Title: Investigation of factors influencing the implementation of two shared decision-making interventions in contraceptive care: a qualitative interview study among clinical and administrative staff

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Version: 1 Date: 10 Sep 2019
Author’s response to reviews:

Response to Reviewer reports:

IMPS-D-19-00368

Investigation of factors influencing the implementation of two shared decision-making interventions in contraceptive care: a qualitative interview study among clinical and administrative staff

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Editor's comment:

Please attend to the suggestions of the reviewers. Also there need so be a justification for so many authors on an essentially qualitative paper. It is highly unusual - unprecedented in my opinion to have 17 authors on a qualitative paper. I think it is unlikely that more than 6 authors had a significant enough role to warrant authorship of this type of paper. Please could the author review the authors and include up to 6 with others included in an acknowledgement

Response:

We agree that a co-author list of 17 individuals does not represent the typical authorship for qualitative studies. This high number is unprecedented in our publication history, too. This study was unique in that it was funded by the Patient Centred Outcomes Research Institute (PCORI) and we were required to adhere to methodology standards in the design and conduct of our patient-centred outcomes research. This included collaborating with patient partners and community stakeholders in all phases of the research process, from study design to interpretation to dissemination of results. Our authorship group is atypically large because of this approach, but all authors made genuine contributions consistent with ICJME guidelines.

We describe our team science and patient engagement approach in the study protocol. Throughout this qualitative component of the study in particular we made a concerted effort to ensure our patient and stakeholder partners contributed their expertise equally alongside researchers and clinicians.
All co-authors were involved the qualitative study design, including operationalizing the Theoretical Domains Framework into interview questions and developing the interview guide. All input was solicited via research team discussions in our recurring monthly teleconference—our main opportunity for real-time communication. We held 28 meetings total during study design, data collection, and analysis. Post-study period, all partners participated in drafting and reviewing the manuscript by email.

The lead author also held one-hour, one-on-one phone calls with the patient partners, stakeholders, and clinicians on the research team to discuss the qualitative data. All feedback was incorporated into the data analysis audit trail and discussed with the analysis team. Patient partners and stakeholders also participated in a one-day in-person workshop in November 2017 to review the study data together in real time. The aim of this group meeting was to ensure meaningful contributions from the partners and allow for reciprocal learning. Finally, in line with PCORI principles, we sought patient partner and stakeholder input on ideas for disseminating the project findings.

We have described these activities in a brief sentence now added to Page 12, line 274. We hope that our description of partner and stakeholder involvement provides adequate justification for including all co-authors. For reference, examples of similar large team that have published qualitative decision aid evaluations (that do not include patient partners) include the following:


Reviewer #1

1. This manuscript is a very well written report of a qualitative arm of a 2X2 factorial cluster RCT that compared outcomes of two evidence-based shared decision making (SDM) interventions for contraception method selection. 16 clinics participated in the RCT with 4 clinics serving as controls, 4 getting both interventions 4 getting one intervention and 4 getting the other intervention. Results of the quantitative outcomes of the study are published elsewhere. This study focused on qualitative interviews with clinicians and administrative staff from the 12 intervention clinics specifically aiming to learn about factors that influenced the implementation and sustainability of the two interventions. The Theoretical Domains Framework was used to guide the interviews and analyze the data. Overall, the design and methods for the study were sound. Three investigators participated in the analysis of the data to ensure reliability of findings and interpretations. In general the findings are fairly consistent with the findings of multiple other studies regarding the barriers and facilitators for implementation and sustainability of a practice change. What is new here is applying SDM interventions for guiding contraception discussions and choices between clinicians and patients. Thus, the readership may be interested in the implications regarding adopting evidence-based shared decision making practices. There were a lot of themes identified that were distilled down to key findings that, again, are consistent with other studies. I have no issues that need addressing; the manuscript findings are not overly novel but meaningful and theory driven.

Response 1.1 : We thank the reviewer for their thoughtful and encouraging remarks and acknowledge that the reviewer has no issues that need addressing.

Reviewer #2

Thank you for the opportunity to review this nicely written paper reporting findings from a well constructed study. The authors may wish to consider the following brief comments:

1. Page 9, line 193. It would be helpful at this point to provide examples of the type of clinical participants e.g nurse etc.

Response 2.1: Thank you for the suggestion. We agree that a fulsome description would be helpful and have moved up the description of clinical staff participants from line 200 to line 195.
2. How did you seek/sample 'extreme case examples of clinical staff ...' (page 10, line 206)?

Response 2.2: We sought highly unusual or extreme cases of clinic staff who reported not seeing or using the interventions by returning to the sampling frame and identifying participants who had either left their position or joined the clinic during the study period and were likely to be less familiar with the interventions. We have added this description in page 10, line 209.

3. I found the tables a more helpful overview of the findings than the text. This may relate to the density of the descriptions under each of the domains. I did wonder if placing the selected quotes in the text would bring the voice of participants to this section.

Response 2.3: We agree with the reviewer that including selected quotes in text is preferable to separating them from the manuscript into data tables. We originally did include selected quotes in our write-up of the results, however we removed them into the tables in order to keep our manuscript within a reasonable word count for Implementation Science. We would be delighted to include selected quotes in text and ask for the editors’ approval as it will increases our word count by roughly 400. Please see additional quotes on pages 13-20.

4. This reader found that reference to decision aids, the intervention (including training), tools, and video and prompt cards were used so frequently and interchangeably that left this reader slightly confused at points - see first sentence of the discussion on page 20, line 431-2.

Response 2.4: This is a helpful suggestion. We have now edited all instances of tool/intervention and use the term ‘intervention’ only, not ‘tool.’ We have also removed or replaced some instances of intervention with the actual label (decision aids and training OR video and prompt cards). Any instances of ‘intervention’ that remain refer inclusively to both interventions. We also hope that when the article is published and Box 1: Right for Me Interventions is in a central, visible location, this will aid the reader in seeing and understanding the multiple components of the interventions.

5. Is it possible to elaborate on context specific facilitators? Context is an important factor in implementation of complex interventions and interpretation of the findings.

Response 2.5: We agree with the reviewer’s suggestion that context-specific factors are critical to include in reporting of implementation research. We sought to do this in each instance in the results where we name a Clinic and highlight contextual factors that influenced routine use of the interventions. We realize that without naming these examples ‘context specific factors’ readers may not recognize how we are attempting to highlight context. We have added “in the context of Clinic X” and “contextual factors included…” where appropriate throughout the results:
6. Interesting point that lack of suitability of the intervention for patients was not a factor that emerged in the study. Does this reflect the patient profile of the practices? People with low literacy in their community language and/or limited health literacy will likely find prompt cards very difficult to engage with. It would be important to discuss this in relation to shared decision making given the diversity of the USA population and that of other high income countries.

Response 2.6: Yes, clinical and staff participants perceived that the interventions were suitable for patients in their patient population, but these perceptions may not reflect actual usefulness among particular populations. As suggested, we have added a sentence to the discussion that contextualizes our findings in the literature on SDM and health literacy. See page 25, line 572 and two new references from research led by Dr. Danielle Muscat from the University of Sydney.