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1 **Title:** Patient Decision Aids for Aortic Stenosis and Chronic Coronary Artery Disease: A  
2 Systematic Review and Meta-Analysis

3 Short title: Cardiac Patient Decision Aids Systematic Review

4

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24

1 **ABSTRACT**

2 **Aim:** Shared decision-making is recommended for patients considering treatment  
3 options for severe aortic stenosis (AS) and chronic coronary artery disease (CAD). This  
4 review aims to systematically identify and assess patient decision aids (PtDAs) for  
5 chronic CAD and AS and evaluate the international evidence on their effectiveness for  
6 improving the quality of decision-making.

7 **Methods and Results:** Five databases (Cochrane, CINAHL, Embase, MEDLINE,  
8 PsycInfo), clinical trial registers and 30 PtDA repositories/websites were searched from  
9 2006 to March 2023. Screening, data extraction and quality assessments were  
10 completed independently by multiple reviewers. Meta-analyses were conducted using  
11 Stata statistical software. Eleven AS and 10 CAD PtDAs were identified; seven were  
12 less than five years old. Over half the PtDAs were web-based and the remainder paper-  
13 based. One AS and two CAD PtDAs fully/partially achieved international PtDA quality  
14 criteria. Ten studies were included in the review; four reported on the  
15 development/evaluation of AS PtDAs and six on CAD PtDAs. Most studies were  
16 conducted in the USA with White, well-educated, English-speaking participants. No  
17 studies fulfilled all quality criteria for reporting PtDA development and evaluation. Meta-  
18 analyses found that PtDAs significantly increased patient knowledge compared to 'usual  
19 care' (mean difference:0.620; 95%CI 0.396, 0.845,  $p<0.001$ ) but did not change  
20 decisional conflict.

21 **Conclusion:** Patients who use PtDAs when considering treatments for AS or chronic  
22 CAD are likely to be better informed than those who do not. Existing PtDAs may not  
23 meet the needs of people with low health literacy levels as they are rarely involved in  
24 their development.

25 **Registration:** PROSPERO: CRD42021264700

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## 1. INTRODUCTION

Over the last 60 years, technological innovations have revolutionised the field of interventional cardiology. Two of the commonest interventions are Percutaneous coronary intervention (PCI) and transcatheter aortic valve implantation/replacement (TAVI). Over 965,000 PCIs are performed annually in the US alone<sup>1</sup>. Global projections of the annual number of TAVI procedures are estimated to rise to 300,000 implants by 2025<sup>2</sup>. Both interventions have the potential to relieve symptoms that negatively impact quality of life<sup>3,4</sup>

Patients with chronic coronary artery disease (CAD) may experience symptoms of angina. First line treatment is medication, but if this is not effective, PCI is a treatment option to consider<sup>5</sup>. Patients with severe aortic stenosis (AS) also live with unpleasant symptoms associated with heart failure. Clinical guidelines indicate that a multi-disciplinary heart team should evaluate the degree of AS along with clinical and anatomical characteristics to inform their recommendations to patients about treatment options, such as TAVI or Surgical Aortic Valve Replacement (SAVR)<sup>6</sup>.

Whilst PCI and TAVI are different interventions, the decision-making processes share common features; the decision to go ahead with the treatment is considered to be 'preference sensitive'. i.e. two or more treatment options exist but the 'best' treatment depends on how acceptable the patient views the potential risks and benefits of each<sup>7</sup>. In these situations, a process of shared decision-making (SDM) helps patients make an informed choice<sup>8</sup>. Accordingly, The American College of Cardiology and European Society for Cardiology recommend that SDM should take place before a patient agrees to an interventional procedure for chronic CAD or AS<sup>5,6,9,10</sup>.

SDM involves a two-way discussion in which patients are informed by their doctors and nurses about what a treatment involves, the benefits and risks, alternative options and what the outcome might be if they decided against having treatment. Importantly, SDM means that patients are encouraged to consider their unique preferences, goals, and values (i.e., what matters most to an individual about attributes of a health decision)<sup>11,12</sup>. In today's clinical practice SDM may be difficult to achieve. Patients' preferences and goals for treatment are not routinely discussed<sup>13</sup>. Moreover, patients treated with PCI

1 often misunderstand the treatment benefits and risks and perceive their treatment as a  
2 'fix'<sup>14,15</sup>. Patients considering TAVI experience uncertainty about their treatment  
3 decision<sup>16</sup>, and want to understand the risks and benefits of all potential treatment  
4 options and outcomes (e.g., TAVI, SAVR or no intervention)<sup>17</sup>.

5 Patient Decision Aids (PtDAs) are effective interventions known to improve the quality of  
6 both the decision-making process and the choice made<sup>18</sup>. Evidence shows that PtDAs  
7 increase patients' knowledge about treatments and support more accurate perceptions  
8 of associated benefits and risks<sup>18</sup>. However, PtDAs are not routinely used in clinical  
9 practice despite the potential benefits<sup>19</sup>. Some cardiologists' do not perceive PtDAs to  
10 be of benefit to their patients<sup>20</sup>. Unfamiliarity and a lack of awareness of PtDAs and  
11 disagreement with the content are also factors that compromise implementation<sup>21</sup>.

12 A recent meta-analysis reported that cardiology PtDAs improved two key decision  
13 outcomes; decisional conflict and patient knowledge<sup>22</sup>. These findings support the use  
14 of PtDAs. However, the review did not report the availability, content, and quality of the  
15 PtDAs, include PtDAs for AS, or summarise evidence on other decision-making  
16 constructs, leaving gaps in the evidence base. Accordingly, the aims of this review were  
17 to 1) identify PtDAs for chronic CAD and AS that include PCI and TAVI as treatment  
18 options, and evaluate their availability, characteristics, and quality, 2) identify and  
19 describe the quality of studies reporting on the development and evaluation of identified  
20 PtDAs, and 3) evaluate their effectiveness on improving the quality of the decision -  
21 making process and the choice made. Findings will provide cardiology teams with an  
22 international overview of available PtDAs designed to improve the quality of SDM for  
23 chronic CAD and AS.

## 25 **2. METHODS**

### 26 **2.1. Review approach**

27 Our review methods were informed by previous reviews<sup>23,24</sup> and Cochrane guidance<sup>25</sup>.  
28 To support the robustness of this review the protocol was developed and registered on  
29 PROSPERO (CRD42021264700) a-priori and Preferred Reporting Items for Systematic

1 Reviews and Meta-Analyses (PRISMA) guidelines<sup>26</sup> implemented (Table S1 in  
2 supplementary file).

### 3 **2.2. Search strategy**

4 A search of multiple databases, trial registries, PtDA repositories and websites was  
5 conducted, to identify eligible PtDAs and published articles that described their  
6 development or evaluation. A search strategy was developed by an Information  
7 Technologist (HC), piloted on MEDLINE (Ovid), refined, and applied to five databases in  
8 all languages: CENTRAL via the Cochrane Library, CINAHL (EBSCO), Embase, Ovid  
9 MEDLINE and APA PsycInfo (ProQuest). Four trial registers were searched: EU clinical  
10 trials register; ClinicalTrials.gov; ISRCTN Registry; ICTRP (WHO). Searches were  
11 limited to articles published since 01/01/2006, because the consensus on criteria for  
12 judging the quality of PtDAs was published in 2006 by the International Patient Decision  
13 Aid Standards (IPDAS) Collaboration<sup>27</sup>. Thirty PtDA repositories/websites were also  
14 hand searched. Searches were conducted in July 2021 and updated in March 2023.  
15 See Tables S2-S7 for search terms and the list of PtDA repositories/websites.

### 16 **2.3. Patient Decision Aid eligibility and selection**

17 PtDAs were defined as tools designed to help facilitate SDM between patients and  
18 health professionals<sup>18</sup>. PtDAs were eligible for inclusion if they fulfilled the following  
19 criteria:

- 20 • Identified as a PtDA, decision tool or an aid to support SDM in their name/title, or  
21 by the developers/authors, or listed within a PtDA repository.
- 22 • Designed for patients (18+ years) with chronic CAD or aortic stenosis.
- 23 • Included at least two treatment options, one of which must either be PCI or TAVI.

24 All identified PtDAs were independently screened for inclusion by two reviewers (EH,  
25 AB). The authors, or organisations listing PtDAs not publicly available were contacted to  
26 request a copy. Eligible PtDAs that met the criteria, but were not available in full, were  
27 included in the overview (Table 2) but not in the evaluation of PtDA characteristics  
28 (Table 2).

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#### **2.4. Article eligibility and selection**

Search results were independently screened for inclusion by at least two reviewers (EH & AB/FA) in three phases; title, abstract, and full-text screening. Where disagreement occurred, consensus was achieved through discussion. Articles and study reports of any design were included providing they reported on the development, user-testing, acceptability, or evaluation of eligible PtDAs. Articles reporting on ineligible PtDAs, literature reviews, and editorials were excluded.

#### **2.5. Data extraction**

Data from each included study were independently extracted by two reviewers (EH, DC, AYC, JS, AB) into a data-sheet. Characteristics from included PtDAs were extracted by one reviewer and independently checked for accuracy by a second author. Any discrepancies in data extraction were resolved by consensus. Data were synthesised into tables and presented in a narrative.

#### **2.6. Statistical analysis**

Studies evaluating the effectiveness of PtDAs were assessed for suitability and those with the same primary endpoint pooled for a meta-analysis. Due to heterogeneity of outcome measures, only two meta-analyses were conducted on the primary interval-level outcomes of patients' Knowledge score and Decisional Conflict score. The meta-analyses were formulated as random effects using the DerSimonian and Laird model<sup>28</sup> to reflect clinical and methodological heterogeneity. For both outcomes, standardised mean differences, based on post-test statistics in intervention and control groups (intervention minus control), and associated 95% confidence intervals (CIs), were measured. For the Knowledge score outcome, clinical improvement was represented by increases in reported scores. For the Decisional Conflict score outcome, clinical improvement was represented by decreases in reported scores. Forest plots were conducted for meta-analyses of both primary outcomes, reporting synthesised estimates, and associated 95% CIs, and a Z-test for the standardised mean difference. Heterogeneity statistics were also reported, including Cochran's Q test for heterogeneity, and the  $I^2$  statistic.

1 Leave-one-out sensitivity analyses were conducted on the meta-analyses of both  
2 primary outcomes to assess the robustness of the derived estimates. Each of the  $k$   
3 included studies were omitted in turn, and a meta-analysis was conducted based on the  
4 remaining  $(k - 1)$  studies. Any study which was suspected of excessive influence was  
5 flagged as an influential study. Funnel plots were proposed for analyses of small-study  
6 effects for meta analyses in which the number of identified studies reached the  
7 recommended minimum<sup>25</sup> but were not conducted. No sub-group analyses were  
8 identified. All analysis was conducted using Stata statistical software (Version 17 I/C)<sup>29</sup>.

### 9 **2.7. Quality assessment**

10 To support the rigour of this review, three approaches were implemented to evaluate  
11 the quality of included studies and associated PtDAs. First, the quality of PtDAs was  
12 evaluated using the six qualifying and six certification criteria of the IPDAS version four  
13 checklist<sup>30</sup>, which are the minimum standards for tools to be defined as a PtDA and  
14 deemed as adequate for patient use. As these criteria are designed for the evaluation of  
15 'full' PtDAs, we excluded brief one-two page consultation/conversation aids from this  
16 assessment. Second, studies reporting an evaluation of PtDAs were assessed using the  
17 "Standards for UNiversal reporting of patient Decision Aid Evaluations" (SUNDAE)  
18 checklist<sup>31</sup>. A modified version of this checklist was used for PtDA development studies.  
19 The IPDAS and SUNDAE checklists were independently completed by two reviewers  
20 and disagreements resolved through discussions with a third reviewer (EH & AB/FA).  
21 To increase consistency of the assessments, three response options were developed:  
22 yes, partially, and no (Tables S8-S9 supplementary file). Third, the studies included in  
23 the meta-analyses were independently assessed by two reviewers (EH & FA/JS) for risk  
24 of bias using either the Cochrane Risk of Bias 2 tool (RoB2<sup>32</sup>) or the NHLBI Quality  
25 Assessment of Controlled Intervention Studies<sup>33</sup>.

## 26 **3. RESULTS**

27 Figure 1 shows the search results for AS and PCI PtDAs combined. In summary, 10  
28 studies were eligible and included in the review, which, in total, reported on the  
29 development or evaluation of 11 PtDAs. A further 10 PtDAs were identified from a trial  
30 registry record and from online PtDA repositories and relevant websites. Therefore, a



1 total of 21 PtDAs (11 AS and 10 CAD PtDAs) were included in this review. Results for  
2 the two groups of PtDAs are presented separately by condition (AS and CAD).

### 3 **3.1. Patient Decision Aids for Aortic Stenosis**

#### 4 **3.1.1. Availability of Patient Decision Aids for Aortic Stenosis**

5 The search identified 11 PtDAs designed for patients with AS considering TAVI (see  
6 Table 1 for an overview). Comparative treatment options included SAVR (n=9) or  
7 symptom management (n=2). Five PtDAs included the same content but were adapted  
8 for use by different age groups (MAGIC TAVI vs. SAVR PtDAs<sup>34-38</sup>). PtDAs were  
9 developed either in the USA (n=5)<sup>39-43</sup>, Canada (n=1)<sup>44,45</sup> or by an international panel of  
10 experts (n=5)<sup>34-38</sup>. All were written in English and seven were available in other  
11 languages (two in Spanish and French<sup>41,42</sup>; five in Norwegian with translation of some  
12 sections available in 12 other languages<sup>34-38</sup>). Over half (n=8) were web-based PtDAs<sup>34-  
13 40,44</sup> and the other three were paper based<sup>41-43</sup>. Five web-based PtDAs could be  
14 converted into a printable format<sup>34-38</sup>. Three PtDAs were less than five years old<sup>40,42,44</sup>  
15 but only one was publicly available<sup>42</sup>, which also fully or partially achieved all 12 IPDAS  
16 quality criteria (see section 3.2.3).

#### 17 **3.1.2. Characteristics of Patient Decision Aids for Aortic Stenosis**

18 The characteristics of eight PtDAs for AS were evaluated (Table 2)<sup>34-38,41-43</sup>. The  
19 remaining three were unavailable for evaluation due to website deactivation<sup>39</sup> or  
20 ongoing development<sup>40,44</sup>.

21 Two types of PtDAs were identified; a PtDA booklet (eight pages) to be reviewed by the  
22 patient at home<sup>41,42</sup>, or an 'encounter PtDA' (paper or web-based) to be used during the  
23 consultation with a health professional<sup>34-38,43</sup>. The type and presentation of information  
24 varied between PtDAs. One 'encounter PtDA' presented information about the risks and  
25 benefits of treatment options on a single page<sup>43</sup>, whereas the other 'encounter PtDAs'  
26 were web-based and required health professionals to navigate between different  
27 sections to present the information<sup>34-38</sup>. All PtDAs included icon arrays to present the  
28 risks and benefits of treatment options. Patient stories were only included in the two  
29 booklet PtDAs<sup>41,42</sup>. Three PtDAs incorporated an explicit values clarification method<sup>41-43</sup>  
30 (i.e. determining what matters to patients about a given health decision by using an

1 approach that requires interaction<sup>12</sup>). The method in the two booklet PtDAs invited  
2 patients to write their hopes and concerns for the treatment options and any questions  
3 for their doctor and family<sup>41,42</sup>. The one-page 'encounter PtDA' invited patients to  
4 verbally respond to the question during a consultation, about what was important to  
5 them about their treatment<sup>43</sup>. This was the only PtDA to invite patients to indicate their  
6 preferred treatment. The readability score was not reported for any PtDA. Two PtDAs  
7 did not report their development method<sup>41,42</sup>.

### 8 **3.1.3. Quality of Patient Decision Aids for Aortic Stenosis**

9 Seven PtDAs<sup>34-38,41,42</sup> were included for quality appraisal using the recommended  
10 IPDAS checklist ('encounter PtDAs' were excluded<sup>43</sup>). Results are summarised in Table  
11 2 (full evaluation in Table S10, supplementary file). To 'qualify' as a PtDA, six IPDAS  
12 criteria need to be achieved; only the two booklet PtDAs fulfilled these<sup>41,42</sup>. In total, the  
13 PtDAs fulfilled between 67% and 92% (median 67%) of all 12 IPDAS criteria. Two  
14 IPDAS criteria were not achieved by all PtDAs: 'Describes the condition related to the  
15 decision' and 'The level of uncertainty around outcome probabilities' (i.e., the likelihood  
16 of an adverse or positive outcome occurring following treatment).

### 17 **3.2. Patient Decision Aids for Chronic Coronary Artery Disease**

#### 18 **3.2.1. Availability of Patient Decision Aids for Coronary Artery Disease**

19 Ten PtDAs designed for patients with chronic CAD considering PCI were identified  
20 (Table 1). The comparative treatment options presented were medical therapy (n=10),  
21 lifestyle changes (n=4) and coronary artery bypass graft (CABG) surgery (n=4). The two  
22 'PCI Choice' PtDAs<sup>46,47</sup> included the same content but adapted the risks/benefits  
23 probabilities for either Class I/II or Class III stable angina. Eight PtDAs were developed  
24 in the USA<sup>46-53</sup>, two in the UK<sup>54,55</sup>, and all were only available in English. Six were web-  
25 based PtDAs<sup>48-52,54</sup> and four were paper based<sup>46,47,53,55</sup> (one also included a 20-min  
26 DVD<sup>53</sup>). One web-based PtDA had a paper-based version<sup>51</sup> and two others could be  
27 converted into a printable format<sup>50,52</sup>. Four PtDAs were less than five years old<sup>48,50,52,54</sup>  
28 but only one was publicly available<sup>48</sup>. This PtDA<sup>48</sup> fulfilled only five of the 12 IPDAS  
29 criteria.

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### 3.2.2. Characteristics of Patient Decision Aids for Coronary Artery Disease

The characteristics of seven PtDAs for chronic CAD were evaluated (Table 2)<sup>46-48,51,52,54,55</sup>. The remaining three were unavailable for evaluation<sup>49,50,53</sup>.

The type of PtDA, approach, and timepoint of use in the patient journey, varied. Two were short paper-based 'encounter PtDAs' (PCI Choice<sup>46,47</sup>) to be used by the doctor with the patient in a consultation prior to diagnostic cardiac catheterisation. Three web-based PtDAs<sup>52,54</sup> (one had a paper version option<sup>51</sup>) could be reviewed by patients either at home or whilst in hospital before the procedure. One paper-based PtDA could be used either pre-consultation or during the consultation<sup>55</sup>. Details about the delivery of one web-based PtDA was absent<sup>48</sup>. The design of PtDAs varied from a basic table comparing treatments, to the use of multi-media to explain health conditions, treatment options and procedures. Treatment risks and benefits were presented using a wide range of approaches. All but two<sup>48,55</sup> included icon arrays to convey the likelihood of risks and benefits. One PtDA<sup>48</sup> omitted the major risks associated with PCI. Patient stories/scenarios were included in two PtDAs<sup>52,54</sup>. Two PtDAs included explicit values clarification methods; a rating scale<sup>52</sup> and completion of questions about what matters to them and concerns<sup>54</sup>. Five PtDAs invited patients to indicate their preferred treatment<sup>46,47,51,52,54</sup>. A personalised summary of patients' responses could be generated in two web-based PtDAs<sup>52,54</sup>. The readability level was not stated within any PtDA, although associated publications for two PtDAs reported the target reading age as 8<sup>th</sup> Grade (age 13-14 years)<sup>56,57</sup>. Development information was published, in varying detail, for some PtDAs<sup>46,47,51,54</sup>, two omitted this information<sup>48,55</sup>, whilst brief details about the development of clinical content was described for the remainder on the developers' websites<sup>52</sup>.

### 3.2.3. Quality of Patient Decision Aids for Coronary Artery Disease

Five PtDAs<sup>48,51,52,54,55</sup> were included for quality appraisal (two 'encounter PtDAs' were excluded<sup>46,47</sup>; Table 2). Three PtDAs<sup>51,52</sup> completely fulfilled the six IPDAS 'qualify' criteria (Table S10). In total, the five PtDAs fulfilled between 42% and 100% (median 75%) of all 12 IPDAS criteria. Two PtDAs<sup>52,54</sup> fully or partially achieved all 12 IPDAS

1 criteria, but are not currently publicly available to patients. The IPDAS criteria least  
2 fulfilled across the PtDAs were 'Providing information about the funding source', 'The  
3 update policy', and 'The level of uncertainty around outcome probabilities'.

### 4 **3.3. Overview of included studies**

5 Table 3 provides an overview of the 10 studies included in the review (full details in  
6 Table S11, supplementary file). One study was conducted in the UK<sup>56</sup>; the remainder in  
7 the USA. Three reported on PtDA development and acceptability testing<sup>56,58,59</sup>, and  
8 seven evaluated PtDA effectiveness in either an RCT<sup>60,61</sup>, or a quasi-experimental  
9 design<sup>20,57,62-64</sup>

#### 10 **3.3.1. Studies reporting the development/acceptability of Patient Decision 11 Aids**

12 One study<sup>58</sup> described the development of a PtDA for AS (TAVI vs. SAVR<sup>39</sup>) that is no  
13 longer available, and two studies<sup>56,59</sup> described the development and acceptability of  
14 PtDAs for chronic CAD (PCI vs. medicines only; PCI Choice<sup>46,47</sup> and CONNECT<sup>54</sup>). The  
15 systematic method of PtDA development recommended by IPDAS was implemented in  
16 the two CAD PtDA studies<sup>56,59</sup>, but only the CONNECT development study<sup>56</sup> cited a  
17 theory underpinning the methodology (i.e., Ottawa Decision Support Framework<sup>65</sup>).  
18 Patients and/or healthcare professionals were involved in either providing feedback or  
19 user testing PtDAs across all development studies<sup>56,58,59</sup>. Methods included semi-  
20 structured interviews<sup>58</sup>, cognitive interviews<sup>56</sup>, video and teleconference calls<sup>56,58</sup>, focus  
21 groups<sup>56,59</sup>, and observations<sup>59</sup>. Participant demographics were only reported in the  
22 CONNECT PtDA study, and was the only study that assessed health literacy levels (HL)  
23 with 71% of participants scoring 'adequate' on the Brief Health Literacy Screen<sup>56</sup>.

#### 24 **3.3.2. Studies evaluating the effectiveness of Patient Decision Aids**

25 Three AS PtDAs<sup>41-43</sup> and seven PtDAs for chronic CAD<sup>46,47,49,51-53</sup> were evaluated  
26 across seven studies<sup>20,57,60-64</sup>. Sample size ranged from 12-203 participants. Most  
27 participants were White and had an advanced level of education (i.e., completed  
28 College). A variety of decision-making process and decisional quality outcomes were  
29 assessed, including, patient satisfaction, treatment preference, patient-centred  
30 communication, involvement in SDM, decisional conflict and knowledge level. Two<sup>20</sup> out

1 of four studies that measured the SDM process (via the OPTION Scale<sup>66</sup> or Control  
2 Preferences Scale<sup>67</sup>) showed a significant improvement after using a PtDA for AS (TAVI  
3 or symptom management/palliative care) and CAD (PCI, medical therapy, or CABG<sup>51</sup>).  
4 High scores for patient satisfaction, patient-centred communication (measured using  
5 CollaboRATE<sup>68</sup>) and the Preparation for Decision-making Scale<sup>69</sup> were reported after  
6 PtDA use for both AS and chronic CAD treatments<sup>20,61-63</sup>. patients' treatment  
7 preference, treatment delivered or treatment concordance with patient preferences did  
8 not significantly change in any study<sup>57,61,64</sup>. Cardiologists in two studies felt that they  
9 already performed SDM consistently and that PtDAs were poorly understood by patients  
10 and negatively impacted on consultations<sup>20,60</sup>. Most patients preferred a DVD or booklet  
11 formatted PtDAs than web-based formats<sup>57,62</sup>.

### 12 **3.3.3. Quality of studies**

13 The 26-item SUNDAAE checklist was used to evaluate the quality of reporting for all  
14 included studies, with results summarised in Table 3 (full evaluation in Table S12,  
15 supplementary file). Across the studies, between 50% to 89% (median 73%) of the  
16 SUNDAAE criteria were completely fulfilled. Three of the four development studies either  
17 fully, or partially, satisfied all applicable SUNDAAE<sup>56,59</sup>. No evaluation study achieved all  
18 26 criteria. One criterion (item 18) was only fully achieved by one study<sup>63</sup>, because the  
19 other six evaluation studies used a bespoke patient knowledge questionnaire, which had  
20 not undergone psychometric testing. Nine SUNDAAE criteria were achieved by all studies.  
21 The criteria least consistently achieved were those related to the methods and results  
22 sections (e.g., 'Description of the development process', 'PtDA fidelity', 'Process  
23 evaluation', and 'Theories/models used to guide the study design and selection of  
24 evaluation measures').

### 25 **3.4. Meta-analyses**

26 All six evaluation studies were assessed for inclusion in meta-analyses. Usable post-  
27 test data for patient knowledge and decisional conflict scores were obtained from four  
28 studies, with a total sample of 476 participants<sup>20,57,60,61</sup>, evaluating two PtDAs for AS<sup>41,42</sup>  
29 and three for chronic CAD<sup>46,47,51</sup>. Variation in the PtDAs and the patient groups across  
30 the four studies necessitated the use of standardised measures in the meta-analyses.

1 Leave-one-out sensitivity analyses revealed no individual study to be exerting excessive  
2 influence on either meta-analysis (Supplementary file).

### 3 **3.4.1. Patient Knowledge**

4 Patient knowledge of treatment options was significantly greater in the PtDA groups  
5 compared with usual care in all four studies<sup>20,57,60,61</sup>. The meta-analysis determined that  
6 the synthesised estimate of the standardised mean difference in knowledge scores  
7 (PtDA – usual care) was 0.620 (95% CI 0.396 to 0.845), favouring the PtDA over usual  
8 care groups. A Z-test of the standardised mean effect indicated strong evidence at the  
9 5% significance level for a non-zero effect ( $Z=5.42$ ;  $p<0.001$ ). Cochran's  $\chi^2$  test for  
10 heterogeneity indicated no evidence for statistical heterogeneity ( $\chi^2_{(3)}=4.12$ ;  $p=0.248$ ).  
11 The  $I^2$  statistic was 27.3%, which may indicate low levels of heterogeneity. Data is  
12 summarised in Figure 2.

### 13 **3.4.2. Decisional conflict**

14 Decisional conflict (measured by the validated SURE score<sup>70</sup> or Decisional Conflict  
15 Scale<sup>71</sup>) was not significantly different between PtDA and usual care groups in all four  
16 studies<sup>20,57,60,61</sup>. However, the 'informed' subscale of the Decisional Conflict Scale score  
17 was significantly lower (i.e. favourable) in the PtDA groups compared with usual  
18 care<sup>57,60</sup>. The meta-analysis determined that the synthesised estimate of the  
19 standardised mean difference in decisional conflict (PtDA – usual care) was -0.159  
20 (95% CI -0.339 to 0.022). A Z-test of the standardised mean effect revealed no  
21 evidence for a non-zero effect ( $Z=-1.717$ ;  $p=0.086$ ). Cochran's  $\chi^2$  test for heterogeneity  
22 indicated no evidence for statistical heterogeneity ( $\chi^2_{(3)}=0.47$ ;  $p=0.925$ ). The  $I^2$  statistic  
23 was 0.00%, indicating that heterogeneity might not be important. Data is summarised in  
24 Figure 3.

### 25 **3.4.3. Risk of bias**

26 The RoB2 tool<sup>32</sup> was used to evaluate potential bias in the two randomised controlled  
27 studies<sup>60,61</sup> with results indicating 'some concerns' (Figure 4). The two non-randomised  
28 studies<sup>20,57</sup> were evaluated using the NHLBI Quality Assessment of Controlled  
29 Intervention Studies, and were rated as 'fair quality', indicating susceptibility to 'some  
30 bias'<sup>33</sup>.

1

## 2 **4. DISCUSSION**

3 PtDAs are evidence-based tools known to be effective in improving the quality of SDM  
4 to help patients receive care that is 'right' for them. Patients who use PtDAs are more  
5 knowledgeable, informed, involved, have more accurate risk perceptions, are more  
6 confident in their treatment decision and clearer about their health goals and treatment  
7 preferences<sup>18</sup>. This benefits patients because those who are more active in making  
8 treatment decisions tend to have better health outcomes and are more satisfied with  
9 their care<sup>72</sup>. Within cardiology, many patients with AS and chronic CAD have unresolved  
10 decisional needs and require support when considering treatment with TAVI and  
11 planned PCI, respectively<sup>14-17</sup>. PtDAs offer a potential solution but cardiology teams'  
12 lack of awareness of available high-quality PtDAs is a barrier to implementation<sup>21</sup>.

13 To the best of our knowledge, this review makes a useful contribution to the research  
14 literature as the first study to systematically identify and evaluate the availability,  
15 characteristics, and quality of PtDAs used to support SDM for AS and chronic CAD. We  
16 also report on the effectiveness of TAVI PtDAs to improve decisional quality, which  
17 extends an existing meta-analysis on SDM in cardiology settings that did not include  
18 this common interventional procedure<sup>22</sup>. These findings, combined with our narrative  
19 summary of PtDA evaluation and development studies, provides a comprehensive  
20 international overview of AS and CAD PtDAs to inform cardiology practice.

### 21 **4.1. Patient Decision Aid availability and quality**

22 Our findings on the availability of PtDAs (Table 1) provide a valuable reference for  
23 cardiology teams and make an important contribution to the international literature. For  
24 the first time, internationally accepted quality criteria were used to evaluate the quality of  
25 AS and CAD PtDAs. We identified 21 PtDAs, but only one AS<sup>42</sup> and one CAD PtDA<sup>48</sup>  
26 were less than five years old, and currently publicly available for patient distribution.  
27 However, only the AS PtDA was rated as high-quality having fulfilled all quality criteria.  
28 Given that SDM is recommended in clinical guidelines and health policy<sup>5,6,9,10</sup>, this lack  
29 of publicly available high-quality AS and CAD PtDAs is a significant finding that has not  
30 previously been reported. Overall, PtDAs scored poorly on criteria that address

1 potentially harmful bias, which is consistent with reviews of cancer PtDAs<sup>23</sup>. This  
2 highlights that information concerning the uncertainty of treatment options, funding  
3 sources and update policies, requires improvement. Doctors may be reluctant to  
4 discuss uncertainties around treatment outcomes, as they believe this will be viewed as  
5 incompetence<sup>73</sup>, and will reduce patient trust and satisfaction with care<sup>74</sup>. Yet from a  
6 patient perspective, higher levels of trust in cardiologists is associated with feeling  
7 listened to and involved in decisions about their health and treatments<sup>75</sup>. Having an  
8 open and honest dialogue is valued by heart disease patients<sup>76</sup>. Increasing cardiology  
9 teams' awareness about patients' communication preferences and additional SDM skills  
10 may improve this important element of SDM<sup>77</sup>.

### 11 **4.2. Patient Decision Aid accessibility**

12 The PtDAs identified in this review had different designs, formats, and delivery  
13 approaches. There was a lack of consensus about the optimum characteristics for AS  
14 and CAD PtDAs. Potentially this might be because patients' and cardiology teams'  
15 preferences varied; a view confirmed in this review<sup>56,57,62</sup>. A recent meta-analysis  
16 reported that the PtDA format (e.g. paper, computer, web-based) had no impact on  
17 effectiveness for improving SDM in cardiology settings<sup>22</sup>. Our results corroborate this  
18 finding; patient knowledge and some aspects of the SDM process (patient perception of  
19 SDM and integration of SDM in consultations) were significantly improved in two studies  
20 despite using PtDAs with different formats<sup>20,57</sup>: a printed one-page within-consultation  
21 'encounter PtDA' for AS<sup>43</sup> and a web-based pre-consultation PtDA for CAD<sup>51</sup>. This  
22 suggests that a paper-based PtDA may be as effective as a more sophisticated digital  
23 version. However, additional research is required to corroborate this finding given the  
24 paucity of studies. We suggest that paper versions of PtDAs could be made routinely  
25 available, as a minimum, to support SDM for two reasons. First, 6-7% of adults in the  
26 US<sup>78</sup> and UK<sup>79</sup> have never used the internet. Second, it is recognised that the  
27 introduction of digital interventions can potentially widen health inequalities<sup>80</sup>.

28 The overall quality of reporting, in both AS and CAD PtDA development and evaluation  
29 studies, was good, according to the recommended SUNDARE criteria. The aims,  
30 rationale, explanation of the PtDA and study methods, implications for practice and  
31 research were comprehensively described in most studies. However, most studies did



1 not measure PtDA fidelity or explore potential mechanisms for their effect on decision  
2 outcomes. The demographics of patients involved in the development and/or evaluation  
3 studies were either unknown<sup>58,59</sup>, under-reported<sup>63,64</sup>, or predominantly White, English-  
4 speaking people educated to high school level or higher<sup>20,56,57,60-62</sup>. Furthermore,  
5 readability levels were not reported in any PtDA, although the target reading age for two  
6 CAD PtDAs was reported as 13-14 years in associated publications<sup>56,57</sup>. These findings  
7 are significant because it's unclear how relevant and accessible existing AS and CAD  
8 PtDAs are for under-represented populations, which makes it challenging for cardiology  
9 teams to evaluate their appropriateness and usefulness within their clinical setting.  
10 Since patient-healthcare professional communication has the potential to reduce or  
11 increase health disparities<sup>81</sup>, it is important that the development and testing of PtDAs  
12 involve patients from diverse backgrounds.

### 13 **4.3. Comparisons with other meta-analyses**

14 Our meta-analyses found significantly improved levels of patient knowledge following  
15 the use of two AS PtDAs<sup>41,42</sup> and three CAD PtDAs<sup>46,47,51</sup>, compared to usual care. This  
16 finding is consistent with a recent meta-analysis of cardiology PtDAs<sup>22</sup>. However, our  
17 meta-analysis found no significant difference in decisional conflict between PtDA and  
18 usual care groups, in contrast to other reviews<sup>18,22</sup>. There are several potential  
19 explanations for this finding. The five PtDAs<sup>42,43,46,47,51</sup> evaluated may have limited  
20 function in eliciting preferences. Decisional conflict may have already been low in  
21 participants at baseline and/or in usual care groups<sup>7, 37, 53, 75</sup> or the measure may have a  
22 ceiling effect. Another explanation relates to educational attainment. A large proportion  
23 of participants across the four studies had achieved a high-school education level or  
24 higher which is known to be associated with lower decisional conflict<sup>82</sup>.

25 Although not included in our meta-analysis due to heterogeneity of study designs,  
26 outcome measures indicating the quality of the decision-making process were  
27 significantly greater following the use of PtDAs across some<sup>20,57,61-63</sup> but not all  
28 studies<sup>60,64</sup> and no negative outcomes were reported. The inconsistent findings might be  
29 explained by differences in study designs, outcomes, measurement instruments, and  
30 the PtDAs themselves. Given the wide variety of measures used to evaluate the quality  
31 of SDM, consensus on the most appropriate is recommended.

#### 4.4. Implementation of Patient Decision Aids in clinical practice

None of the PtDAs were evaluated in a large-scale randomised controlled trial that appeared to be sufficiently powered with a low risk of bias, possibly due to difficulties with recruitment and/or PtDA implementation. Several factors influence the successful implementation of PtDAs; a PtDA that is too complex or competes with existing practice is unlikely to be used<sup>77</sup>. Involvement and commitment from senior leadership and the clinical teams is an enabler to the use of PtDAs as is engagement of the family and significant others<sup>77</sup>. Successful strategies to integrate PtDAs into clinical settings include training the entire cardiology team, linking PtDA outcomes with organisational priorities, proactively encouraging patients to engage with the PtDA, and reflecting on existing pathways to identify opportunities for PtDA use and SDM conversations<sup>77</sup>. The latter strategy could be particularly useful for elective PCI where the timing of PtDA delivery is challenging because diagnosis and treatment often occur together in the same procedure<sup>83</sup>. Providing PtDAs and seeking patients' treatment preferences and goals earlier in the severe AS pathway should be considered<sup>13</sup>.

#### 4.5. Strengths and limitations

We comprehensively and systematically searched multiple databases, trial registers and 30 online sources to identify AS and CAD PtDAs and their development and evaluation studies. However, we may not have identified all eligible PtDAs and six were not available so an evaluation of their characteristics and quality was not possible. The wide range of measurement instruments used to evaluate the quality of SDM limited the number meta-analyses conducted and made cross study comparisons challenging. Nevertheless, this review provides a high-quality international review of AS and CAD PtDAs.

### 5. Conclusions

A diverse range of AS and CAD PtDAs have been developed over the past 16 years, but few are up to date and currently available. To increase the transparency around PtDA quality and effectiveness information about the uncertainty of treatment outcomes, funding sources and future updates should be added. The 'voice' of underserved populations and those with low health literacy levels is needed in the development or evaluation of PtDAs as to date this has been lacking. Paper-based versions of digital

1 PtDAs should be available to avoid widening health inequalities associated with the  
2 digital divide. We recommend that cardiology teams use the most up-to-date and  
3 highest quality PtDAs available. We concluded that patients who use PtDAs when  
4 considering treatments for AS or chronic CAD are likely to be better informed than those  
5 who do not.

6

## 7 **AUTHOR CONTRIBUTIONS**

8 Conceptualization: EH, FA, DC; Methodology: EH, FA; Formal analysis: EH, JS;  
9 Investigation: EH, FA, AB, DC, AYC, HC; Project administration: EH; Visualization: EH,  
10 FA, JS; Writing – original draft: EH, FA, JS; Writing – review & editing: EH, FA, AB, JS,  
11 DC, AYC, HC.

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## 20 **DATA AVAILABILITY**

21 The data underlying this review are available in the article and in its online  
22 supplementary material.

## 23 **CONFLICTS OF INTEREST**

24 FA, EH, and DC, received research funding in a competitive peer review process from  
25 Grow MedTech ((POF000186, POF000103) and the National Institute of Health and  
26 Care Research (NIHR204012) to develop and test a PCI PtDA called CONNECT, which  
27 is included in this review. A second author (AB), not involved in the development or  
28 testing of CONNECT, assessed its quality. AYC receives honoraria and an unrestricted  
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## GRAPHICAL ABSTRACT LEGEND

AS: aortic stenosis; CAD: coronary artery disease; CI: Confidence Interval; PtDAs: Patient Decision Aids; PCI: Percutaneous Coronary Intervention; TAVI: Transcatheter Aortic Valve Implantation

## TABLE TITLES AND LEGENDS

### Table 1. Overview of PtDAs

Online sources: <sup>a</sup><https://sharedcardiology.org>; <sup>b</sup>European Society of Cardiology Website <https://www.escardio.org/>; <sup>c</sup>The Ottawa Hospital Research Institute Decision Aid Library Inventory <https://decisionaid.ohri.ca/index.html>; <sup>d</sup>EBSCO Health care <https://www.ebsco.com/health-care/products/my-health-decisions>; <sup>e</sup>Vale of York NHS <https://www.valeofyorkccg.nhs.uk/rss/home/patient-decision-making/shared-decision-making/>

### Table 2: Characteristics of PtDAs

\* Only paper version evaluated, web version unavailable. EVC: Explicit values clarification; HCP: Healthcare professional; Tx: Treatment

### Table 3. Overview of studies

\*: statistical significance ( $p < 0.05$ ); \*\*: Sum of scores on 3-item questionnaire, max score, 12; lower values indicate higher health literacy.  $\leftrightarrow$ : no change;  $\uparrow$ : higher value/score;  $\downarrow$ : lower value/score AS: aortic stenosis; CAD: coronary artery disease; CSE: Cardiac Self-Efficacy; DAOH: Days Alive And Out Of Hospital; DCS: Decisional Conflict Scale; DM: Diabetes Mellitus; GAD-7: Generalised Anxiety Disorder-7; IPDAS: International Patient Decision Aid Standards; NS: not significant ( $p > 0.05$ ); OMT: optimal medical therapy; PCI: percutaneous coronary intervention; PtDA: patient decision aid; RCT: Randomised Controlled Trial; SD: standard deviation; SDM: shared decision-making; SAVR: Surgical Aortic Valve Replacement; TAVR: Transcatheter Aortic Valve Replacement; UC: usual care

## FIGURE TITLES AND LEGENDS

**Figure 1: PRISMA 2020 flow-diagram<sup>26</sup>**

**Figure 2: Forest plot for the meta-analysis of patient knowledge scores**

**Figure 3: Forest plot for meta-analysis of decisional conflict scores**

**Figure 4: Risk of bias summary using the Cochrane RoB2 tool**

## NOVELTY BOX

- This is the first review to systematically identify and evaluate the availability, characteristics, and quality of patient decision aids for use in severe aortic stenosis and chronic coronary artery disease patient pathways.
- A barrier to implementing shared decision-making for people with heart disease or aortic stenosis is the lack of high quality, up to date, publicly available patient decision aids.
- Existing patient decision aids are not tailored to meet the needs of people with low health literacy levels or from underserved populations.
- Patient decision aids in this review improved patient knowledge but decisional conflict scores were unchanged, possibly due to a ceiling effect.

**Table 1. Overview of PtDAs**

PtDA	Treatment options	Author(s) and/or developing Organisation	Date developed or updated	Country and language	Format	Availability	Source of identification
<b>PtDAs for aortic stenosis treatment options</b>							
ADVICE: Navigating Aortic Valve Treatment Choices <sup>39</sup>	<ul style="list-style-type: none"> <li>• TAVI</li> <li>• SAVR</li> </ul>	Brennan JM, <i>et al.</i> , Duke University	2017	USA, English	Web-based	Not available: Website deactivated.	Literature <sup>5</sup> 8 identified via online sources <sup>a</sup>
Aortic Stenosis Choice (CHOICE-AS) <sup>44,45</sup>	<ul style="list-style-type: none"> <li>• TAVI</li> <li>• SAVR</li> </ul>	Lauck S, <i>et al.</i> <sup>45</sup>	Ongoing	Canada, English	Web-based	Not currently available. PtDA development and testing study ongoing. Contact authors for access.	Online sources <sup>b</sup>
Aortic valve improved treatment approaches (AVITA) tool <sup>40</sup>	<ul style="list-style-type: none"> <li>• No valve replacement (medication s/ comfort care)</li> <li>• TAVI</li> <li>• SAVR</li> </ul>	Shared Decision-Making Resources collaborating with Edward Lifesciences	Ongoing	USA, English	Web-based	Not currently available. PtDA development and pilot study ongoing. Contact authors for access.	Trial registry NCT04755426
A decision aid for treatment options for severe aortic stenosis (TAVI vs Symptom Management) <sup>41</sup>	<ul style="list-style-type: none"> <li>• Symptom Management (Taking medications only)</li> <li>• TAVI</li> </ul>	American College of Cardiology	August 2017	USA, English, Spanish, French	Eight-page booklet (pdf)	<a href="https://www.cardiosmart.org/assets/decision-aid/choosing-between-tavr-and-symptom-management">https://www.cardiosmart.org/assets/decision-aid/choosing-between-tavr-and-symptom-management</a>	Literature <sup>6</sup> 3
A decision aid for treatment options for severe aortic stenosis for patients deciding between TAVI and surgery <sup>42</sup>	<ul style="list-style-type: none"> <li>• TAVI</li> <li>• SAVR</li> </ul>	American College of Cardiology	July 2020	USA, English, Spanish, French	Eight-page booklet (pdf)	<a href="https://www.cardiosmart.org/assets/decision-aid/choosing-between-tavr-and-surgery">https://www.cardiosmart.org/assets/decision-aid/choosing-between-tavr-and-surgery</a>	Literature <sup>6</sup> 1,63
Severe Aortic Stenosis Decision Aid <sup>43</sup>	<ul style="list-style-type: none"> <li>• Symptom Management (Palliative care)</li> </ul>	American College of	2014	USA, English	One-page pdf	<a href="https://sharedcardiology.org/tools/">https://sharedcardiology.org/tools/</a> and available in Figure 1 in published study <sup>20</sup>	Literature <sup>2</sup> 0

## Cardiac Patient Decision Aids Systematic Review

PtDA	Treatment options	Author(s) and/or developing Organisation	Date developed or updated	Country and language	Format	Availability	Source of identification
	<ul style="list-style-type: none"> <li>TAVI</li> </ul>	Cardiology					
TAVI versus SAVR for patients with severe symptomatic aortic stenosis at low to intermediate perioperative risk: for patients above 85 years with severe symptomatic aortic stenosis, at low or intermediate perioperative risk <sup>34</sup>	<ul style="list-style-type: none"> <li>TAVI</li> <li>SAVR</li> </ul>	MAGIC Evidence Ecosystem Foundation (BMJ RapidRecs)	May 2017	Multiple countries, English, Norwegian; partial translation into 12 other languages on website	Web-based with option to create a 13-page pdf	<a href="https://app.magicapp.org/#/guideline/1308">https://app.magicapp.org/#/guideline/1308</a>	Online sources <sup>a</sup>
TAVI versus SAVR for patients with severe symptomatic aortic stenosis at low to intermediate perioperative risk: for patients 75-85 years with severe symptomatic aortic stenosis who are at low or intermediate perioperative risk <sup>35</sup>	<ul style="list-style-type: none"> <li>TAVI</li> <li>SAVR</li> </ul>	MAGIC Evidence Ecosystem Foundation (BMJ RapidRecs)	May 2017	Multiple countries, English, Norwegian; partial translation into 12 other languages on website	Web-based with option to create a 13-page pdf	<a href="https://app.magicapp.org/#/guideline/1308">https://app.magicapp.org/#/guideline/1308</a>	Online sources <sup>a</sup>

## Cardiac Patient Decision Aids Systematic Review

PtDA	Treatment options	Author(s) and/or developing Organisation	Date developed or updated	Country and language	Format	Availability	Source of identification
TAVI versus SAVR for patients with severe symptomatic aortic stenosis at low to intermediate perioperative risk: for patients aged 65 to < 75 years and eligible for transfemoral TAVI or SAVR <sup>36</sup>	<ul style="list-style-type: none"> <li>• TAVI</li> <li>• SAVR</li> </ul>	MAGIC Evidence Ecosystem Foundation (BMJ RapidRe cs)	May 2017	Multiple countries, English, Norwegian; partial translation into 12 other languages on website	Web-based with option to create a 13-page pdf	<a href="https://app.magicapp.org/#/guideline/1308">https://app.magicapp.org/#/guideline/1308</a>	Online sources <sup>a</sup>
TAVI versus SAVR for patients with severe symptomatic aortic stenosis at low to intermediate perioperative risk: for patients aged < 65 years and eligible for transfemoral TAVI or SAVR <sup>37</sup>	<ul style="list-style-type: none"> <li>• TAVI</li> <li>• SAVR</li> </ul>	MAGIC Evidence Ecosystem Foundation (BMJ RapidRe cs)	May 2017	Multiple countries, English, Norwegian; partial translation into 12 other languages on website	Web-based with option to create a 13-page pdf	<a href="https://app.magicapp.org/#/guideline/1308">https://app.magicapp.org/#/guideline/1308</a>	Online sources <sup>a</sup>
TAVI versus SAVR for patients with severe symptomatic aortic stenosis at low to intermediate perioperative risk who cannot undergo	<ul style="list-style-type: none"> <li>• TAVI</li> <li>• SAVR</li> </ul>	MAGIC Evidence Ecosystem Foundation (BMJ RapidRe cs)	May 2017	Multiple countries, English, Norwegian; partial translation into 12 other languages	Web-based with option to create a 13-page pdf	<a href="https://app.magicapp.org/#/guideline/1308">https://app.magicapp.org/#/guideline/1308</a>	Online sources <sup>a</sup>

## Cardiac Patient Decision Aids Systematic Review

PtDA	Treatment options	Author(s) and/or developing Organisation	Date developed or updated	Country and language	Format	Availability	Source of identification
transfemoral TAVR but can undergo transapical approach <sup>38</sup>				ges on website			
<b>PtDAs for chronic coronary artery disease treatment options</b>							
Angina treatment: Stents, drugs, lifestyle changes - What's best? <sup>48</sup>	<ul style="list-style-type: none"> <li>• Medications</li> <li>• Angioplasty and stent placement</li> <li>• Enhanced external counterpulsation (EECP) therapy</li> <li>• Lifestyle changes</li> </ul>	Mayo clinic	May 2021	USA, English	Web-based	<a href="https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/in-depth/angina-treatment/art-20046240">https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/in-depth/angina-treatment/art-20046240</a>	Online sources <sup>c</sup>
Angina: treatment options Option Grid <sup>TM49</sup>	<ul style="list-style-type: none"> <li>• Medical Management</li> <li>• Stenting (angioplasty)</li> </ul>	Option Grid Collaborative	2015/16	USA, English	Web-based	Out of date: no longer available.	Literature <sup>64</sup>
Chest Pain (Stable Angina) Treatment Options Option Grid <sup>TM50</sup>	<ul style="list-style-type: none"> <li>• Non-invasive treatment (medicines, lifestyle changes)</li> <li>• Invasive treatment (stent or bypass surgery)</li> </ul>	DynaMed Decision Tools, EBSCO Health	December 2021. Updated when new relevant scientific evidence becomes available	USA, English	Web-based with option to create a 4-page pdf	Not publicly available. Contact EBSCO Health for cost ( <a href="http://www.ebsco.com">www.ebsco.com</a> ).	Online sources <sup>d</sup>
CONNECT: COroNary aNgioplasty dECision Tool <sup>54</sup>	<ul style="list-style-type: none"> <li>• Medicines only</li> <li>• Coronary angiogram test and treatment with coronary</li> </ul>	Harris, E, <i>et al.</i> <sup>56</sup>	February 2021	UK, English	Web-based	Not currently publicly available. Randomised feasibility study ongoing. Contact authors for access.	Literature <sup>56</sup>

## Cardiac Patient Decision Aids Systematic Review

PtDA	Treatment options	Author(s) and/or developing Organisation	Date developed or updated	Country and language	Format	Availability	Source of identification
	angioplasty, if beneficial, AND medicines						
Coronary Artery Disease: What treatment would you prefer? <sup>51</sup>	<ul style="list-style-type: none"> <li>• Medicines only</li> <li>• Angioplasty (stent)</li> <li>• Bypass surgery</li> </ul>	Duke University Medical Center clinicians and Healthwise	2015	USA, English	Web-based; 8-page paper version available within publication	Web version: access unknown. Paper version shown in the supplementary material in published study <sup>57</sup> <a href="https://doi.org/10.1161/circoutcomes.118.005244">https://doi.org/10.1161/circoutcomes.118.005244</a>	Literature <sup>57</sup>
Deciding what to do about stable angina <sup>55</sup>	<ul style="list-style-type: none"> <li>• Lifestyle changes</li> <li>• Medical treatment</li> <li>• Revascularisation (angioplasty or coronary artery bypass graft)</li> </ul>	NHS England Vale of York Clinical Commissioning Group	January 2017	UK, English	Nine-page pdf	<a href="https://www.valeofyorkccg.nhs.uk/rs/home/patient-decision-making/shared-decision-making/">https://www.valeofyorkccg.nhs.uk/rs/home/patient-decision-making/shared-decision-making/</a>	Online sources <sup>e</sup>
PCI Choice: Class I/II Stable Angina <sup>46</sup>	<ul style="list-style-type: none"> <li>• Medicines alone</li> <li>• Medicines + stents</li> </ul>	Mayo Foundation for Medical Education and Research	2012	USA, English	Two-page pdf	<a href="https://carethatfits.org/pci-choice/">https://carethatfits.org/pci-choice/</a>	Literature <sup>59,60</sup>
PCI Choice: Class III Stable Angina <sup>47</sup>	<ul style="list-style-type: none"> <li>• Medicines alone</li> <li>• Medicines + stents</li> </ul>	Mayo Foundation for Medical Education and Research	2012	USA, English	Two-page pdf	<a href="https://carethatfits.org/pci-choice/">https://carethatfits.org/pci-choice/</a>	Literature <sup>59,60</sup>
Should I Have Angioplasty for Stable Chest Angina? <sup>52</sup>	<ul style="list-style-type: none"> <li>• Take medicines and have a healthy lifestyle</li> </ul>	Healthwise	Updated 2022	USA, English	Web-based with option to create a 19-	<a href="https://decisionaid.ohri.ca/Azsumm.php?ID=1202">https://decisionaid.ohri.ca/Azsumm.php?ID=1202</a> Licence required for distribution to patients or consumers.	Literature <sup>62</sup>

## Cardiac Patient Decision Aids Systematic Review

PtDA	Treatment options	Author(s) and/or developing Organisation	Date developed or updated	Country and language	Format	Availability	Source of identification
	<ul style="list-style-type: none"> <li>• Angioplasty , along with taking medicines and having a healthy lifestyle</li> </ul>				page "printer friendly " version		
Treatment Choices for Stable Chest Discomfort <sup>53</sup>	<ul style="list-style-type: none"> <li>• Medical therapy</li> <li>• Percutaneous coronary intervention (PCI)</li> </ul>	Health Dialog and Foundation for Informed Medical Decision Making	2014 version	USA, English	Booklet (36-page paper) and DVD (20 min)	Not publicly available. Contact Health Dialog for cost.	Literature <sup>6</sup> <sub>2</sub>



**Table 2: Characteristics of PtDAs**

PtDA	Format & Delivery	Design & Development	EVC method	Tx preference indication	Other interaction	Risk/benefits presentation	Patient stories	No. of IPDAS criteria achieved
<b>PtDAs for aortic stenosis treatment options</b>								
A decision aid for treatment options for severe aortic stenosis (TAVI vs Symptom Management) <sup>41</sup>	Paper booklet reviewed by patient pre-consultation	Colour text, graphics, text boxes, photos of people, images to explain disease and procedure. 15-min video on website. Development not described.	4 questions with open-text responses about hopes, concerns, questions for HCPs and family	None	-	Side-by-side list & icon arrays (100 heart icons); natural frequencies (denominator : 100); positive & negative framing	2 scenarios. Patient's tx choice shown	Fully: 11 Partially: 0 Not met: 1
A decision aid for treatment options for severe aortic stenosis for patients deciding between TAVI and surgery <sup>42</sup>	Paper booklet reviewed by patient pre-consultation	Colour text, graphics, text boxes, photos of people, images to explain disease and procedure. 18.5-min video on website. Development not described.	4 questions with open-text responses about hopes, concerns, questions for HCPs and family	None	-	Side-by-side list & icon arrays (10 people icons); natural frequencies (denominator : 10 & 100); mostly negative framing used; positive & negative used for survival	2 scenarios. Patient's tx choice shown	Fully: 11 Partially: 1 Not met: 0
Severe Aortic Stenosis Decision Aid <sup>43</sup>	Brief 1-page paper 'Encounter PtDA' reviewed during consultation with HCP	Colour text, text boxes, graphs Development briefly described <sup>20</sup>	Conversation guide with 1 question asking the patient "What matters most to you?"	Open-text response to indicate patient and HCP's shared decision	-	Side-by-side list, icon arrays (100 circles) & line graphs; positive & negative framing	None	N/A

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PtDA	Format & Delivery	Design & Development	EVC method	Tx preference indication	Other interaction	Risk/benefits presentation	Patient stories	No. of IPDA S criteria achieved
TAVI versus SAVR for patients with severe symptomatic aortic stenosis at low to intermediate perioperative risk (5 versions for different age groups <sup>34-38</sup> )	Web-based interactive 'Encounter PtDA' reviewed during consultation with HCP	Text, pop-up boxes, black/white icons Clinical content review described on website. Option to download as pdf.	None	None	Web version only: HCP navigates between sections to guide discussion and explore outcomes the patient wants to discuss	Icon arrays (1000 people icons); side-by-side natural frequencies (denominator: 1000); mix of positive or negative framing	None	Fully: 8 Partially: 3 Not met: 1
<b>PtDAs for chronic CAD treatment options</b>								
Angina treatment: Stents, drugs, lifestyle changes - What's best? <sup>48</sup>	Website. Delivery not specified	Text, colour image to explain procedure. Development not described.	None	None	-	Only states one risk (blockage reforming). Likelihood not provided.	None	Fully: 5 Partially: 2 Not met: 5
CONNECT: COroNary aNgioplasty dECision Tool <sup>54,56</sup>	Web-based reviewed by patient pre-consultation. Personalised summary to be shared with HCP during consultation	Text, drop-down boxes, pop-up boxes, tables, colour icons, colour diagrams to explain disease and procedure, multiple short animated videos,	Open-text box for patient to add the top 3 things that matter most to them when considering their tx options	Multiple choice question with 'not sure' as an option. A smiley face 5-point Likert scale to indicate level of certainty	Patient input: navigation between sections; 6-item multiple-choice Angina Symptom Evaluation Questionnaire; Open-text box to add worries or questions. Generates personal summary of answers.	Side-by-side comparison table; icon arrays (1000 people icons for PCI risks, 100 people for benefits of both options); natural frequencies (denominator: 1000, 5000); positive & negative framing	Text and audio quotes from 5 fictional patients. Tx choice not shown.	Fully: 12 Partially: 0 Not met: 0

## Cardiac Patient Decision Aids Systematic Review

PtDA	Format & Delivery	Design & Development	EVC method	Tx preference indication	Other interaction	Risk/benefits presentation	Patient stories	No. of IPDAS criteria achieved
		photos of people. Development fully described <sup>56</sup> .		y with choice				
Coronary Artery Disease: What treatment would you prefer? (paper version only)* <sup>51</sup>	Web and paper reviewed by patient on the day of diagnostic angiogram	Paper version: Text, colour graphics, table, pictures and icons, colour diagrams to explain disease and procedures. Development described briefly <sup>57</sup> .	None	One question asking patient to record preferred tx	-	Side-by-side lists; icon arrays (100 people icons); natural frequencies (denominator : 1000); negative framing	None	Fully: 9 Partially: 0 Not met: 3
Deciding what to do about stable angina <sup>55</sup>	Paper-based reviewed by patient pre-consultation or with HCP during consultation	Text, diagram, tables. Development not described.	None	None	6 questions for the patient to consider (no space for patient answers)	Side-by-side comparison table; positively framed natural frequencies for symptom improvement for PCI/CABG option only (denominator : 100); negatively framed natural frequencies (denominator : 100) for medicines option; descriptive words for PCI	None	Fully: 9 Partially: 1 Not met: 2

## Cardiac Patient Decision Aids Systematic Review

PtDA	Format & Delivery	Design & Development	EVC method	Tx preference indication	Other interaction	Risk/benefits presentation	Patient stories	No. of IPDA S criteria achieved
						& CABG (small, low, higher)		
PCI Choice (2 versions for either Class I/II or Class III Stable Angina <sup>46,47</sup> )	Brief 2-page paper 'Encounter PtDA' reviewed during consultation with HCP	Colour text, text boxes, colour icons. Development fully described <sup>59</sup> .	None	Two questions asking for preferred tx	None	Side-by-side icon arrays (100 circles icons); natural frequencies (denominator : 100) with positive & negative framing	None	N/A
Should I Have Angioplasty for Stable Chest Angina? <sup>52</sup>	Web-based pre-consultation. Delivery determined by distributor. In publication <sup>62</sup> , the link to the PtDA website was e-mailed to patients' pre-consultation.	Web: Text, drop-down boxes, pop-up boxes, tables, colour diagrams to explain procedure with real angiogram x-ray image. Clinical content review described on website. Option to download as pdf.	Rating scales: Four 7-point 'importance' Likert scales for 3 pre-set attributes & 1 open-box for patient to add other important attributes/values.	Two 7-point Likert scales to indicate preferred tx and level of certainty with choice	Patient input: navigation between sections; 3-item yes/no knowledge test; 3 yes/no questions about support & understanding, open-text box to add worries or questions. Generates personal summary of answers.	Side-by-side list; icon arrays (100 people icons); side-by-side natural frequencies (denominator : 100) with positive & negative framing for benefits; Negative framing for PCI risks	Quotes from 4 fictional patients. Tx choice shown.	Fully: 9 Partially: 3 Not met: 0

**Table 3. Overview of studies**

Study details	Study design	Methods, sample, and setting	Results	No. of SUNDARE items met
<b>Studies reporting on the development, acceptability, and evaluation of PtDAs for aortic stenosis treatment options</b>				
Brennan et al. <sup>58</sup> 2020, USA	Multi-methods development study of risk calculator and PtDA for patients with AS ( <b>ADVICE</b> <sup>39</sup> )	Setting: Duke University Medical Center 1) Development of risk calculator: Patient survey (SAVR n=10; TAVR n=10); Registry data review and questionnaire by 3 caregivers and 5 patients to identify patient characteristics to include in risk models. 2) Feedback on risk calculator: 4 rounds of semi-structured interviews with 6 TAVR and SAVR patients and caregivers. 3) SDM education resource development: multiple teleconference calls with a multi-disciplinary team including 7 patients and 3 caregivers to determine content. 4) Feedback on PtDA: Review by patient and caregiver stakeholders and semi-structured interviews with 6 patients scheduled for TAVR.	<ul style="list-style-type: none"> <li>• Web-based and mobile risk calculator developed. Risk models included 1-year outcomes for mortality, stroke, discharge location and QoL</li> <li>• Patient and caregivers wanted risks to be presented in multiple ways (numeric and pictographs) and for a personalised interpretation of their data. Website readability scores: FRE: 60.93; FKGL: 7.02</li> <li>• Web-based resource developed with links to the risk calculator but no longer accessible (website deactivated).</li> <li>• Feedback incorporated into resource. Website visits in 11 months: 2589 users. Average time on website: 1.5 min. 'Engaged users' n=817.</li> </ul>	Fully: 13 Partially: 3 Not met: 2 N/a: 8
Coylewright et al. <sup>20</sup> 2020, USA	Single-centre nonrandomised pre-test post-test pilot study with 3 patient groups: UC (no PtDA); cardiologist's 1st use of PtDA ( <b>Severe Aortic Stenosis Decision Aid</b> <sup>43</sup> ); cardiologist's 5 <sup>th</sup> use of PtDA	Setting: 2 TAVR centres in Northern New England 35 patients (56% female) with severe AS, at high or prohibitive surgical risk, for whom HCPs agree potential equipoise for TAVR and SAVR. <u>UC:</u> Each cardiologist (n=4) or pair (n=1) audio recorded a consultation without PtDA with 5 patients each (25 total). Patients' mean (SD) age: 85 (7.5) years; 75% achieved high-school education or greater. <u>1st use of PtDA:</u> Each cardiologist/pair used the PtDA with 1 patient (5 total). Patients' mean (SD) age: 82 (10.5) years; 100% achieved high-school education or greater (1 missing response). <u>5th use of PtDA:</u> Each cardiologist/pair's 5th time of using the PtDA with a patient (n=5). Patients' mean (SD) age*: 93 (2.7) years; 80% achieved high-school education or greater.	<ul style="list-style-type: none"> <li>• SURE score for decisional conflict: ↔</li> <li>• Post-consultation knowledge: ↑ with PtDA*</li> <li>• OPTION score for SDM: ↑ with PtDA*</li> <li>• Patient satisfaction: ↑ with PtDA*</li> </ul>	Full: 19 Partial: 4 No: 3 N/a: 0

## Cardiac Patient Decision Aids Systematic Review

Study details	Study design	Methods, sample, and setting	Results	No. of SUNDAE items met
Einfeld <sup>63</sup> 2020, USA	Single-centre uncontrolled pre-post intervention (peer support and use of PtDAs in patients considering TAVR) pilot study with 1 patient group 2 PtDAs: <b>Treatment options for severe aortic stenosis- TAVI vs Symptom Management</b> <sup>41</sup> and <b>Treatment options for severe aortic stenosis for patients deciding between TAVI and surgery</b> <sup>42</sup>	Setting: Community hospital in Pacific Northwest Patients with AS (n=12; 63-89 years; 42% Female) eligible for TAVR participated in peer-support (Mended Hearts programme). TAVR PtDAs integrated into UC consultations.	<ul style="list-style-type: none"> <li>• Preparation for Decision Making Scale (post PtDA use): All patients felt that the PtDAs were 'somewhat' to 'a great deal' helpful in preparing for decision-making.</li> <li>• 11 patients completed peer-support</li> <li>• GAD-7 score: 4 patients ↓ anxiety, 5 ↔, 2 patients ↑</li> <li>• Perceived cardiac self-efficacy with CSE scale before and after peer support: ↑ in 58% patients</li> </ul>	Full: 19 Partial: 3 Not: 4 N/a: 0
Valentine et al. <sup>61</sup> 2022, USA	Single-centre pilot 1:1 RCT (PtDA vs UC) of a PtDA delivered to patients with AS considering TAVR or SAVR PtDA: <b>Treatment options for severe aortic stenosis for patients deciding between TAVI and surgery</b> <sup>42</sup> Comparator: UC in-clinic discussion of treatment options, risks, and benefits, and an animation of the TAVR procedure. No written materials.	Setting: Massachusetts General Hospital, USA Patients (n=60, 100% White) with mild or moderate AS being assessed for either TAVR or surgical SAVR were randomised to PtDA or UC group. PtDA (n=31): mean age 74 (SD 6) years; 39% female; 89% achieved College education or greater. UC (n=28): mean age 71 (SD 8) years; 25% female; 75% achieved College education or greater.	<ul style="list-style-type: none"> <li>• SURE scale for decisional conflict: ↔</li> <li>• Knowledge: ↑ with PtDA*</li> <li>• CollaboRATE score: ↑ with PtDA*</li> <li>• SDM process scale: ↔</li> <li>• Treatment preference: ↔</li> <li>• Treatment received: ↔</li> <li>• Preference concordance: ↑ with PtDA (NS)</li> <li>• Informed patient-centred decision: ↑ with PtDA (NS)</li> </ul> <p>68% reported reviewing all the PtDA</p>	Full: 19 Partial: 2 Not: 4 N/a: 1
<b>Studies reporting on the development, acceptability, and evaluation of PtDAs for chronic coronary artery disease treatment options</b>				
Coylewright et al. <sup>59</sup> 2012, USA	Multi-phase development and single-centre acceptability study of PtDA ( <b>PCI Choice</b> <sup>46,47</sup> ) for patients with stable CAD	Setting: Mayo clinic 1) Evidence review and synthesis. 3) Prototype PtDA developed by 2 HCPs plus designer.	<ul style="list-style-type: none"> <li>• Evidence from clinical guidelines and trials informed the risk and benefit information in the PtDA</li> <li>• Encounter PtDA developed, to be used 'upstream' from PCI procedure itself</li> </ul>	Fully: 13 Partially: 5 Not met: 0 N/a: 8

## Cardiac Patient Decision Aids Systematic Review

Study details	Study design	Methods, sample, and setting	Results	No. of SUNDAE items met
	facing treatment with either OMT or PCI+OMT	4) Tested by Diabetes Research Advisory Group (15-20 community members with DM), and Cardiovascular Patient and Family Advisory Council (over 25 patients and family members) to develop first prototype. 5) Observed use in clinical setting with 25 patients. Revised PtDA over 1-2 weeks after each clinical observation.	<ul style="list-style-type: none"> <li>• Preference for reduction in text and increased use of pictographs to illustrate risks and benefits of OMT and PCI</li> </ul>	
Coylewright et al. <sup>60</sup> 2016, USA	Single-centre, randomised controlled (1:1) trial of PtDA ( <b>PCI Choice</b> <sup>46,47</sup> ) vs. UC (no PtDA)	Setting: Mayo clinic 124 Patients with stable CAD considering OMT +/- PCI treatment randomised to PtDA or UC group. <u>PtDA (n=65)</u> : mean age 69 (SD 10.9) years; 28% female; 100% White; 65% achieved College education or greater <u>UC (n=59)</u> : mean age 68 (SD 10.2) years; 25% female; 98% White; 71% achieved College education or greater.	<ul style="list-style-type: none"> <li>• Overall DCS: ↔</li> <li>• Informed subscale of DCS: ↓ with PtDA (NS)</li> <li>• Knowledge: ↑ with PtDA*</li> <li>• OPTION Scale for SDM: ↔</li> <li>• PtDA fidelity score: 70.9%. contamination (i.e. discussion of SDM items) occurred in UC (50.6%) but significantly fewer SDM items were discussed compared to PtDA consultations*</li> </ul>	Full: 18 Partial: 5 No: 3 N/a: 0
Doll et al. <sup>57</sup> 2019, USA	Two-part study: A) Single-centre prospective nonrandomised controlled pre-post-test study of PtDA ( <b>Coronary Artery Disease: What treatment would you prefer?</b> <sup>51</sup> ) vs. UC (no PtDA, no treatment preferences)  B) Pilot cluster randomised study embedded within above study	Setting: Duke University Hospital. A) 203 patients with chest pain, angina (acute and chronic) or NSTEMI, referred for diagnostic coronary angiography and considering treatment with either medical therapy, PCI or CABG, nonrandomised to PtDA or UC group. <u>UC (n=100)</u> : median age (IQR) 64 (56-70) years; 34% female; 76% White; 63% achieved College education or greater; Health literacy** mean (SD) 2 (2.6). <u>PtDA (n=103)</u> : median age (IQR) 63 (55-72) years; 43% female; 71% White; 71% achieved College education or greater; Health literacy** mean (SD) 1.5 (2.1). B) 103 patients in PtDA group randomised 50:53 to preference group (cardiologist received patients' treatment preferences) or control group (preferences not shared).	<ul style="list-style-type: none"> <li>• Overall DCS: ↔</li> <li>• Informed subscale of DCS: ↓ with PtDA*</li> <li>• Values clarity subscale of DCS: ↓ with PtDA*</li> <li>• Knowledge: ↑ with PtDA*</li> <li>• Control Preferences Scale: ↑ sense of SDM with PtDA*</li> <li>• Treatment preference: ↔</li> <li>• Treatment received and concordance with patient preference: ↔</li> </ul>	Full: 13 Partial: 8 Not: 5 N/a: 0

## Cardiac Patient Decision Aids Systematic Review

Study details	Study design	Methods, sample, and setting	Results	No. of SUNDAE items met
Harris et al. <sup>56</sup> 2022, UK	Multi-phase, multi-centre development and acceptability testing of a PtDA for people with stable angina considering elective coronary angioplasty treatment ( <b>CONNECT</b> <sup>56</sup> )	<p>Setting: 2 District General Hospitals in Northern England. 34 patients and 29 HCPs in total involved in various stages</p> <p>1) Steering Group convened, evidence review, and 3 co-design workshops with 4 cardiologists, 9 nurses, &amp; 9 members of heart support groups.</p> <p>2) Alpha-testing of prototype 1 (cognitive interviews and acceptability questionnaire) with 9 HCPs and 6 patients, 1 patient/partner dyad in non-clinical settings. Patient sample: mean age 63 (SD 11) years; 29% female; 85% achieved College education; 71% had adequate HL.</p> <p>3) PtDA refined and prototype 2 developed following consultations with 10 service users, 7 HCPs and the Steering Group. Feedback on prototype 2 collated from 9 new volunteers from community heart support groups, 1 Steering Group lay member, and 2 consultant cardiologists.</p>	<ul style="list-style-type: none"> <li>• Web-based PtDA designed to be delivered at point of referral for PCI. Clinical evidence informed risks and benefits of treatment options.</li> <li>• Participants felt the PtDA was acceptable, usable, comprehensible, desirable; has potential to facilitate SDM; and may improve patient safety via evaluation &amp; communication of symptoms. Some cardiologists disagreed with the risk information content.</li> <li>• CONNECT prototype 2 achieved all 12 applicable mandatory qualifying and certification criteria of the IPDAS checklist. Preferences for risk presentation varied.</li> </ul>	Full: 16 Partial: 2 Not: 0 N/a: 8
Hinsberg et al. <sup>62</sup> 2018, USA	Single-centre randomised comparator pilot trial to compare effects of two PtDAs for stable angina. DVD/booklet PtDA: <b>Treatment Choices for Stable Chest Discomfort</b> <sup>53</sup> Web-based PtDA: <b>Should I Have Angioplasty for Stable Chest Angina?</b> <sup>52</sup>	<p>Setting: Massachusetts General Hospital Heart Centre Patients (n=28) who had recently made decisions about treatment of stable CAD were randomised to DVD/paper booklet PtDA or web-based PtDA.</p> <p><u>DVD/booklet PtDA</u> (n=15): mean age 73 (SD 11.6) years; 60% female; 100% White; 80% achieved College education or greater.</p> <p><u>Web-based PtDA</u> (n=13): mean age 67 (SD 10.62) years; 23% female; 92% White; 54% achieved College education or greater.</p>	<ul style="list-style-type: none"> <li>• Total knowledge scores: ↑ with DVD/booklet PtDA*</li> <li>• Treatment preference for PCI: ↑ with web-based PtDA (NS)</li> <li>• Patient satisfaction: ↑ with DVD/booklet PtDA (NS)</li> <li>• Viewed all the PtDA: ↑ with DVD/booklet PtDA (NS)</li> <li>• &gt;20 min viewing the PtDA: ↑ with DVD/booklet PtDA (p=0.05)</li> </ul>	Full: 19 Partial: 4 Not: 2 N/a: 1
Scalia et al. <sup>64</sup> 2018, USA	Cross-sectional observational study to evaluate whether Option Grid PtDAs change treatment preferences and which items of the PtDA are most important to users	Audit data collected from users of Option Grid PtDAs who had an account on the Option Grid website, over a 19-month period (June 2015 onwards). User responses in the PtDAs were collected from the top 5 most-used PtDAs. The Angina PtDA was accessed and fully completed by 88 users (47% female; 11% Hispanic, 46% not Hispanic, 43% ethnicity not stated;	For Angina treatment options: no significant preference shift between medical management and stenting; p=0.200.	Full: 16 Partial: 6 Not: 2 N/a: 2



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Study details	Study design	Methods, sample, and setting	Results	No. of SUNDAs items met
	PtDA: <b>Angina treatment options Option Grid</b> <sup>49</sup>	age range: 11% 20-30 yrs, 16% 31-40 yrs, 18% 41-50 yrs, 17% 51-60 yrs, 10% ≥ 60 yr, 27% not stated).		

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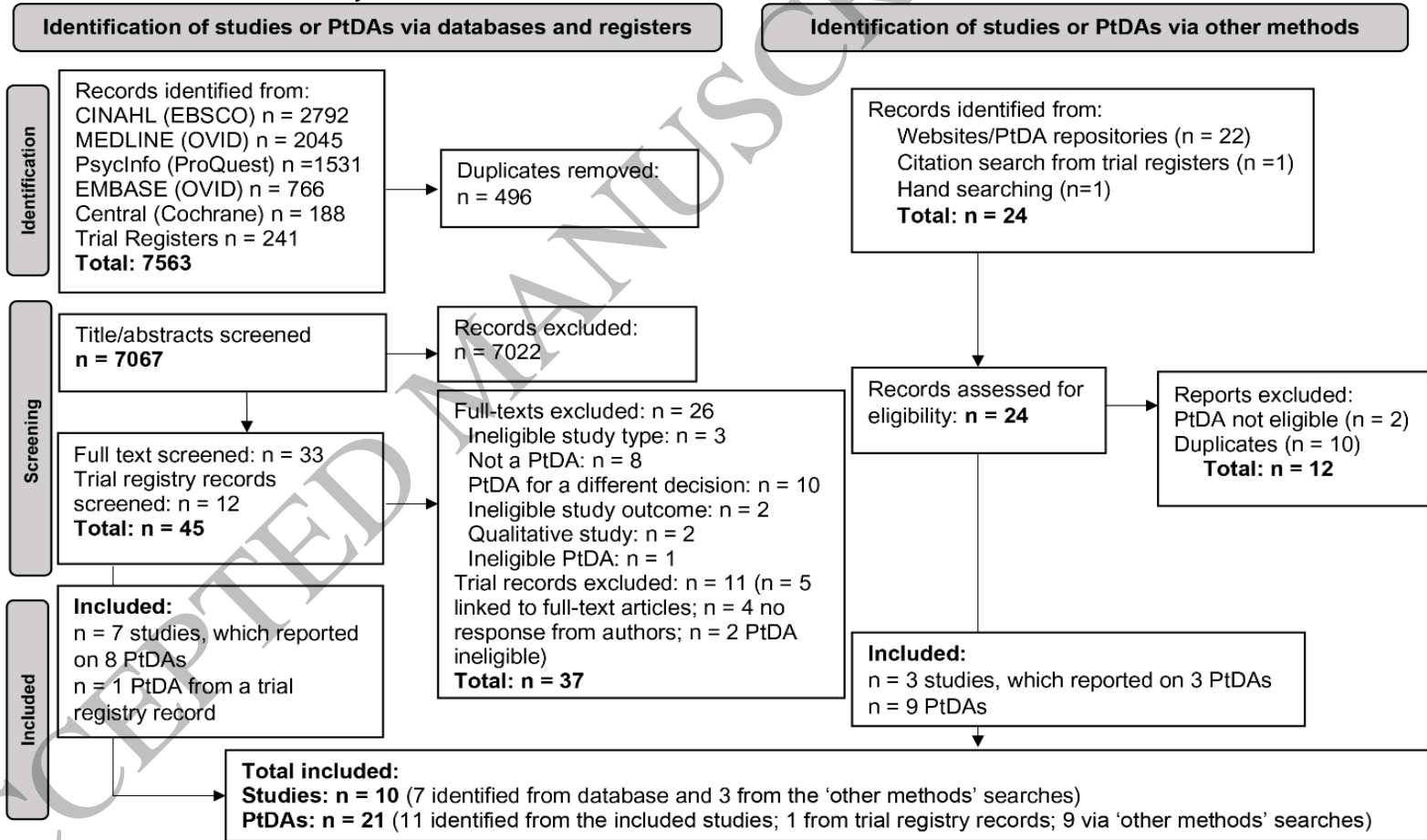


Figure 1  
 167x102 mm (x DPI)

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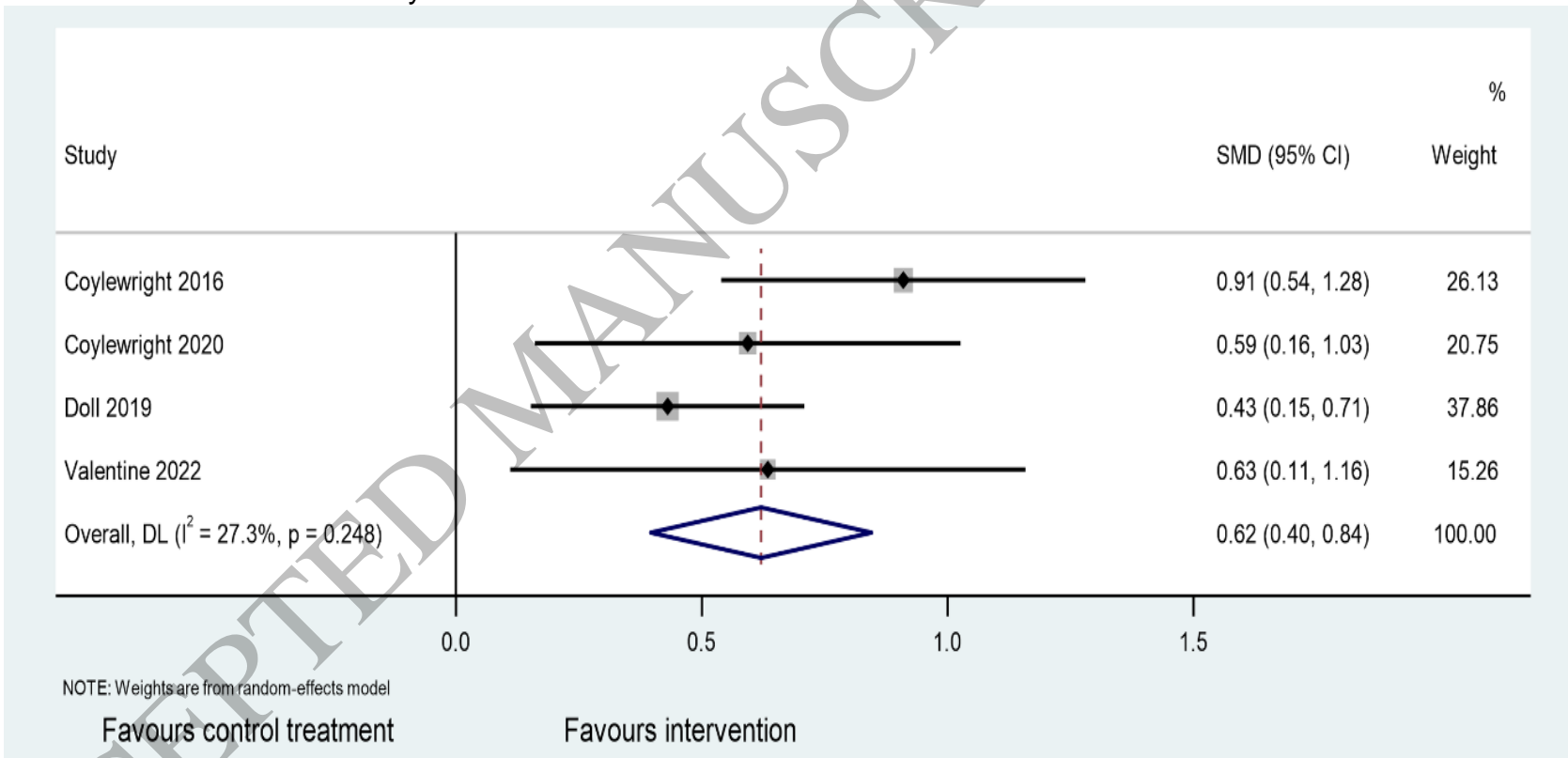


Figure 2  
158x58 mm (x DPI)

Cardiac Patient Decision Aids Systematic Review

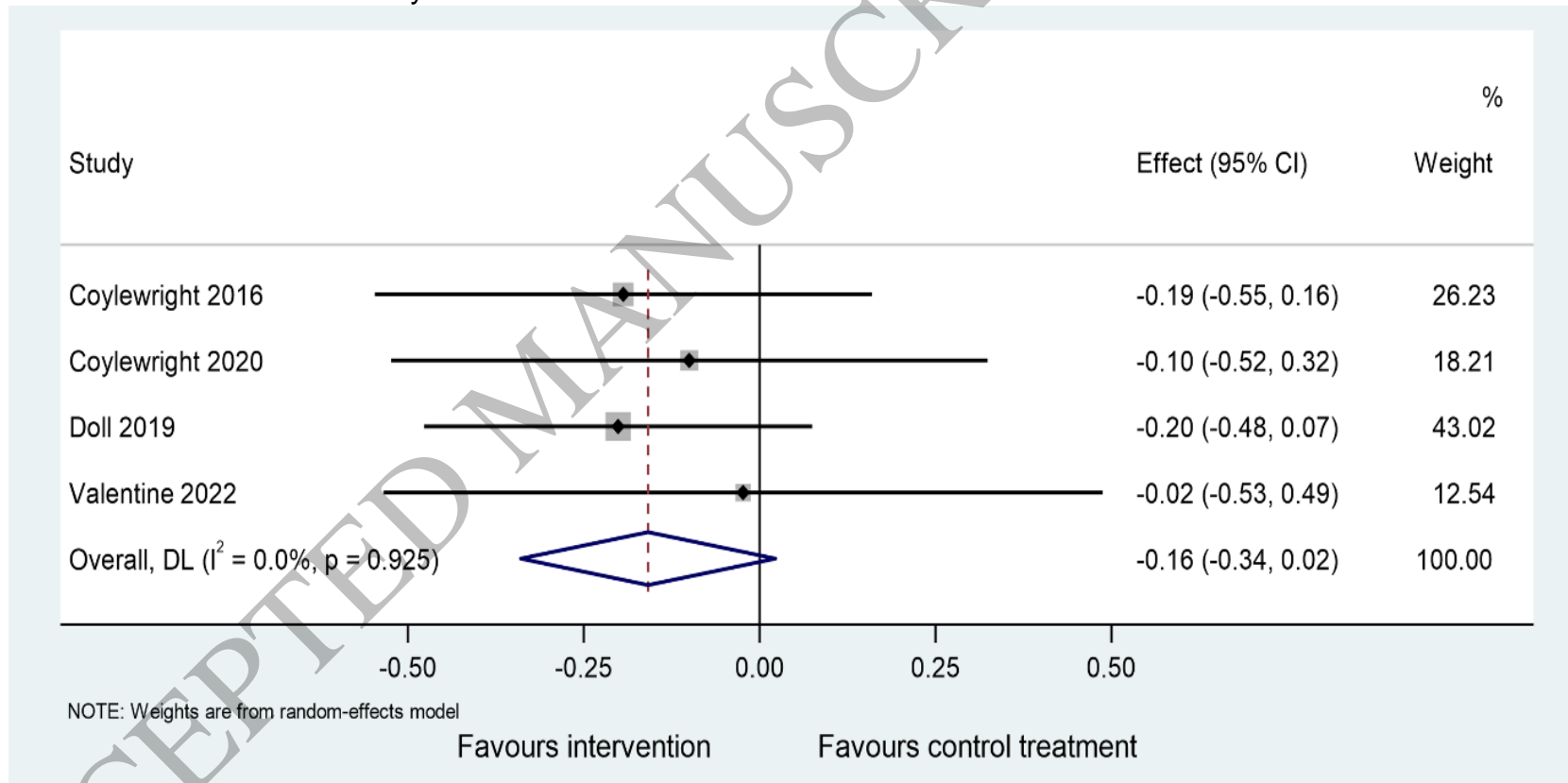


Figure 3  
158x69 mm (x DPI)

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	<u>D1</u>	<u>D2</u>	<u>D3</u>	<u>D4</u>	<u>D5</u>	<u>Overall</u>
Coylewright et al. 2016						
Valentine et al. 2022						

D1 Randomisation process

D2 Deviations from the intended interventions

D3 Missing outcome data

D4 Measurement of the outcome

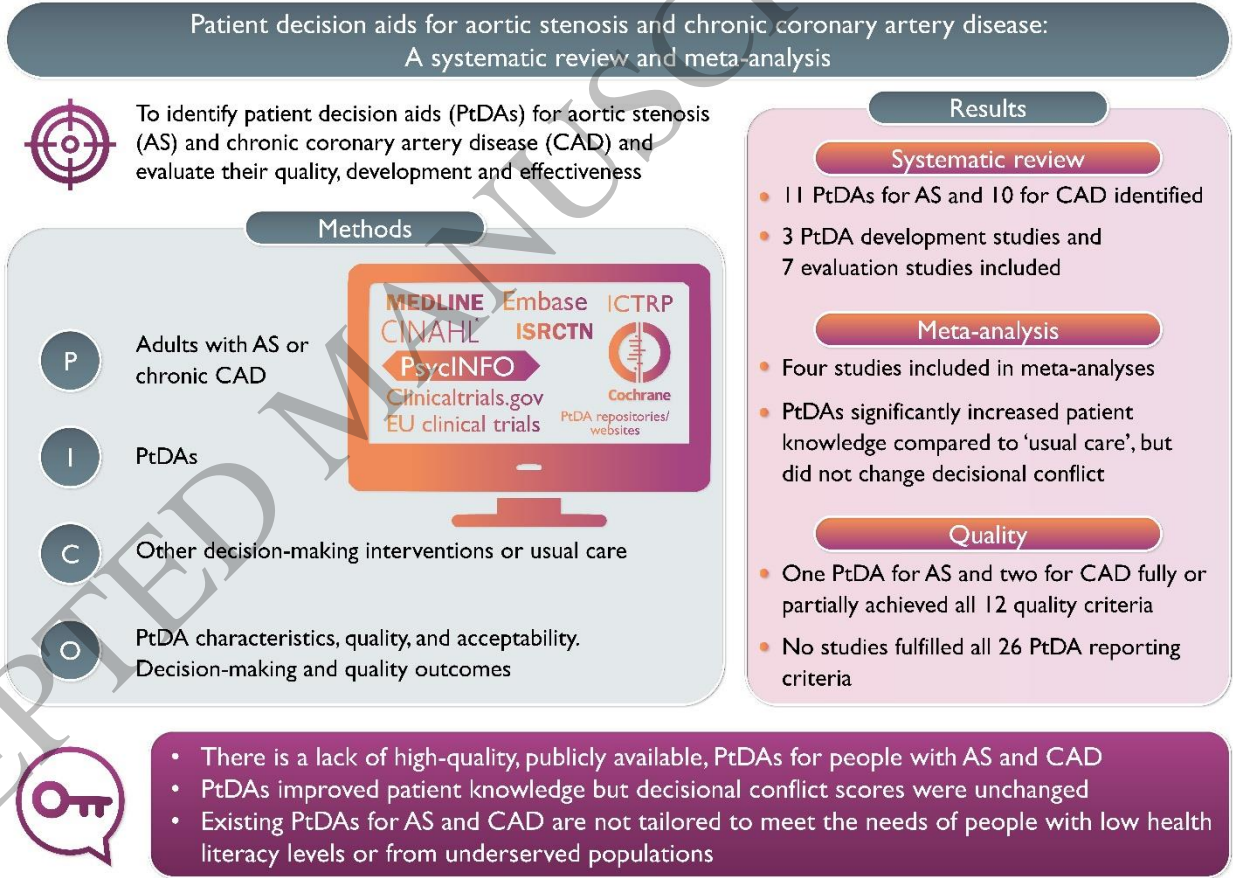
D5 Selection of the reported result

Low risk

Some concerns

Figure 4  
167x59 mm (x DPI)

# Cardiac Patient Decision Aids Systematic Review



## Graphical Abstract

167x121 mm (x DPI)