

**Conclusions** Based on the available web based health information in Norway, users cannot make informed choices about contraceptive methods.

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### CULTURAL ADAPTATION OF A DECISION AID FOR YOUNG AND ADULTS IN CHOOSING CONTRACEPTIVE METHODS

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**Introduction** Decision aids (DA) are useful tools to promote shared decision making (SDM), but developing them from scratch is resource intensive. We adapted the Spanish version of 'My Birth Control' (developed in the USA) to our cultural context, to help patients choose a contraceptive method that best fits their needs and preferences.

**Methods** Following the cultural adaptation framework of health communication materials developed by the European Centre for Disease Prevention and Control, we did a literature review of decision aids, selected and revised the content of 'My Birth Control', conducted interviews with physicians and patients to assess its comprehensibility and acceptability, and made a proposal for its cross-cultural adaptation.

**Results** The general reception of the DA was positive and participants considered it useful to address this topic. Specific modifications are necessary to adapt it to our context. We propose ensuring that the section of questions about personal preferences is available throughout the decision aid, and adapting theoretical information to content endorsed by the Argentine Ministry of Health guidelines. Additionally, including information on the accessibility and coverage of different contraceptive methods and reinforcing the prevention of sexually transmitted infections.

**Discussion** Some doctors and patients questioned the significance of delving into users' preferences to make a decision, probably unfamiliar to the SDM approach. This is still a prevalent barrier in our setting, despite ongoing efforts to implement SDM. We hope the DA will help patients and healthcare professionals to have SDM conversations, but we acknowledge that we will need to complement it with other implementation strategies to improve its applicability.

**Conclusions** In order to ensure that healthcare professionals and patients have a good user experience with this DA, we consider necessary to make the proposed changes to adapt it to our sociocultural context and our usual medical practice.

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### EVALUATION OF THE IMPACT OF A PATIENT SUPPORT PROGRAM ON SHARED DECISION-MAKING, COMMUNICATION, AND PATIENT CONFIDENCE DURING CLINICAL ENCOUNTERS: A RETROSPECTIVE, CROSS-SECTIONAL STUDY

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**Introduction** Agenda-setting is a collaborative process where patients and providers discuss questions and the goals for the medical appointment. The Patient Support Corps (PSC) aims to facilitate agenda-setting by 1) facilitating question/concern list before patient visits and 2) accompanying the patient to take notes and reminding patients of question lists as needed. It is critical to evaluate whether the routine provision of patient-centered agenda-setting improves patient experience.

**Methods** We are conducting a retrospective, cross-sectional study to explore the impact of the PSC program since its inception at Dartmouth Health to 2023. We are exploring 1) the impact of PSC on patient perception of provider communication; 2) variation in patient-reported shared decision-making during PSC clinical encounters across clinical settings and patient demographics; 3) the role of PSC on patient confidence in asking questions during clinical encounters; and 4) patient and provider survey and written feedback to assess experience with participating in PSC.

**Results** Since the program's inception, it has served over 3,000 patients (median age 60 years;71% female). A top-box analysis of patient satisfaction finds 74% of patients were completely satisfied with the PSC experience. Among clinicians surveyed, most respondents used the patient question lists, believed that the question lists informed them of what is important to the patients and helped with patient interaction. Further analyses are in progress and will be completed by March 2024.

**Discussion** Preliminary results suggest that services provided by PSC, such as question-listing, may have positive impacts on patient satisfaction and provider experience.

**Conclusions** Any conclusions should be interpreted carefully as data analysis has not yet finished. Upon completion, we hope to better understand the impact of programs, like PSC, on patients during clinical encounters at a tertiary medical center in rural New England.

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### SUPPORTING CONTRACEPTIVE DECISION MAKING THROUGH PARTNERSHIPS WITH SETTLEMENT SERVICE PROVIDERS AND NEWCOMER YOUTH: RESULTS FROM THE ASK US PROJECT

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**Introduction** Despite being recognized as a human right by the United Nations, contraception remains inaccessible for many newcomer youth in Canada. Through this national qualitative investigation, called 'Ask Us', we investigated the experiences, attitudes, and decision-making needs of newcomer youth in Canada.

**Methods** This study was co-designed with youth patient partners and settlement service providers (SSP) and guided by constructivist grounded theory. Youth peer researchers conducted national, community-based outreach to advertise the study with underserved youth. We conducted one-on-one video-conference interviews with newcomer youth of all genders, aged 15 to 25, living across Canada. After transcribing audio-recorded interviews, we completed an inductive analysis to

identify youth's decisional needs for contraception choices. We then conducted a deductive analysis using Levesque's Patient-centred Access to Healthcare framework, identifying opportunities to implement shared decision-making interventions.

**Results** Analysis of 14 newcomer youth interviews resulted in three themes about youth's contraception decisional needs: a) Sex is a shameful thing that we don't talk about; b) Preferring discreet contraception options that allow youth to 'Grab n Go'; and c) I think you learn from and trust your friends. We also identified that youths' 'Ability to Seek and Pay', and 'Ability to Perceive and Engage' with contraception prescribers in the health system constrained their ability to make values-congruent choices.

**Discussion** Newcomer youth's perspectives highlight that stigma, confidentiality, and social influences are key factors in their contraception choices. Our results indicate the need to provide newcomer youth with tailored information, and decision-making resources for contraception. Involving SSPs in interprofessional shared decision-making may further support newcomer youth in navigating the healthcare system.

**Conclusion** Shared decision-making interventions for newcomer youth may be tailored to address issues of stigma,

confidentiality, and the social influence of peers on contraception choices.

**129 PATIENT-CLINICIAN COLLABORATION IN MAKING CARE FIT: A QUALITATIVE ANALYSIS OF CLINICAL CONSULTATIONS IN DIABETES CARE**

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**Introduction** Patient-clinician collaboration to make care fit has been described to include nine relevant dimensions, based on expert opinion and a literature review. The purpose of this

**Abstract 129 Table 1** Thematic map (dimensions and subdimensions of making care fit) with exemplary quotes

<b>1. Patient's unique situation</b>	
A. Biomedical situation	"You are now in time of target range at 43%. Relatively few hypos."
B. Personal situation	"As Chief Director of Finance. So I managed financial administration."
C. Mix biomedical and personal situation	"I am very tired [...] Whether that's the diabetes, I don't know."
<b>D. Problematic situation (defined by the patient)</b>	
"Big toe, left foot. [amputated] It's painful and I'm heavily on painkillers."	
<b>2. Patient's priorities</b>	
A. Priorities in trade-offs	"That is a precursor of macular oedema, I really don't want to get that."
B. Wishes (without the formulation of a goal)	"HbA1c is 58. I would like something lower."
C. Goals (to reach desired situation)	">13.9 is now 4%. I would actually, if you ask me, like to have 1%"
D. Worries (about past, current or anticipated situation)	"It still bugs me a bit. [...] what could I have prevented?"
<b>3. Patient's lives</b>	
A. Work or burden of being a patient	"I think my values are good [...] but it takes a lot of effort. A lot of effort."
B. Impact of condition or care on patient's life and wellbeing	"I still think diabetes is a very nasty disease. You are never free from it."
C. Capacity (acknowledgement, acceptance or efforts to build)	"I should also exercise more. [...] but I can't leave my husband alone [...]"
<b>D. Devices (technology impacting patient's care/life)</b>	
"Ideal in terms of pump, if I have to change at work, it is very quickly."	
<b>4. Patient's social networks</b>	
A. Experiences of social network (impact of condition/care)	"It is.. I expected.. Sorry. I just don't know. [...] I need to let this sink in."
B. Supporting social network	"[...] your daughter [...] If she wants to, we can prescribe something."
C. Work or burden of social network	"[...] I depend on her. Not only do I have diabetes, she actually does too."
<b>5. Collaboration: content</b>	
A. Fostering choice awareness	"In your case, it's just a little bit elevated, so then it's what you prefer."
B. Discussing pros and cons of options	"You can try another insulin [...] it has a somewhat more stable profile."
C. Discussing values and preferences concerning options	"What bothers me, is that I had side-effects from that medication."
<b>D. Discussing rational, emotional or practical sense of options</b>	
"[...] what if such a moment comes, what can I do best? That choice."	
<b>6. Collaboration: manner</b>	
<b>A. Shared agenda setting</b>	
"Were there things you wanted to discuss?"	
B. Building or maintaining relationship (team talk)	"That's how you should see it, us as a team, we want the best for you."
C. Emotional behaviours enabling collaboration	"Are you hanging in there? Because it's also quite intensive, isn't it?"
<b>D. Clinician sharing personal details (two-sided openness)</b>	
"I will be on vacation" "Far away?" "Yes, Italy" [...] "It's beautiful there".	
E. Using support tools for collaboration	n/a
<b>F. Lack of collaboration (clinician steering)</b>	
"Of course, it [target value] could be a bit tighter. It should be set to 6."	
<b>7. Ongoing and iterative process</b>	
<b>A. Possibility to reconsider</b>	
"We have applied for 3 months and if you don't like it [...] we can stop."	
B. Planning future care appointments and activities	"Well, what we're going to arrange: an appointment with [name]."
C. Efforts to optimize continuity of care	"We have to coordinate the care with the ophthalmologist."
D. Adapting care to biomedical situation (efforts/experiences)	"lowered to 11 [insulin, because of weight loss]" "You did the right thing"
E. Adapting care to personal situation (efforts/experiences)	"You can try, not to inject short-acting insulin at all before cycling."
<b>F. Adapting care to organization of care (efforts/experiences)</b>	
"We have chosen that we will pay extra for this specific insulin."	
<b>8. Time and pace</b>	
A. Unhurried collaboration	n/a
<b>9. Consequences of making care fit</b>	
A. For patient's wellbeing	"I feel good about myself [...]. And I can function well."
B. For clinician's wellbeing	n/a
C. For wellbeing of patient's social networks	n/a
D. For healthcare systems	n/a