Table S2. Reported barriers, facilitators, and levels of implementation

Author, year, study citation, country. **Setting: study type.** **Funding.**	**Identified barriers**	**Identified facilitators**	**Level of implementation achieved** 1. Orientation 2. Insight 3. Acceptance 4. Change 5. Maintenance
Holmes-Rovner, 2000, [1], US. Secondary care hospital: observational study. Funding: Blue Cross and Blue Shield health insurers.	DESI provision not integrated into role or task expectations, i.e. clinicians 'forgot' to give tools to patients. Logistical challenges also reported, e.g. collection of tools from a separate center and rapid scheduling of patients for surgery did not provide time for patients to consider decisions fully. Professional skepticism about value of decision support was reported and accounts that tools were viewed as good sources of information but to involve patients in decisions.	Not reported.	2. Insight.

Stapleton, 2002, [2], UK. Secondary care maternity units: quasi-experimental and observational study. Funding: Department of Health.	Competing demands in clinical environments, time pressures, clinical unavailability of some treatments (leaflets described options that were not available locally) and staff disagreement with leaflet content, hierarchical professional power structures, where obstetricians defined "right" choices, failure to distinguish leaflets from other information related to pregnancy, packaging of leaflets in advertising or maternity folders, failure to understand shared decision making and lack of continuity of care during pregnancy.	Not reported.	2. Insight.
Stacey, 2005, [3], Canada. Call-centers: observational study. Funding: sources related to Canada research Chair.	Difficulty in using DESIs via telephone, lack of ability and confidence to address callers' decisional needs, increased call length, and a lack of knowledge regarding available health services within the caller's community. Organizational factors: e.g. pressure to minimize call length, novelty of providing decision support at a call center, and lack of performance standards.	Prior nursing experience of patient decision support. Existence of tailored call-center infrastructure.	2. Insight.

Silvia, 2006, [4], US. Secondary care oncology: observational study. Funding: IMDF.	Lack of clinical motivation to use DESIs and reported shortage of time and resources. Logistical challenge of providing patients with time and space to view DVDs. Decision support was viewed as being in competition with other existing patient information. Concerns about 'overwhelming' patients.	Existence of a clinical champion, especially when in a leadership position. Systematic approach for integrating provision and use of patient DESIs support into clinical pathways.	2. Insight.
Stacey, Pomey et al., 2006, [5], Canada. Call-center: case study. Funding: Canadian Institute for Health Research.	Difficulty in using decisions support materials over telephone. Concern that call efficiency might be compromised. Perceived inadequate skills and low confidence in providing decision support.	The provision of training and introduction of a patient decision support protocol.	2. Insight.
Stacey, O'Connor et al., 2006, [6], Canada. Call-center: RCT. Funding: Ontario Ministry of Health.	Not reported.	Not reported.	2. Insight.
Garden, 2008, [7],UK. Secondary care urology clinics: observational study. Funding: Department of Health, UK.	No barriers reported.	Not reported.	2. Insight.
Silvia, 2008, [8], US.	Lack of clinician support for using DESI, due to lack of time and unfamiliarity with	Accepting added value of using DESIs facilitated implementation: more patients	2. Insight.

Secondary care oncology: observational study. Funding: IMDF	content. The resistance of other professionals, e.g. nursing staff, also reported, specifically due to a concern that patients resist engaging in decisions at a time of cancer diagnosis.	received and used DESIs when nurses were involved in recommending their use.	
Stacey, 2008, [9], Australia. Cancer helpline service: pre- and post-assessment. Funding: not reported.	Limited awareness of patient decision support, potential organizational ambivalence for the task, and low confidence in new specific skills.	Positive attitudes to patient involvement in decision-making, having sufficient time for more complex calls, the provision of training and orientation.	2. Insight.
Belkora, 2009, [10], US. Secondary care breast care: case study. Funding: IMDF.	Costs of producing and distributing decision support, lack of infrastructure for patients to view DESIs, lack of patient access to telephones, and delivery of decision support was not integrated into role or task expectations.	Re-engineer pathway so that viewing DVDs and decision coaching is provided to eligible patients prior to clinical encounters.	3. Acceptance.
Brackett, 2010, [11], US. Primary care, rural academic medical centers: quasi-experimental study. Funding: IMDF.	Distribution failed due to clinicians being 'distracted by other duties'. Identification of eligible patients and referral of patients to DESIs are not part of existing routines.	Systematize the distribution of patient DESIs. This is made easier when categories of patients can be identified, e.g. due for screening or preventative visits.	4. Change.

Belkora, 2011, [12], US. Secondary care: quality improvement study. Funding: IMDF.	Delivery of decision support was not integrated into role or task expectations.	Telephone delivery of decision coaching and flexible scheduling to maximize use of marginal staff time. Removing the task of identifying patients eligible for decision support from clinical roles. Systematize the distribution of patient DESI– for example, use mail rather than use referral dependent loan services.	4. Change.
Feibelmann, 2011, [13], US. Mixed care settings for breast cancer: quasi-experimental study. Funding: IMDF.	Difficulty identifying eligible patients. Lack of time and resources contribute to the logistical challenge of distributing DESIs. The diversity and volume of other existing educational materials. Resistant professional attitudes reported: e.g. lack of 'trust' in DESI content and design, and a view that patients lack sufficient literacy and 'do not want' to be involved in decisions.	Not reported.	4. Change (28 of 111 sites).
Holmes-Rovner, 2011, [14], US. Primary care internal/family medicine clinics: observational study. Funding: IMDF.	No barriers reported.	Clinician skill development using simulations and reimbursement for undertaking shared decision making.	3. Acceptance.

Frosch, 2011, [15], US. Primary care practices: observational study. Funding: IMDF	Lack of adequate infrastructure, inefficient identification of eligible patients, work environment tensions among physicians and support staff, patient frustration due to long wait times, staff juggling competing demands, disinterested physicians.	Efficient infrastructure; efficient identification of eligible patients; good rapport between physicians, staff, and patients; interested motivated professionals who provide 'warm hand-offs' as they refer patients to DESIs.	3. Acceptance.
Miller, 2011, [16], US. Academic internal medicine practice: observational study. Funding: IMDF	Difficulty identifying eligible patients, infrastructure required for DVD viewing and time needed view DESIs in clinic.	Not reported.	4. Change.
Uy, 2011, [17], US. Primary care practices: observation, qualitative. Funding: IMDF	Scare workforce capacity, competing clinical demands, language barriers (DESIs only available in English), clinician perception of patient resistance to DESIs, low levels of staff interest.	Lead physician engagement and buy-in. Other facilitators: DESI storage and accessibility, clear lists of available DESI, content summaries for use by staff, posters advertising the availability of DESIs to patients.	2. Insight.

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