

actions patients can take (page 2 and figure 1). We sought to field test the KOP to iteratively improve its usefulness and ready it for testing in a randomized trial.

Methods Transplant candidates were enrolled to participate in a shared decision-making discussion with a transplant coordinator. Enrolled patients gained access to the online decision support tool before the discussion. During the discussion, the patient and transplant coordinator reviewed the KOP. Discussions were recorded with video or audio. We summarized observations from recordings to inform future iterations.

Results Five transplant candidates participated in the prototype evaluation phase. Each clinical visit lasted about 20–60 minutes. Two investigators reviewed participant recordings. Initial findings indicate patients and providers followed prompts in the KOP and reviewed consent decision, potential donor risks, and actions to prepare for an offer.

Discussion New shared decision-making tools for offer decisions may address gaps in patient counseling, particularly after waitlist evaluations.

Conclusion Prototype testing of the Kidney Offer Plan supports ongoing iteration of this intervention in preparation for its evaluation in a randomized trial.

023

CHAT-GP: PARTNERING WITH CONSUMERS, CLINICIANS & STAKEHOLDERS TO CODESIGN SHARED DECISION MAKING RESOURCES FOR HEART HEALTH CHECKS

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Introduction Despite strong evidence that decision aids support shared decision making, effective implementation, adaption and updating of these resources is a significant gap. The CHAT-GP (Communicating Heart disease risk Assessment using Translational strategies in General Practice) partnership project aimed to work with consumers, clinicians and stakeholders to codesign and implement shared decision making support for heart health checks in Australia.

Methods Phase 1 involved working with GPs and patients to codesign decision aids and integrate them with clinical guidelines for heart health checks. Phase 2 explored wider implementation strategies with non-profits, health services and government, to identify and test different ways to reach end users. Phase 3 involved working with an expert guideline committee, and adapting the resources to revised guidelines to meet the health literacy needs of different groups.

Results Phase 1 resulted in a suite of acceptable and effective decision aids that improved knowledge amongst GPs and patients with varying health literacy levels. Phase 2 identified and tested opportunities to integrate the decision aids into clinical software, education and quality improvement programs, resulting in over 80,000 uses across 16 health service

regions. Phase 3 led to a clinical recommendation to use decision aids in the national cardiovascular disease prevention guidelines, integration of IPDAS elements into the clinical risk assessment tool, and two new shared decision making support websites for Aboriginal and Torres Strait Islander communities and consumers with low health literacy.

Discussion The CHAT-GP project demonstrates partnerships with multiple groups to codesign and implement decision aids for heart health checks into different systems. This required adaption of the resources to ensure their ongoing relevance with evolving evidence, guidelines and priority group needs.

Conclusion The findings show how long term partnerships across multiple sectors and end user groups can be used to effectively implement shared decision making resources.

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THE ROLE OF WOMEN IN BREAST CANCER DECISION MAKING: A QUALITATIVE STUDY IN THREE CHILEAN HOSPITALS

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Introduction In Chile, the Cancer Law recognises the importance of putting patients at the centre and encourages them to participate actively in health care. Participation is a key element to improve patient satisfaction. However, there needs to be more information on how patient participation translates into the medical decision-making process and the clinical encounter. Objective: To analyze the participation experience of women in breast cancer treatment.

Methods A qualitative study was conducted, based on 29 online semi-structured interviews with women undergoing breast cancer treatment from three healthcare centres in Santiago, Chile. The interviews were audio-recorded and analysed through a thematic analysis using the Atlas ti program. Ethical approval was granted at the three hospitals.

Results Two types of participation emerge from the results¹: Participation in the care process, understanding these as all the choices that are made before the start of treatment, which is influenced by economic capacity, information from third parties, urgency of care and ² participation in decision-making about the medical treatment plan, understanding these as all the decisions that women make when it comes to decide the course of treatment, where a high degree of delegation of the decision is observed in the figure of the doctor.

Discussion The participation of women in the decision-making of the medical treatment plan for breast cancer seems to be minimal, prioritising practical criteria of healthcare, that is, in the care process over the choice of medical treatment.

Conclusion The findings contrast with one of the objectives of public cancer policy and with what is reported by global evidence. In this scenario of scarce participation, it is essential to consider how public policy could diminish the possibility of participation by mainly ensuring access to healthcare.