Assessing Patients’ Values and Preferences in Shared Decision Making

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Overview

1. Defining values clarification and preference elicitation (VC/PE) in shared decision making

2. A framework of VC/PE approaches

3. Methods of VC/PE in decision support – examples and state of the evidence
Informed Decision Making (IDM)

When an individual:

1. Understands the nature of the disease/condition (core knowledge)
2. Understands the preventive service/treatment, including risks, limitations, benefits, alternatives, uncertainties (core knowledge)
3. Considers preferences and values as appropriate (values)
4. Chooses a level of participation in decision making with which he/she is comfortable (role preferences)
5. Makes (or defers) a decision based on his/her preferences and values (values-based decision)

Shared Decision Making (SDM)

- SDM is defined as decisions that are shared by doctors and patients, informed by the best available evidence, and weighted according to the specific characteristics and values of the patient.

Brooks, Cochrane. Introduction to SDM. Dartmouth-Hitchcock Medical Center.
Defining Values and Preferences

Values

- A person’s informed attitudes about the desirability/undesirability of a health care option’s unique characteristics, including its protocol, benefits, and harms.

Values

- A person’s informed attitudes about the desirability/undesirability of a health care option’s unique characteristics, including its protocol, benefits, and harms.

What’s important to you?

Preferences

• The overall most-favored option, after taking into account attitudes toward the options’ detailed characteristics (values).

Defining Values and Preferences

Preferences

• The overall most-favored option, after taking into account attitudes toward the options’ detailed characteristics (values).

Which option do you want?

Values Clarification

• Historically, assumed patients’ values were intrinsic and task was to “uncover these underlying values” through a VC exercise.

• Current thinking is values are co-constructed with health care provider (and others) as the patient learns about the options and explores trade-offs.

Anatomy of a Patient Decision Aid and a SDM Process

- Clear statement about decision to be made
- Description of the options
- Description of benefits and harms of options
- Values clarification component
- Guidance on deliberation
- Preferences and forming an action plan

DECISION AID TOOL

Adjuvant Endocrine Therapy for Hormone Receptor-Positive Breast Cancer

This booklet is what is often called a decision aid. The goal of decision aids is to help patients better understand their treatment choices and to help them make the best medical decision possible for their situation.

This decision aid is for women who are post-menopausal and who have hormone receptor-positive (ER+ and/or PR+) breast cancer and are trying to decide whether or not to take adjuvant (after surgery) endocrine therapy and what type of endocrine therapy to take. The goal of this decision aid is to help patients and doctors talk to each other in order to make decisions about treatment. It is based on recommendations from the American Society of Clinical Oncology’s updated Clinical Practice Guideline on adjuvant endocrine therapy. Use of this decision aid is voluntary.
Adjuvant Endocrine Therapy
After you have surgery, radiation, and/or chemotherapy, you should think about whether or not to take adjuvant endocrine therapy. Adjuvant endocrine therapy is medicine only for women with ER+ and/or PR+ breast cancer. There are two basic types of adjuvant endocrine therapy: tamoxifen and aromatase inhibitors. Tamoxifen has been proven to lower the chance of breast cancer returning and helps women with early-stage breast cancer live longer. Tamoxifen is a pill that is taken every day. Aromatase inhibitors lower the amount of estrogen in the body. There are three different aromatase inhibitor medicines: anastrozole, letrozole, exemestane; but they all work the same way. Aromatase inhibitors are also pills that are taken every day.

Options:
1. Tamoxifen
2. Aromatase inhibitors
3. Tamoxifen + aromatase inhibitors
**Benefits**

The first set of pictographs, below, show the chances of breast cancer coming back in the same breast in 5 years.

**Chances of breast cancer coming back (in the same breast your cancer was in)**

1. Out of 100 women taking tamoxifen for 5 years, 17.4 had breast cancer return.

2. Out of 100 women taking an aromatase inhibitor for 5 years, 16 had breast cancer return.

3. Out of 100 women who took tamoxifen and switched to an aromatase inhibitor, 16.7 had breast cancer return.

Therefore, the number of women who had breast cancer come back was quite similar with all three treatments. There were small differences favoring the use of an aromatase inhibitor as either first treatment, or after tamoxifen.
Bone fracture
After menopause, a woman can lose bone and her bones may be more likely to break. Aromatase inhibitors may slightly increase the chances of a bone break compared to tamoxifen.

In a woman who is postmenopausal, tamoxifen may help prevent osteoporosis [fragile bones].

### Chance of getting a bone fracture in 5 years

1. Out of 100 women taking tamoxifen for 5 years, about 7 women (7.3) had a bone fracture.

2. Out of 100 women taking an aromatase inhibitor for 5 years, about 10 women (9.8) had a bone fracture.

3. Out of 100 women who took tamoxifen and switched to an aromatase inhibitor, about 10 women (9.4) had a bone fracture.

Therefore, about 2 to 3 fewer women (2.1-2.5) taking tamoxifen had a bone fracture, compared to those taking an aromatase inhibitor.
The following pages are to help you think about what type of adjuvant therapy (for hormone receptor-positive (ER+ and/or PR+) breast cancer) to have after you have talked to your doctor. You may want to do this on your own or with someone you trust. Your treatment choices include:

- Taking tamoxifen
- Taking an aromatase inhibitor
- Taking tamoxifen and an aromatase inhibitor

### WEIGHING YOUR OPTIONS

<table>
<thead>
<tr>
<th>Benefits</th>
<th>How much does this matter?</th>
<th>How likely is this to happen to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowering the chances of breast cancer coming back</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Lowering the chances of getting breast cancer in the other breast</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>You can add another benefit here:</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks</th>
<th>How much does this matter?</th>
<th>How likely is this to happen to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood clots</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Bone fracture</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Endometrial cancer</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Hot flashes</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>You can add other concerns here and below:</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>
4. **Plan the next steps**
Consider planning your next steps based on your needs:

a. If you feel you do not have enough support and/or if you feel pressure from others—you may want to look for other support. Your doctor, hospital, or clinic may be able to refer you to others who could help you find additional support.

b. If you feel you do not have enough facts about adjuvant endocrine medicines, you may want to get more. For example, you could visit cancer.net (www.cancer.net).

Please use the space below or another page to write any questions or concerns you have:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Characteristics of studies that use VC/PE in decision aids

• VC/PE is placed after the information section

• Media
  – Paper – 49%
  – Computer – 38%
  – Verbal – 15%

• Methods
  – Pros vs cons – 46%
  – Utility assessments w/ & w/out CDA – 18%
  – Prioritization – 11%
  – Rating scales – 11%

• 57% did not provide explicit feedback to patients about the result of the VC/PE
## Theories or Frameworks Guiding VC/PE

<table>
<thead>
<tr>
<th>Theories or Frameworks</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ottawa Decision Support Framework</td>
<td>pros &amp; cons; leaning scales</td>
</tr>
<tr>
<td>Expected Utility Theory</td>
<td>utilities, expected value</td>
</tr>
<tr>
<td>Adaptive Conjoint Analysis</td>
<td></td>
</tr>
<tr>
<td>Information Processing Paradigm</td>
<td>(pros &amp; cons)</td>
</tr>
<tr>
<td>Precaution Adoption Process Model</td>
<td>(pros &amp; cons)</td>
</tr>
<tr>
<td>Differentiation and Consolidation Theory</td>
<td>(rating)</td>
</tr>
</tbody>
</table>

Witteeman et al., SMDM 2012; Fagerlin et al, BMC Med Inform Dec Making forthcoming.
A framework of VC/PE approaches
“Interactive” and “Noninteractive” VC/PE Approaches

• **Interactive VC/PE**
  
  – Designed to deliberately engage the patient in tasks that involve explicitly comparing, ranking, and/or rating the relevant options and their characteristics.
  
  – Tasks can be paper-based or increasingly electronic, and employ devices such as sliding scales and sortable cards.

Llewellyn-Thomas. Medical Care Research and Review 2012.
“Interactive” and “Noninteractive” VC/PE Approaches

• Noninteractive VC/PE
  – Do not incorporate explicit VC/PE. Rely on implicit assumption that, as patients learn about options and tradeoffs, they simultaneously weigh the desirability of the options’ characteristics.
  – As people learn about the options (or are exposed to new information) they are also “valuing” the options.

Llewellyn-Thomas. Medical Care Research and Review 2012.
Interactive VC/PE Approaches

**Indirect VC/PE (some Utility-Based)**
- Utility assessment
- Classic decision analysis
- Conjoint analysis*
- Analytic hierarchy process*

**Direct VC/PE (Non-Utility-Based)**
- Balance technique
- Explicit social matching
- Bidirectional leaning scale
- Card sort
- Affective forecasting prompts
- Threshold techniques
- Rating scale
- Dynamic tailoring*

Adapted from Llewellyn-Thomas. Medical Care Research and Review 2012.
Indirect interactive VC/PE
Interactive approaches that work indirectly

Inputs

Patient completes a set of evaluative tasks

Computational strategy is used to evaluate patient’s responses

Outputs

Result is a patient’s favored option

Rational choice approaches
Interactive approaches:
Utility Assessment / Clinical Decision Analysis

• **Utility assessment alone**
  – Patient completes utility assessments using visual analog scales, TTO, or other approach. Utilities not used in a model.

• **Clinical decision analysis**
  – Patient completes utility assessment (using same approaches) and utilities are used to determine optimal strategy based on maximizing expected value from model.
Interactive approaches: Utility Assessment

**Visual analog scales**

Task:
- Health states are placed on the scale, relative to perfect health and death.
- Health states can be ranked as well.
- Utility is VAS value re-expressed on 0-1.0 scale.
Interactive approaches: Utility Assessment / Clinical Decision Analysis

Visual analog scales

Task:
- Health states are placed on the scale, relative to perfect health and death.
- Health states can be ranked as well.
- Utility is VAS value re-expressed on 0-1.0 scale.
Interactive approaches: Utility Assessment

Time trade-off

Option A

A fixed period of time (e.g., 10 years) in a diminished health state.

Option B

A shorter period of time in perfect health.

Which would you choose, A or B?

• Choice is re-offered, varying amount of time in perfect health until subject is indifferent between A and B.

• Tradeoff is re-expressed as a utility, with a value ranging from 0 (death) to 1.0 (perfect health).
Interactive approaches: Clinical Decision Analysis

Screening for prostate cancer model

60 y/o male, 1 time screen

Screen

- D+
  - T+ -> biopsy
    - Biopsy/Treatment Branch
  - D-
    - T- -> biopsy
      - Biopsy/No treatment branch
    - T- -> biopsy
      - Normal life expectancy branch

- D-
  - T- -> biopsy
    - Normal life expectancy branch
  - T+ -> biopsy
    - Disease progression/Treatment Branch

No Screen

- D+
  - T+ -> biopsy
    - Disease progression/Treatment Branch
  - D-
    - T- -> biopsy
      - Normal life expectancy branch
    - T- -> biopsy
      - Normal life expectancy branch
Interactive approaches: Clinical Decision Analysis

Classic example
Decisions about Hep B vaccination in physicians

Guiding Individual Decisions: A Randomized, Controlled Trial of Decision Analysis

CAROLYN M. CLANCY, M.D.
RANDALL D. CEBUL, M.D.
SANKEY V. WILLIAMS, M.D.
Philadelphia, Pennsylvania

In early 1983, all 1,280 faculty and resident physicians at one hospital who were eligible to be vaccinated against hepatitis B were divided randomly into three groups: Group 1 physicians received general information about the risks and benefits of alternative vaccine decisions; Group 2 physicians were additionally invited to provide personal

<table>
<thead>
<tr>
<th>Actual Decisions</th>
<th>Group 1 Information</th>
<th>No Decision Analysis</th>
<th>Advised to Be Screened or Vaccinated</th>
<th>Advised Not to Be Screened or Vaccinated</th>
<th>Group 3 Control</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened or vaccinated</td>
<td>36 (24)†</td>
<td>141 (31)</td>
<td>24 (62)</td>
<td>4 (24)</td>
<td>33 (22)</td>
<td>258 (29)</td>
</tr>
<tr>
<td>Not screened or vaccinated</td>
<td>117 (76)</td>
<td>317 (69)</td>
<td>15 (38)</td>
<td>13 (76)</td>
<td>120 (78)</td>
<td>582 (71)</td>
</tr>
<tr>
<td>Totals</td>
<td>153 (100)</td>
<td>458 (100)</td>
<td>39 (100)</td>
<td>17 (100)</td>
<td>153 (100)</td>
<td>820 (100)</td>
</tr>
</tbody>
</table>

* Includes Subgroup 2A.
† Numbers in parentheses are percentages of column totals.

Utility Assessment and CDA

• Advantages
  – Consistent with axioms of expected utility theory.
  – Helpful for policy and clinical perspectives when aggregate or group preferences are of interest.

• Disadvantages
  – Difficult to do in real time “at the bedside” (need a model).
  – Cognitively complex.
  – Patient does not learn about options.
  – Can miss outcomes important to patient.
Direct (non-utility based) interactive VC/PE
Rating Scales

- **Advantages**
  - Intuitively appealing to patients.
  - Easy to complete.
  - Direct connection to preferred choice.

- **Disadvantages**
  - Only appropriate for decisions with 2 options: best when options are “do it/don’t do it” dichotomy.
  - May be difficult to capture other concerns not reflected in rating list.
Interactive VC/PE: Threshold Approaches / Probability Tradeoff

2 options: A – no treatment; B – treatment

• “Achievable Risk Reduction” (ARR)
  – Represents the absolute reduction (or increase) in an outcome that can be expected from Option B.

• Determine “Required Risk Reduction” (reqRR)
  – From patient’s perspective, difference in the probabilities of an outcome if Option B is selected over Option A.

Interactive VC/PE: Threshold Approaches / Probability Tradeoff

If reqRR is > ARR, choose Option A

If reqRR is < ARR, choose Option B

Or can use ratios: reqRR / ARR

> 1.0, go with Option A
< 1.0, go with Option B

**Hypercholesterolemia probability trade-off**

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inconveniences and Costs</strong></td>
<td><strong>Inconveniences and Costs</strong></td>
</tr>
<tr>
<td>Not eating foods high in saturated fat and/or cholesterol</td>
<td>A medication without cost to you: 1 to 2 capsules taken 1 to 2 times/day now and for the rest of your natural life</td>
</tr>
<tr>
<td>No medication</td>
<td>See your doctor and have your blood checked about 3 times a year for the 1st year, and at least once a year thereafter</td>
</tr>
<tr>
<td>See your doctor and have your blood checked about 3 times a year for the 1st year, and at least once a year thereafter</td>
<td>See your doctor and have your blood checked about 3 times a year for the 1st year, and at least once a year thereafter</td>
</tr>
</tbody>
</table>

**Possible Risks/Side Effects**

<table>
<thead>
<tr>
<th>None</th>
<th>Possible Risks/Side Effects (many of which will lessen with time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>More frequent (experienced by about 60 out of 1000 people)</td>
</tr>
<tr>
<td></td>
<td>Constipation, muscle aches, or cramps</td>
</tr>
<tr>
<td></td>
<td>Less frequent (experienced by 10 to 30 out of 1000 people)</td>
</tr>
<tr>
<td></td>
<td>Diarrhea, heartburn, nausea, headache, dizziness, skin rash, unusual tiredness, or weakness</td>
</tr>
</tbody>
</table>

**Chance of Heart Attack**

| $[x = \text{individualized coronary heart disease risk}]$ out of 1000 people will have a heart attack (which may or may not be fatal) sometime over the next 10 years | $[x = \text{individualized coronary heart disease risk}]$ out of 1000 people will have a heart attack (which may or may not be fatal) sometime over the next 10 years |

[Initially dominated presentation of choice situation. Respondent initially chooses option A. Then, chance of heart attack in option B is systematically reduced until respondent eventually accepts option B.]

*Figure 1. Example of information presented at the beginning of the hypercholesterolemia probability trade-off task.*
Hormone therapy for intermediate risk prostate cancer

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBRT without a short course of ADT</td>
<td>EBRT with a short course of ADT</td>
</tr>
<tr>
<td>EBRT description</td>
<td>EBRT description</td>
</tr>
<tr>
<td>duration, number of visits</td>
<td>duration, number of visits</td>
</tr>
<tr>
<td>ADT description</td>
<td>ADT description</td>
</tr>
<tr>
<td>administration and duration</td>
<td>administration and duration</td>
</tr>
<tr>
<td>Side Effects of ADT</td>
<td>Side Effects of ADT</td>
</tr>
<tr>
<td>Hot flashes for [duration] where you feel [severity]</td>
<td>Hot flashes for [duration] where you feel [severity]</td>
</tr>
<tr>
<td>Fatigue for [duration] where you feel [severity]</td>
<td>Fatigue for [duration] where you feel [severity]</td>
</tr>
<tr>
<td>Loss of libido for [duration]</td>
<td>Loss of libido for [duration]</td>
</tr>
<tr>
<td>Weight gain, where you can expect to gain an average of [number of pounds]</td>
<td>Weight gain, where you can expect to gain an average of [number of pounds]</td>
</tr>
</tbody>
</table>

**Chance of Surviving**
At 10 years after treatment, about [from disease specific survival estimate] patients will be alive of out 100, and [from disease specific mortality estimate] patients will have did from prostate cancer.
Interactive VC/PE:
Threshold Approaches / Probability Tradeoff

• **Option A**
  – Risk of death in 10 years is 10 of 100 (10%)

• **Option B**
  – Risk of death in 10 years is x of 100 (where x is reduced from 10%)

Assume ARR is 3%, so reqRR must exceed 3% to choose ADT.

Hoffman, Cantor, Volk, 2013.
Interactive VC/PE:
Threshold Approaches / Probability Tradeoff

Advantages
• Gives direct estimate of magnitude of risk/benefit acceptable to patients.

Disadvantages
• Limited to decisions with 2 options.
• Must know achievable RR or have a reasonable estimate.
• Cognitively complex.
Interactive approaches: The Balance Technique

• 2 options

• Characteristics of options arranged side by side (clinician & pt derived)

• Patient rates importance of each characteristic
  
  0 = not at all; 10 = extremely important

• Importance ratings displayed on “weigh scale” and compared to “leaning scale” responses.

Interactive approaches: The Balance Technique


Hormone therapy after menopause (published in 1998!)
The Balance Technique

• Advantages
  – Predictive of actual choices.
  – Intuitively appealing to patients.
  – Portable – easy for clinician and patient to jointly.
  – Can identify sources of decisional conflict.

• Disadvantages
  – Limited to decisions with 2 options.
  – May miss relevant attributes of options.
Interactive approaches: Bidirectional Leaning Scales

Which way are you leaning about being tested?

- Want to be tested
- Not sure
- Do not want to be tested

Adapted from O’Connor et al, 1998.
Interactive VC/PE: Leaning Scale

Healthwise® Leaning Scale

Decision Point
You may want to have a say in this decision, or you may simply want to follow your doctor’s recommendation. Either way, this information will help you understand what your choices are so that you can talk to your doctor about them.

Alzheimer's Disease: Should I Take Medicines?

Where are you leaning now?
Now that you’ve thought about the facts and your feelings, you may have a general idea of where you stand on this decision. Show which way you are leaning right now.

Taking medicines

Not taking medicines

Leaning toward

Undecided

Leaning toward

https://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=ty7566#
Bidirectional Leaning Scales

• Advantages
  – Intuitively appealing to patients.
  – Gives a global “preference” for options. Arrives at an “end result.”
  – Can flag unsure patients needing additional decision support.

• Disadvantages
  – Limited to decisions with 2 options.
  – Does not reveal which values are driving the preference.
Interactive approaches: Card Sort

- Set of cards, each describing how options relate to an attribute.
- Patients selects most important attribute “card” first and eliminates ones not to discuss.
- After discussion with clinician, a “ruled-in” option is selected.

Adapted from Llewellyn-Thomas & Crump, 2011.
Interactive approaches: Card Sort

Figure 1. The Diabetes Medication Choice decision aid cards (reproduced with permission from the Mayo Foundation for Education and Research)

© 2011 Mayo Foundation; Mullen et al., 2009; Adapted from Llewellyn-Thomas & Crump, 2011.
Card Sort

- **Advantages**
  - Good evidence about improving decisions (knowledge, involvement, adherence).
  - Can be used with more than 2 options.
  - Portable – easy to use during clinical encounter.
  - End result is intuitive for patient.

- **Disadvantages**
  - Requires direct deliberation with clinician.
  - Important facts about options (eg, administration) can be ruled out by patient.
Interactive approaches: Explicit Social Matching

Main character “he’s unsure”

Another view

Another view

Which of these 3 people is most like you?
“If you decided to not be tested and later were found to have prostate cancer, would you regret your decision?”

Not sure

Would regret decision

Would have not regrets

Which of these 3 people is most like you?
Explicit Social Matching

• Advantages
  – Intuitively appealing to patients.
  – May reflect one factor influencing how decisions are made in “real life.”

• Disadvantages
  – Little/no evidence-base about effectiveness.
  – May be highly biasing.
Interactive approaches: Affective Forecasting Prompts

AHRQ Patient Decision Aids

Thinking About Your Priorities
What is important to you in deciding to treat your cancer now or watch it closely?

Here are some issues men might consider in making a decision. There also may be other issues important to you that are not listed here. For each question, check the response that best describes how you feel.

1. How willing would you be to have frequent testing to monitor your cancer (for example, blood tests and biopsies)? It would be:
   - Not a problem for me.
   - A minor problem for me.
   - A big problem for me.

2. If you decided to have your cancer monitored closely instead of treating it right away, how would you feel about your decision?
   - I would feel very anxious.
   - I would feel anxious, but I could handle it.
   - I would not feel too anxious.

3. If you did not treat your cancer right away and it spread, how would you feel about your decision?
   - I would have no regrets about my decision.
   - I would have some regrets but would be okay with my decision.
   - I would greatly regret my decision.

4. If you were to lose your ability to have an erection, what would the loss of that ability mean to you? It would be:
   - So bad I might never adjust to it.
   - Bad, but I would adjust to it.
   - A small adjustment for me.

5. If you were not able to control your bladder and needed to wear an absorbent pad during your daily activities, what would that loss of control mean to you? It would be:
   - So bad I might never adjust to it.
   - Bad, but I would adjust to it.
   - A small adjustment for me.
### Affective Forecasting Prompts

<table>
<thead>
<tr>
<th><strong>Advantages</strong></th>
<th><strong>Disadvantages</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>– Intuitively appealing to patients.</td>
<td>– Need to make relationship to preference clear to patient.</td>
</tr>
<tr>
<td>– Consistent with utility-based approaches (validity).</td>
<td>– Little evidence about effectiveness.</td>
</tr>
<tr>
<td>– Portable – easy of use during clinical encounter.</td>
<td>– May miss other important concerns</td>
</tr>
</tbody>
</table>
Newer approaches: Dynamic Tailoring

A Patchwork of Life

Uses analogy of a jewelry box to keep track on important concerns

https://www.bcm.edu/centers/cancer-center/patchwork-of-life/cdss.htm
Concluding Comments

• Evidence of benefits of explicit VC/PE is encouraging.
• Strategies may be part of decision aid or used during a SDM process.
• Developers’ desire for prescriptive VC/PE may be in conflict with how patients make real decisions.
• Head-to-head comparisons of different VC/PE strategies are needed.