lacking cost-effectiveness. We may be more cautious about the conclusion for the economic evaluation of SDM.

408 - Barriers to Trial of labor after a caesarean section as a limitation for a shared decision-making approach: Preliminary results from interviews with Obstetrics and Gynecology physicians from a public reference hospital in Lima-Peru

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Background and aims: Trial of labor after a C-section (TOLAC) is recommended in pregnant women (PW) who have a prior C-section (C-section) and no contraindications, but it is performed infrequently. The aim of this study is to describe barriers to discussing/offering TOLAC as reported by Obstetrics and Gynecology (O&G) specialists in Lima-Peru.

Methodology: O&G physicians who work at a public reference hospital were interviewed by a trained psychologist using a semi-structured interview guide.

Results: 11 O&G physicians were interviewed. Median of their length of work experience was 11 years. Interviewees reported certain factors that relate to prenatal care. PW with a prior C-section receives most of their prenatal care at primary care settings where they don't receive accurate information about the mode of delivery options from primarily midwife providers: "... come (PW, from primary care clinic) with errors in the perception of labor and cesarean section...". In addition, prenatal care visits are not long enough and there is no educational material to explain delivery options to PWs: "We have no time, we don't have educational material for the patients." Other factors relate to the delivery itself. There is a lack of both human resources (e.g. anesthesiologists, pediatricians, etc.) and available operating rooms for emergency repeat C-sections: "...during shifts (night or weekend ones), there's only two anesthesiologists, two nurses, two technicians and no for any reason they will open a third room (Operation room)." Finally, there was fear of legal problems and the perception of no legal support from the institutional medical providers and leaders or legal team: "... neither the boss or the director or nobody will support you, nobody. You alone go and you take responsibility, you pay your lawyer..."

Conclusion: This study identified barriers to discussing/offering TOLAC to PW related to prenatal care, hospital resources at delivery, and legal issues. Efforts to ensure PW access accurate information and early referral to an O&G specialist may facilitate discussion about TOLAC, but improvements in hospital human and structural resources and legal support are also needed to encourage specialists to apply a shared decision-making process for the mode of delivery.

412 - Decision-making around mode of delivery in pregnant woman with a prior C-section from a public reference hospital in Lima-Peru: A qualitative approach using observation

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Background and aims: Pregnant woman (PW) with a prior cesarean section (C-section) and no contraindications for Trial of labor after a C-section (TOLAC) can decide between TOLAC and elective repeat cesarean delivery (ERCD). The aim of this study is to describe the decision-making process during the first prenatal care consultation of PW with a prior C-section from a reference public hospital in Lima-Peru.

Methodology: This study included: Obstetrics and Gynecology (O&G) physicians providing prenatal care; and PW with a prior C-section and no contraindications for TOLAC who received their first prenatal care visit at a public reference hospital. O&G-PW prenatal visits were observed by a research assistant who completed a standardized instrument to document the following: Discussion of TOLAC and/or repeat ERCD; PW's understanding of the information provided; PW's preferences regarding future mode of delivery; people involved in the decision and PW's agreement with the decision. The frequency of observed events was summarized.

Results: 19 visits were observed, where 19 PWs and 8 O&G physicians participated. At the beginning of the consultation, both TOLAC and ERCD were offered to 5 PWs (26.3%) and only TOLAC to 14 PWs (73.7%). Discussion about PWs' expected delivery mode was observed in 5 consults (26.3%) and about evidence-based information in 4 consults (21.1%), which included disadvantages and benefits of TOLAC and characteristics for successful TOLAC. By the end of the consultation, PWs had the chance to say what she understood in 14 visits (73.7%) and stated their preferred mode of delivery in 14 visits (73.7%). The decision was TOLAC in 2 consultations (10.3%), ERCD in 3 (15.8%) and "to differ decision to other consultation" in 14 (73.7%), and was made by both physician and PW in 2 (10.3%) consultations, one TOLAC and one ERCD. PWs said that they agreed with the decision in all cases.

Conclusion: Evidence-based information and expectations about delivery mode were discussed with few PW. However, assessment of PWs' understanding, preferences, and agreement with decisions were higher. We need to ensure that patients have access to information and that their expectations are considered in the decision-making process during prenatal care.

417 - Implementing shared decision-making in interprofessional home care teams: a stepped wedge cluster randomized trial

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Background and objective: For older adults beginning to lose their autonomy, deciding whether to stay home or to move to another location is a difficult decision they and their caregivers have to make. An interprofessional shared decision-making (IPSDM) approach would help ensure that they make an informed value congruent choice. We sought to evaluate the impact of a training programme in IPSDM on the proportion of older adults and caregivers who report taking an active part in the decision-making process regarding the location of care, compared with the passive dissemination of a decision guide.

Method: Between September 2015 and December 2018, we conducted a cross-sectional stepped wedge cluster randomised trial (cRT). We recruited 16 home care teams in nine health and social service centres in the province of Quebec. The trial compares the effect of passive dissemination of a decision guide with dissemination of the decision guide combined with training on IPSDM and on use of the decision guide. At the beginning of the project, each home care team received a decision guide (control); then the clusters were randomized to the order in which they received the training IPSDM workshop (intervention) in successive steps or time points. By the end of the project, all teams had been trained. Data were collected from cognitively-capable 65+ year-old clients being followed by the homecare teams, or from caregivers of cognitively-impaired patients who had made a location of care decision. The unit of analysis will be the client (or caregiver). Our primary outcome (dichotomous) will be analysed using multilevel logistic regression analysis. Time will be modelled as a fixed categorical variable, while the center will be modelled as a random effect to account for the intracluster correlation.

Results: Data collection has just been completed and analysis will start early in 2019.

Conclusions: Our results will provide the following information: if the addition of a training programme in IPSDM to the passive dissemination of a decision guide is needed in order to increase the proportion of clients and caregivers reporting an active role in the decision-making process regarding the location of care.

420 - Working toward a patient-centered healthcare visit

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Background: Patient-centered care is a process that includes developing a good patient-provider relationship, developing skills, sharing decisions, managing uncertainty and emotions, and supporting the process. To date, there has been little work to build comprehensive, evidence-based tools to support the overall process of patient-centered care for patients and providers.

Methods: Using evidence from a recently published scoping review on patient-centered high value care, we identified patient and provider needs for patient-centered care and effective interventions to support it. We then used this evidence to develop a paper-based patient decision aid prototype and a series of checklists to support the process of patient-centered care during the healthcare visit. During development, we applied best practices in readability and document design and reported on key features of development. We sought input on the decision aid and checklists from two individuals actively engaged in healthcare decisions at two university hospitals, making iterative revisions as needed.

Results: Our two-page decision aid prototype meets U.S. national certification criteria for treatment decision aids. Accompanying checklists (13 pages) provide the knowledge, motivation, and list of effective skills and interventions for developing a good patient-provider relationship, sharing decisions, managing uncertainty and emotions, and supporting and following-through on decisions. Together, these tools can be used to develop habits in patient-centered care. Specifics of patient input can't be specifically enumerated given that they occurred in the context of clinical care. However, both patients reported they found the intervention useful.

Conclusions: A 15-page intervention to support the process of patient-centered care shows preliminary evidence of usefulness and needs further testing to determine its effectiveness in promoting patient-centered outcomes.

421 - Favoriser l'établissement de pratiques cliniques collaboratives entre des proches aidants, des personnes atteintes d'un trouble mental et des professionnels en santé mentale: une recherche collaborative pour dégager les enjeux liés au partage d'informations et au respect de la confidentialité

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Introduction : Le rôle de soutien exercé par les membres de l'entourage, de même que la collaboration entre les proches aidants et les professionnels, jouent un rôle déterminant dans le pronostic et le rétablissement des personnes atteintes de troubles mentaux. Toutefois, l'établissement de pratiques collaboratives entre les proches aidants et les équipes d'intervention se heurte à des enjeux de confidentialité, plus particulièrement lorsqu'il est question de partager des informations entre les acteurs concernés. Il s'ensuit que l'apport des proches aidants et leur besoin de soutien sont peu reconnus.

Objectifs : L'objectif de cette étude exploratoire et descriptive est d'identifier, à partir du point de vue croisé des proches aidants, des professionnels et des utilisateurs de services, les enjeux liés au partage d'informations et au respect de la confidentialité. Cela dans le but de dégager des recommandations favorisant l'établissement de pratiques collaboratives en santé mentale. L'originalité de cette recherche repose sur l'attention particulière accordée à l'actualisation de la notion de confidentialité et aux actions concrètes à mettre de l'avant pour améliorer les pratiques en matière de partage d'informations.

Méthodologie : La phase 1 de cette étude visera à réaliser des entrevues semi-dirigées auprès de proches aidants et de professionnels du domaine de la santé mentale, dans les régions de Québec et du Bas-St-Laurent afin de documenter leur expérience au sujet du partage d'informations. En phase 2, des groupes de discussion avec des personnes utilisatrices de services en santé mentale permettront d'approfondir la compréhension des récits de pratique réalisés auprès des proches aidants et des professionnels et de dégager des pistes de solutions respectueuses de la vie privée des personnes atteintes, en plus de tenir compte des contraintes légales liées au respect des normes de confidentialité.

Conclusion : Cette affiche a pour but de présenter le projet de recherche qui débutera en 2019 et de favoriser les échanges autour des considérations méthodologiques et empiriques liées à la réalisation de l'étude. La démarche de recherche collaborative sera également présentée et discutée par quelques-uns des membres du comité consultatif de recherche.

422 - Purposeful SDM—A Schema of Shared Decision Making Purposes in Patient Care

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Background

Shared decisions of which antidepressant to use; how to reconfigure care for a person struggling with life with multiple chronic conditions; and when to move from a longstanding family home to a nursing home are all different. This difference is not only in diagnosis, clinical urgency, risks, participants, and options. These decisions also vary by the humanly experienced problem that makes decision making necessary, what kind of resolution decision making needs to provide, and consequently by how decision-making proceeds. For instance; the choice of antidepressant may be focused on choosing a drug by weighing pros, cons and preferences; in the chronic care case decision making may require problem solving to re-design care in response to the changing practical and emotional demands of the patient's life situation; while the decision to move to a nursing home may hinge on issues of how a person's life story should move towards a close. Using SDM methods appropriate to weighing pro's, cons, and preferences may not be helpful when problem solving or finding existential meaning is required.

Method

We developed *Purposeful SDM*, a schema of four kinds of SDM, the kinds of problems they address, their purposes, and communicative strategy. In developing *Purposeful SDM* we drew on the work of the philosopher Richard McKeon and his understanding of the plurality of human problems and methods of addressing them. The schema of *Purposeful SDM* is demonstrated through the differences in problems and decision making arising in instances of selecting birth control, being conflicted between vaginal and C-section delivery, care management in the ICU, and end of life decision making.

Results

Rather than initiating SDM on the basis of a stated need to make a decision, choose from options, or involve a patient, *Purposeful SDM* begins from the human problem experienced by those making decisions and seeks the appropriate purpose and method of SDM required to address this situation.

Conclusion

Purposeful SDM offers a complimentary theoretical and methodological approach to SDM. It's applicability to diverse care situations warrants further research. We are exploring the schema in medical education and decision aid development.

423 - The impact of health literacy on decision quality for periviable decision-making

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Background: It is critical that parents facing periviable delivery comprehend neonatal treatment options (resuscitation versus palliation) to optimize decision quality given the high-stakes nature of these decisions. Parents with low health literacy may be particularly vulnerable in these complex decision-making settings. In this study, we sought to explore the relationship between health literacy and decision quality among women and their important others following a periviable birth.

Methods: We conducted a mixed-methods, prospective study of decision-making among women hospitalized for a threatened periviable delivery (22+0-24+6 weeks) and their support person/important other (IO) using semi-structured interviews and validated measures. Participants were interviewed prior to delivery and 3-months postpartum. Health literacy was measured at baseline using the 18-item Short Assessment of Health Literacy (SAHL) tool. Decisional quality was measured postpartum using the Decision Evaluation Scales (subscales: satisfaction uncertainty, informed choice, and decision control), Satisfaction with Decision Scale, Decision Regret Scale, and the SURE Decisional Conflict Scale. All scales were verbally-administered. Descriptive analyses and linear regression modeling were conducted using SAS version 9.4. Tests were conducted at 90% confidence due to the exploratory and pilot nature of the quantitative analyses.

Results: Twenty-four pregnant women and 12 IOs completed the SAHL and were interviewed at 3-months postpartum. The average age was 30 years. The majority were white (55.6%) and had an education level of high school or less (58.3%), and 41.7% had an annual income of less than \$50,000. Half were publically insured and five were uninsured. The average SAHL score was 16.84 (SD=1.33) and ranged from 12-18 (max). Among pregnant women, lower health literacy was significantly associated with lower decisional control ($p=0.086$), while higher health literacy was associated with higher decisional regret scores ($p=0.082$), but also with higher satisfaction with decision ($p=0.063$). Among IOs, higher health literacy was only associated with lower decisional conflict ($p=0.005$).

Conclusion: In this pilot study, our findings suggest that a relationship exists between healthy literacy and decision quality among families facing the threat of periviable delivery. Decision support that is tailored to the needs of low literacy populations may improve the quality of periviable care and decision-making.

424 - Role models for shared decision-making: a qualitative study among doctors and patients in the Netherlands.

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Background and aims

Shared decision-making demands a different attitude and new skills from patients and their family members. At the same time, it requires healthcare professionals to take on a different role and to be trained in a different way. The manner in which young doctors learn and are taught shared decision-making in real-life situations is the focus of this study.

Ideally, the emphasis of learning shared decision-making is in the intern and resident phase of medical training. Here, experienced physicians act as role models: examples from which young doctors learn by observing and imitating. How these role models function in learning to put shared decision-making into practice has not been studied yet.

This project has two main questions:

Ultimately, we aim to develop well founded recommendations for applying role models in teaching shared decision-making in clinical practice in the Netherlands.

Methods

To this end, we will conduct a qualitative study among the following four categories of participants:

- a) medical students (interns)
- b) resident physicians
- c) experienced physicians
- d) (former) patients and their family members

For each category, we will conduct two focus group interviews: one with participants from the context of fertility medicine, one from intensive care medicine. This will result in eight focus group interviews in total.

Using ATLAS.ti, we will analyze the transcripts through thematic analysis.

We will present and discuss the results in a one-day work conference with forty representatives from each of the eight aforementioned groups.

Results and conclusion

This study is ongoing. Results will be available in Spring 2019 and will be updated once they become available.

425 - Patient Preference Weighted Benefit-Risk Assessment of Type 2 Diabetes Medications with Demonstrated Cardiovascular Benefit.

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Background: Several randomized controlled trials demonstrated cardiovascular benefits of the Sodium Glucose Co-Transporter-2 (SGLT2) inhibitors and the Glucagon-like Peptide-1 (GLP1) receptor agonists in patients with pre-existing or with multiple risk factors for cardiovascular disease. As a result, both SGLT2 inhibitors and GLP1 receptor agonists are preferred second-line therapies for individuals with cardiovascular disease. However, these medications have different benefit-risk profiles that make treatment decisions challenging. Quantitative risk-benefit analysis is one method to provide relative comparisons of benefit and harm between therapies.

Purpose: To estimate the benefit-risk balance of using the SGLT2 inhibitors compared to GLP-1 receptor agonists in the treatment of adult patients with type 2 diabetes and cardiovascular disease.

Methods: We conducted a quantitative benefit-risk assessment using two incremental net benefit (INB) models – INB using maximum acceptable risk (MAR) and INB using relative-value-adjusted life-years (RVALYs). These models weight outcome probabilities with patient preference values and the expected duration of impact of outcomes. Outcomes included in the models were: myocardial infarction, stroke, hospitalization for heart failure, composite microvascular outcome, all-cause mortality, hypoglycemia, urinary tract infection, genital infection, diabetic ketoacidosis, fracture and amputation. Outcome probabilities and duration of impact were derived from literature sources. Canadian Preference weights were derived from a discrete choice experiment. Three base-case scenarios were used based on patient age (55, 65 and 75 years of age). A series of sensitivity analyses were conducted to address parameter uncertainty.

Results: This study is ongoing, results will be updated.

Conclusions: Using patient preference weighted outcome probabilities to evaluate the benefit-risk balance between medications, helps identify outcomes that are most important for distinguishing between medications, which in turn can support shared decision making between prescriber and patient.

428 - Development of the CKD Journeys Conversation Aid

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Background

Chronic kidney disease (CKD) patients are often not given an opportunity to discuss their trajectory to end-stage renal disease or the decision of whether or not to dialyze until it is essentially too late. A common clinical situation is for patients to experience acute renal failure in the ICU and begin dialysis as a form of life support. Moreover, patients may perceive that to forego dialysis is to choose death, whereas evidence suggests that elderly, frail patients may not benefit from dialysis. There is a need for clinicians to engage CKD patients in planning how to manage the progression of CKD. We are developing the CKD Journeys Conversation Aid in response.

Methods

We employed a user-centered design (UCD) method to understand the experiences of CKD patients in clinic. Our research included observations of clinical encounters in the chronic kidney disease and access clinics (16); semi-structured patient interviews; dialysis center site visits; and a systematic review of existing decision aids (reported elsewhere). We facilitated two focus groups, one with clinical staff and one with patient advisors, to identify salient stages of CKD care and the clinical conversations involved. We then developed a set of hypotheses about how clinical conversation might support better CKD patient care.

Results

During observations in the CKD clinic, we found it difficult to identify whether and when people were making decisions regarding dialysis. This led us to the insight that care for CKD patients unfolds longitudinally, resonating with literature that says patients seek to delay dialysis until they are forced by circumstances to choose. After several rounds of internal iteration, we produced a prototype for testing in clinical encounters. We are currently on our second-round prototype, with nine prototyping observations and patient interviews. The results of this and further prototyping rounds will be presented.

Conclusion

CKD Journeys is a conversation aid-in-development that seeks to support planning and management conversations between CKD patients and their clinicians. We continue to refine the design of CKD Journeys through prototyping in clinic. Our initial prototypes have shown promise to promote conversations about prognosis and choice in CKD care.

432 - Evaluation of an Educational Intervention to Promote Healthcare Transition Planning Among Pediatric Residents

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Background/aim: Healthcare transition (HCT) is “the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered care to the adult-oriented healthcare system.” Inadequate preparation for HCT is associated with increased morbidity and mortality. Most pediatric providers are ill-equipped to help patients learn the skills needed to effectively manage their adult healthcare. An electronic medical record (EMR)-based Transition Planning Tool (TPT) was developed to guide provider-patient interactions and provide resources addressing patient deficits in knowledge/skills regarding healthcare self-management. We evaluated an intervention to promote TPT use by pediatric and medicine-pediatric residents on a one-month adolescent medicine rotation. **Methods:** A prospective, non-randomized, quasi-experimental design with intervention and historical control groups was used. Approximately 40 residents (30 to date) have/will receive the educational intervention (TPT demonstration, case-conference incorporating TPT use, attending physician modeling TPT use) during their rotation (July 2018 – April 2019). Another 23 historical control residents received minimal formal training in HCT planning during their rotation (January – May 2018). Residents in the intervention completed pre/post rotation assessments measuring perceived importance of/comfort with transition planning and self-reported transition planning activities. TPT use was compared between residents in intervention and historical control groups. **Results:** Among intervention participants, the perceived importance of HCT planning increased over the rotation, with 67% and 83% at pre vs post rotation, respectively, rating it as “very important” ($p=0.037$). Residents reported being significantly ($p=0.001$) more likely to engage in shared HCT planning activities with their patients after being trained to use the TPT than before the rotation started. Nearly all (96%) reported that the training they received helped them feel more comfortable helping youth with special health care needs manage their healthcare transition. As compared to the historical control group, residents who completed the intervention were significantly more likely to use the TPT (93% vs. 37%, $p<0.001$) and had a higher mean number of uses (5.07 ± 3.2 vs. 2.55 ± 1.16 , $p<0.001$). **Conclusions:** Pediatric residents' ratings of the importance of HCT preparation and their skills in facilitating HCT planning using an EMR-based TPT were improved with a targeted intervention program.

433 - Women's Preferences for Management of Pregnancy Hypertension

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Background

Clinical practice guidelines recommend two approaches for management of pregnancy hypertension: 'less tight' control (LTC) and 'tight control' (TC). These approaches differ in medication requirements and maternal outcomes, but it is unclear if they have different impacts on infant outcomes. No research has explored how women weigh these outcomes and treatment requirements when choosing a treatment approach. This study aimed to: assess women's preferences for management of pregnancy hypertension; identify preference predictors; and explore women's decisional needs.

Methods

Participants completed an online survey. Informed by qualitative work, the survey included information provision and knowledge assessment; elicitation of treatment preference; and decisional needs assessment.

All question responses were analyzed descriptively. T-tests were used to assess the relationship between knowledge and each of history of pregnancy hypertension and treatment preference. Logistic regression was used to assess predictors of treatment preference (i.e., LTC vs. TC).

Results

All participants (n = 183) were pregnant at the time of the study and more than one quarter reported pregnancy hypertension in a past or current pregnancy.

Participants were evenly divided on treatment preference: 51% preferred LTC and 49% preferred TC. Mean knowledge scores were higher for those who preferred TC than LTC (p < 0.001).

The final multivariable model found that odds of preferring TC (vs. LTC) were greater among those with: higher knowledge score; Caucasian ethnicity; and with a university education or professional qualification.

Participants reported diverse decisional needs and most preferred to make the final treatment decision themselves with (48%) or without (22%) their physicians' input.

Conclusions

Results show that women are divided about preferred treatment, that knowledge predicts treatment preference, and that preferences for decisional supports are diverse. These findings emphasize the importance of an individualized approach to treatment recommendations that considers patient values and preferences. Future research should use a longitudinal approach to explore the impact of education on treatment preference among women with pregnancy hypertension.

434 - Involvement of nurses in integrating prenatal education service with community-based organizations for informed decision-making: a multiple case study protocol

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The professional activities of the perinatal nurse fall within the scope of promoting the health and well-being of families. In her role, the nurse provides prenatal education by sharing information and expertise to help future parents make informed choices about pregnancy, childbirth and the first weeks after birth. Group prenatal education services are offered by all Québec integrated health and social services establishments (HSSE). Many work with different types of community-based organizations (CBO) (e.g. community-based family organizations, perinatal resource centers, etc.). Some HSSEs have opted to implement or recommend online prenatal education, while continuing the offer of group prenatal education. While there is often interest in the involvement of nurses in clinical service networks, few studies have focused on collaborations with CBOs. Considering the latest structural transformations – integration of online prenatal education – it is important to position the nursing contribution regarding collaborations with CBOs and new intervention strategies that can be applied in the decision-making process. **Objectives:** 1) To understand the involvement of the nurse and the determinants of collaboration in the integration of prenatal education services recommended by the HSSEs with the CBOs; and 2) to highlight the nursing involvement in the support of organizational intervention promoting shared decision-making. **Method:** A multiple case study design including individual interviews with organizational stakeholders (n planned = 40) and documentary sources. Directed content analysis based on a reference framework combining the determinants of collaborations with the characteristics of efficient networks. **Expected Outcomes:** The study is in progress and the results are forthcoming. We expect the results to increase knowledge of prenatal education services with CBOs and nurse involvement in perinatal information continuums including group and online services. This study will also contribute to the optimization of the use of human and material resources as well as the pooling of skills and resources through intersectoral collaboration that will have an impact on parents' decision-making in terms of perinatal health. This collaboration will also improve the coordination of services for future parents and strengthen accessibility, continuity and quality of prenatal education services for the health and well-being of newborns and their families.

435 - Piloting online decision support for individuals completing depression screening with Mental Health America

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Background. Since the initiation of Mental Health America (MHA) Screens in 2014, 2.5 million people have completed online depression screening, with 83% reporting moderate to severe depression. Despite a range of evidence-based treatments for depression, 60% of these individuals do not seek care. A major barrier to help-seeking is a lack of mental health (MH) literacy, defined as knowledge and beliefs about mental disorders which aid their recognition, management, and prevention. In this project, we aimed to determine the feasibility and acceptability of an online decision aid (DA) for depression as a strategy to improve MH literacy.

Methods. MHA offers web-based depression screening using the Patient Health Questionnaire (PHQ-9). For this pilot, MHA made a link to a depression DA available to all individuals completing PHQ-9 screening from October – November 2017. The DA consisted of information on frequently asked questions about three treatment approaches: watchful waiting, talk therapy, and antidepressants. Respondents viewing the DA could complete a short survey assessing the perceived helpfulness of the DA and whether they would be “willing to consult a doctor online” about symptoms. Descriptive statistics were calculated, while a multiple logistic regression model identified characteristics associated with viewing the DA.

Results. Of 74,936 PHQ-9 screens completed, 599 (8%) proceeded to review the decision aid; 92% of these individuals screened positive for moderate to severe depression and 86% had never sought treatment. Of the 599, 46% found the DA to be helpful, 45% were unsure, while only 8% said the DA was not helpful. Higher levels of depression severity, female sex and older age were associated with increased likelihood of viewing the DA, while higher income levels and Black/African Americans were less likely to view the DA. A majority of respondents (72%) stated they would be willing to discuss their symptoms with a clinician online.

Conclusion. Screening for depression and providing decision support outside of traditional settings appears feasible and acceptable. Future work will determine the best placement of such decision support to maximize DA access and assess the potential for an online pathway to treatment facilitated by screening and decision support.

439 - Healthcare professional perspectives of shared decision-making among adolescents and young adults with cancer (AYAs) and their families

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Background and aims

Triadic decision-making interactions with clinicians, patients and their families represent the routine clinical picture among adolescents and young adults with cancer (AYAs). However, there is no current shared decision-making framework for communicating with this group and research is yet to explore the impact of health literacy in this context. We aimed to investigate healthcare professional perspectives on: i) how AYAs and their families are involved in processes of information sharing and decision-making, ii) health literacy within this group, and iii) strategies that clinicians use for improving triadic decision-making.

Methods

Semi-structured qualitative interviews were conducted with healthcare professionals working with AYAs aged 15-25 years old, including oncologists, general medical practitioners, nurses, psychologists and social workers. Primary recruitment took place at the 3rd Global Adolescent and Young Adult Cancer Congress. Interviews were recorded and transcribed, to allow for coding and thematic analysis.

Results

To date, ten healthcare professionals have participated, with a 15 further interviews to be conducted following purposive sampling. The current sample consists of oncologists ($n=2$), nurses ($n=6$), a clinical psychologist ($n=1$), and a social worker ($n=1$), with an average of 10.07 years' experience treating AYAs. AYAs were accompanied by a family member in 85% of consultations, most commonly their mother. All healthcare professionals reported engaging in clinician-patient-family communication processes regarding treatment decisions, associated healthcare decisions, social or lifestyle decisions (i.e., fertility preservation), participation in a clinical trials, and end of life decisions. Family members used health literacy skills to: i) contribute to knowledge about the AYAs condition and management, ii) activate the AYA, iii) help them negotiate their options prior to a decision, and iv) give support in shared decisions.

This study is ongoing and results will be updated.

Conclusion

This research is the first important step in the development of novel decision support tools to enhance patient- and family-centred healthcare for AYAs that recognise health literacy skills distributed within families. By better understanding the facilitators and barriers of effective communication and the process of decision-making, researchers can develop informed and relevant tools and strategies that address AYAs needs in this unique setting.

440 - Heterogeneity in Patient Preferences: Measurement and Implications for Shared Decision-Making

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Introduction

Heterogeneity in patient values is a key driver of shared decision-making. Identifying different patient preference subgroups enables patient decision support to be tailored to each subgroup's priorities. The present study elicited preferences of pregnant women, explored how preference heterogeneity could be measured, and considered implications for shared decision-making.

Methods

Participants completed an online survey developed with patient partners, clinicians and decision scientists. The survey included questions on knowledge about management of high blood pressure in pregnancy and a preference task based on best-worst scaling (BWS) methods. In BWS, participants are shown lists of treatment attributes and asked to identify the "most important" and "least important" attribute in each list (e.g. "reducing likelihood of taking antihypertensive medication from 94 in 100 to 77 in 100"). The task included seven treatment characteristics identified as important in qualitative work. Lastly, respondents reported their preferred treatment (i.e., 'tight' control or 'less tight' control). Responses to the BWS task were analyzed using traditional techniques and latent class analysis. Results from the two techniques were compared.

Results

183 pregnant participants answered the survey. A third of participants were 35 years of age or older and 55% completed university or a professional qualification. Half of participants preferred tight control.

Traditional analyses found that participants did not prioritize any attribute (i.e., all attributes were equal). Latent class analysis identified three distinct groups of treatment priorities: 1) "equal prioritizers"; 2) "early delivery avoiders"; and 3) "medication minimizers". Two-thirds of "early delivery avoiders" preferred tight control compared to approximately half of "medication minimizers" and "equal prioritizers".

Conclusions

More advanced analytic techniques identified three preference subgroups with different treatment priorities. The implications of identifying subgroups are two-fold. First, identifying which subgroup an individual is in may help physicians understand and assess patient priorities by providing guidance on how patients may differ. In addition to improving understanding, knowledge of patient subgroups may help physicians identify patient preferences more quickly and thus allow more consultation time for patient priorities. Furthermore, tailoring tools to preference subgroups may increase the relevance of decision support tools and ultimately increase patient uptake.

442 - **considerATE Across Socioeconomic Strata: ensuring a new measure of serious illness experience is accessible and understandable to everyone**

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Background: Symptom burden and distress are rising among people with serious illness and low socioeconomic status (SES) can exacerbate these problems. To improve serious illness experience, we developed a patient-reported experience measure called **considerATE questions**. In this study we aimed to analyze **considerATE** development data to explore the accessibility and understandability to people of varying education levels.

Methods: User-centered design for **considerATE questions** included cognitive interviews and a pilot test with seriously ill patients and family members. We administered a single item health literacy screener. We purposively selected 6 transcripts from the cognitive interviews for transcript analysis: 3 from each end of the SES spectrum, using education as a proxy for SES. Using inductive thematic analysis, we explored differences in measure development responses. We also analyzed free-text responses on the measure and a post-measure questionnaire across SES strata.

Results: Forty-six people participated in interviews and pilot testing (23 patients; 23 family members). Across both phases, 16/29 people with higher education status reported high health literacy, compared to 8/17 of those with lower education.

Preliminary analysis found that people with lower education levels and those suffering from the cognitive burden of serious illness initially struggled to understand the questions and concepts in the measure. When we simplified phrases and added visual cues, however, almost everyone understood the questions. During piloting, 4/17 high education level participants said the questions were confusing, compared to 1/13 lower education participants. Higher education participants included free-text feedback on the measure or post-measure questionnaire 6 times, compared to 1 time among the people in the lowest education strata. Analysis is ongoing.

Conclusion: User-centered design for healthcare improvement should be inclusive of patients of all SES. We found participants from different educational backgrounds interacted differently with the measure development process. Although our measure was ultimately understandable across educational levels, people with less education were more likely to offer written feedback for their care teams, while higher education participants were more likely to offer feedback on the measure itself. This may inform future development projects that strive to include all people, regardless of SES.

443 - Shared decision-making involving family carers in early psychosis intervention services: What do clinical guidance documents recommend in terms of values, concrete practices and indicators?

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Background and aims

Carers of youth with mental illness, particularly psychosis, face numerous challenges as first-time caregivers, from healthcare system navigation to unmet needs and the perplexities of new roles/responsibilities. National and international clinical practice guidance for early psychosis strongly advocate for the support and involvement of carers in treatment of their ill relative, however, several Canadian program reviews reveal discrepancies between family services offered, and those utilized by them. Focusing on clinical practice guidance for psychosis, this presentation critically assesses recommendations for involving carers in treatment decision-making at various phases.

Methods

A systematic scoping review of electronic databases and grey literature was searched from January 2000 to early 2018. Eligible documents were focused on Early Psychosis Intervention Services, for people aged between 14 and 35 years, in either English or French. Document selection and data extraction were independently carried out by two researchers and final inclusion was determined based on consensus. A total of 39 clinical guidance documents were included. Methodological quality was assessed using the Appraisal of Guidelines, Research and Evaluation (AGREE) II instrument and a specific form was developed and used to assess for data mining of family recommendations at the clinical practice level. Data synthesis was primarily qualitative in approach.

Results

Preliminary results indicate that the rated methodological quality of documents ranges from low to moderate. There seems to be poor consistency among recommended practices between documents about involving family carers in shared decision-making process such as carer consultation is required to devise treatment plans vs no mention of consultation, Most documents also lack direction for involving families when faced with complications (*e.x: what to do when patient refuses to consent for family involvement*). As this is an ongoing review, results will be updated prior to the presentation.

Conclusion

This review provides valuable suggestions that can inform guideline design and program policy changes. Indeed, the use of appraisal of guideline tools could improve methodological rigor in developing/updating current clinical practice guidelines. Furthermore, there is a strong need for improving evidence, practices, and developing specific recommendations on how to involve families in treatment decision making.

444 - COORDINATEs: teChnology tO suppORt DeclsioN Making about Aging aT homE: A research program conduct in Canada/Sweden/Netherlands

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Background: Tools and technology already exist to support SDM regarding housing decisions among older adults. However, little is known about how these tools can be adapted to older adults presenting disabilities. Thus we sought, in a three years research program, to study how some technology could be adapted to better enable self-management of older adults living with early stage dementia in Canada/Sweden/Netherlands and foster SDM regarding housing decisions.

Methods: This 3-year research program is an international, multipronged and mixed methods study integrating knowledge translation activities throughout its duration. It is conducted in Canada, Sweden and the Netherlands. It brings together diverse disciplines and professions (e.g. architecture, nursing, geography, medicine) and rely upon partnership with a ehealth enterprise. The COORDINATEs project consists of 3 phases: 1) assessing the potential of GPS-trackers technology to specifically assess autonomy and mobility of older adults with early stage dementia in their home and neighbourhoods; 2) integrate the GPS-tracking technology and adapt SPINACH, a platform for helping version of the TakeCare platform to inform SDM about housing options for older adults; 3) evaluate the effect of the newly adapted technology in supporting self-management and SDM to a broader extent. Using participatory research methods that abide to integrated knowledge translation (iKT), each phases are carried out simultaneously and in collaboration between all country teams. Data from all phases and countries will be triangulated and compared taking into account intra- and inter-country differences between older adults, between healthcare systems, geography environments, and national regulations.

Results: This study began in April 2018 and is ongoing. It will provide self-reported and objectively measured data on autonomy and mobility and also on health status changes among elderly people living at home in 3 countries, an improved support platform for self-management of care for older adults living with early stage dementia; and an user tested and adapted technology regarding housing decisions (phase 3).

Conclusion: New technologies have the potential to provide information on changes in lifestyle, health and safety status. These information could help older adults presenting disabilities, their caregivers and health professionals to make informed and shared decisions about housing options

451 - Views and perceptions on communication experiences in a primary healthcare setting with refugees, asylum seekers and newly arrived migrants: A critical review and narrative synthesis

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Background and Aims

The advanced model of Shared Decision Making provides many challenges, when being adapted for a vulnerable population group such as refugees and asylum seekers, one key challenge is having effective communication. The ever-changing political climate for this population group means that for these patients to fully participate in the shared decision-making process, there needs to be an awareness of their communication challenges in healthcare.

The aim of this review will be to provide an overview and assessment of literature which looks at the views and preferences of refugee towards interaction and communication and provide an overview of current methods to improve this interaction.

Methods

A systematic search of the literature was conducted on seven electronic bibliographic databases from inception to 31 January 2019. Studies were included if they were (i) original research studies that describe views and preferences (ii) included patients from refugees and/or asylum seekers backgrounds (iii) aim to improve or assess communication in the health care setting.

A scoping review identified that qualifying studies mainly employ qualitative methodologies and are varied in nature. Therefore, a narrative synthesis of the literature was undertaken and involved using inductive thematic analysis in which dominant and recurrent themes were identified.

Results

This study is on-going, and the results will be updated

455 - Aids for Shared Decision-Making in Surgery: Systematic Review and Meta-Analysis of the Existing Evidence

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Background

Shared decision-making (SDM) is a popular care paradigm between patients and clinicians to facilitate treatment agreement. Decisional aids (DAs) are frequently used in SDM for improving knowledge sharing and facilitating the decision process. The use and outcomes of decisional aids in surgery, however, have not been investigated to date.

Methods

The search strategy was developed with a medical librarian. Seven databases were searched from inception until June 7, 2018. A 2-person title and abstract screen was performed, followed by a full-text publications review. A meta-analysis was performed to quantify the impact of the decisional tools used, as well as their heterogeneity, given variable sampling techniques. Forest plots were created and Chi-squared tests were employed for each associated variable.

Results

In total, 5,344 studies were retrieved. After duplicates were removed, 4905 titles and abstracts were screened, and of 140 full texts reviewed, 42 studies were included in the analysis. Heterogeneity was high in 3 of 6 variables (surgery chosen, decisional conflict, and knowledge obtained), moderate in 2 (decisional anxiety and decisional satisfaction), and low in 1 (decisional regret). For all except the rates of surgical intervention, the results for decisional conflict, knowledge obtained, decisional satisfaction, and decisional anxiety were significant at a 95% confidence interval. Paper-based DAs resulted in the largest consistent increase (average of 1.2 points for associated scales) in added knowledge and loss of decisional conflict. They were also associated with a decrease in choosing surgical treatment over non-surgical alternatives. Decisional satisfaction was observed to be most increased with coaching-type DAs, compared to paper, video, coaching, and web-based DAs. Web-based DAs were associated with less significant changes in the health variables studied compared to physical or in-person DAs.

Conclusion

The results suggest that SDM-oriented DAs are associated with greater quality in patient satisfaction and value agreement, leading to decreased conflict and anxiety, increasing knowledge and satisfaction. Efficacy of each variable varies among types of DAs. Given the varied outcome response dependent on the type of DA employed, this data is useful in guiding the development of DAs for use in surgical disciplines.

460 - Analysis of Observer OPTION5 scores in the What Matters Most trial comparing two decision aids against usual care for breast cancer surgery choices

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Background and aims

Shared decision making (SDM) can help clinicians ensure that patients' preferences and values, as well as evidence on each treatment option, are collaboratively considered so that patients can make the best possible decision for their care. Observer OPTION⁵ measures the extent of a clinician's SDM behavior witnessed in a consultation. This study aims to 1) measure the level of SDM occurring as women make a surgical choice for early-stage breast cancer, and 2) determine if a text-based (Option Grid) or picture-based (Picture Option Grid) encounter decision aid can increase the level of SDM occurring in the consultation, as measured by Observer OPTION⁵.

Methods

We recruited women 18 years of age and over, with a confirmed diagnosis of stage I-IIIa breast cancer, as part of a comparative effectiveness trial provided they spoke English, Spanish, or Mandarin Chinese. We randomized surgeons to use 1) Option Grid, 2) Picture Option Grid, or 3) usual care. We audio recorded the consultations of all women who consented to recording. Two trained raters independently assessed each recording. We averaged the two scores given for each encounter into a combined score and analyzed these scores by study arm and patient demographics.

Results

As of January 2019, 305 of 585 recruited women (52.1%) had consented to and had their consultations recorded. We completed two calibrations, first after five ratings and again after 100 ratings, which confirmed inter-rater reliability. Once recruitment is completed in February 2019, we will analyze Observer OPTION⁵ scores across arms to determine if the introduction of a text or picture-based decision aid changes the level of shared decision making in the breast cancer surgical encounter. We will also report our results in the context of patient-reported demographic characteristics. This study is ongoing; final results will be updated.

Conclusion

We will determine whether the introduction of a text or picture-based encounter decision aid can improve the level of shared decision making observed in the surgical encounter when women are choosing between mastectomy and breast-conserving surgery.

467 - “Time to move?” Factors associated with burden of care among informal caregivers of cognitively impaired older people facing housing decisions: secondary analysis of a cluster randomized trial

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Background: Making health-related decisions about loved ones with cognitive impairment may contribute to caregiver burden of care. We sought to explore factors associated with burden of care among informal caregivers who had made housing decisions on behalf of a cognitively impaired older person.

Methods: We conducted a secondary analysis within a cluster randomized trial (cRT) conducted in 16 publicly-funded home care service points across the Province of Quebec. The cRT assessed the impact of training home care teams in interprofessional shared decision making (IP-SDM). We assessed burden of care with the Zarit Burden Interview (ZBI) scale. We adapted Pallett’s framework to inform our data analysis. This framework posits that factors influencing burden of care among caregivers fall within four domains: (a) characteristics of the caregiver, (b) characteristics of the cognitively impaired older person, (c) characteristics of the relationship between the caregiver and the cognitively impaired older person, and (d) the caregiver’s perception of their social support resources. We computed the ZBI score and performed multilevel linear regression modelling.

Results: Among 296 caregivers included in the dataset, the mean ZBI score was 29.8 (SD=17.5) out of 88. The typical participant was 62.6 years old (SD=11.7), female (74.7%), and caring for a mother or father (59.9%). Using multivariate analysis, factors significantly associated with caregiver burden mapped onto: caregiver characteristics (caregivers with higher burden were female, experienced higher decision regret and decisional conflict, preferred that their loved one move into the caregiver’s home, into a private nursing home or a mixed private-public nursing home, and had made the decision more recently); relationship characteristics (spouses and children experienced higher burden); and caregiver’s perception of social support resources (caregivers who perceived that a joint decision making process had occurred had higher burden).

Conclusion: In line with the proposed framework used, we found that caregiver characteristics, relationship characteristics and caregiver’s perception of social support resources were associated with burden of care. Our results will help design interventions to prevent and/or reduce caregivers’ burden of care.

470 - Exploring patient informed consent experience regarding cancer clinical trials

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Purpose: The study aimed to explore patient informed consent experience regarding cancer clinical trials.

Methods: The study used a survey research design. The questionnaire contained four parts, including demographics, informed consent experience, and understanding of clinical trials. Patients were eligible if they were older than 18 years, diagnosed with cancer, had been informed consent for a clinical trial within three months prior to being approached, and could concentrate on the study questionnaire for around 30 minutes. Data collection was conducted in two medical centers in Taiwan.

Results: A total of 241 patients with cancer had been approached to complete the survey questionnaire. They all decided to participate in a clinical trial after informed consent process. Of these participants, 66% were male (n=159); nearly 70% were high school graduates or below (n=167); nearly 95% lived with their family (n=228) and 73% had family/friends with them for clinic visits (n=176). For the informed consent process, nearly 30% of participants (n=71) indicated they did not discuss or clarify their concerns with a medical team member if they did not understand the trial information being provided. Regarding the participant information and consent form, less than 40% of participants (n=93) read the entire document before making a decision regarding trial participation; over 55% (138) did not understand the content of this document and nearly 40% (n=96) did not discuss with a medical team member. The mean score of patient understanding of clinical trials was 9.63 ± 2.63 with a full score of 16, indicating patient understanding was moderate. Education levels ($\beta=.306$) and age ($\beta=-.216$) were strong predictors of understanding of clinical trials, explaining 17.8% of total variance.

Conclusion: It is necessary to encourage patients to engage in informed consent discussion and clarify their concerns in order to make an informed decision. In addition, patient understanding of cancer clinical trials is a critical issue. It is recommended that health professionals use plain language to explain trial information in order to assist patient understanding clinical trials.