

key in making this work. Having no electronic medical record, eligible patient identification has been the biggest challenge. The warm hand-off and having patients watch DAs in the clinic have been our most successful delivery modes. For productive interactions, DAs inform and activate our patients, and they help prepare and make proactive our practice teams.

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**Learning how to share: Challenges in implementing decision aids in routine maternity care**

*R. Thompson, Y.D. Miller, C. Gallois*

Queensland Centre for Mothers & Babies, BRISBANE, Australia

**BACKGROUND**

Despite evidence that decision aids are valued by patients and effectively increase patient knowledge, reduce decisional conflict and promote shared decision-making, far less is known about their efficacy in real-world settings, or about factors that impede or enable their implementation in routine health care.

**DESIGN AND METHODS**

We have recently undertaken research to identify effective methods of promoting shared decision-making between maternity care consumers and their care providers. In consultation with maternity care stakeholders (consumer groups, clinicians and policy-makers), we developed a suite of decision aids for pregnancy and birth. While both the implementation and impact of these decision aids are currently undergoing evaluation in a randomised controlled trial, the process of decision aid development provided key insights into barriers to shared decision-making in maternity care.

**RESULTS**

Consultation with maternity care stakeholders revealed diverse perspectives on the value of decision aids in routine maternity care. While the vast majority of stakeholders endorsed the concept of consumer involvement in decision-making, people differed considerably in (i) their assumptions about women's capacity to comprehend health information and to make 'reasonable' decisions about their care, (ii) their views about the types of options that can 'safely' be included in decision aids, and (iii) the extent to which they support unbiased and non-directive provision of information about care options to maternity care consumers. Due to inadequate opportunities for addressing more fundamental barriers to the implementation of decision aids within this project, a number of compromises were made to maximise acceptability of the decision aids (e.g., removing a decision aid on infant feeding, when widespread disapproval of non-directive information about infant feeding options was predicted to undermine acceptability of the suite of decision aids).

**CONCLUSIONS**

Overall, we found that the prevailing culture in maternity care in Australia does not readily facilitate the practice of shared decision-making or the routine implementation of decision aids. Our learnings substantiate and extend existing knowledge of barriers to the implementation of decision aids in health care more broadly and underscore the importance of focusing efforts on promoting the benefits of shared decision-making among health care providers and other key stakeholders.

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**278 ORAL PARALLEL SESSION 4**

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*R. Thompson, Y.D. Miller, C. Gallois*

Queensland Centre for Mothers & Babies, BRISBANE, Australia

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## 198 SYMPOSIUM PARALLEL SESSION 3

### Decision support in complex settings - the challenge of context

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#### BACKGROUND

There is growing demand for, and development of, decision support to enhance engagement of patients in decisions about treatment options (including patient decision aids). These are complex interventions and, as such, merit robust development and evaluation. To stimulate more effective development and evaluation of decision support it is important to take account of the context of the particular index decision for which support is required.

#### DESIGN AND METHODS

We set out to develop a framework for considering decision context in order to help those seeking to develop and evaluate decision support. This was initially drawn up from experience of exploratory research into decision making and developing/evaluating decision support in a range of clinical decisions and settings. These ranged from chronic disease in the elderly, through hyperacute treatments (such as thrombolysis in acute stroke care), and pain relief in labour to engaging children and parents in decisions about treatment for squint. An initial framework of contextual factors was drafted and tested with workshops in two international conferences, with subsequent refinements based on feedback from attendees.

#### RESULTS

A framework has been developed that incorporates five categories of contextual variables including: patient factors (e.g. age, co-morbidities, capacity); other actors (e.g. parents, carers); decision variables (e.g. acute/chronic, severity, number of options); organisational variables (e.g. multidisciplinary

team, care pathway, health system design); and delivery variables (e.g. face-to-face by clinician, on-line). Variables subsumed within (and between) the five categories interact with one another, which further captures the intricacies and context dependent nature of decision support, and highlights the need for a multidisciplinary and inter-professional approach to development, delivery and evaluation.

## CONCLUSION

We have developed a framework that might help those involved in developing and/or evaluating decision support. This has been constructed with reference to a range of experience and further validated through discussion within expert workshops using a range of index decisions. We next plan to operationalise this framework into specific guidance for developers and researchers.

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## 199 POSTER SESSION MONDAY

### Development and usability testing of a shared decision support tool for cardiovascular risk reduction in primary care

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#### BACKGROUND

The UK NHS is implementing cardiovascular (CVD) risk screening in primary care for everyone aged 40-74 to initiate lifestyle changes or other interventions for those at raised risk. We developed and tested the usability of a computerised risk communication and shared decision support tool.

#### DESIGN AND METHODS

This incorporated three elements: 1) software development; 2) relevant predictive equations, including the Framingham equation for CVD risk, and the effectiveness of interventions and their adverse effects; and 3) a period of iterative development with clinicians and patients. We drew upon the literature and experience with previous software development to design a prototype that included a range of risk and benefit presentations using pictograms and text. We tested this version in demonstrations and interviews with eight primary care professionals and ten patients with known cardiovascular risk.