

IIR 15-
085 Preferences for Open Vs. Endovascular
 Repair for Abdominal Aortic Aneurysm

Document Date 4/10/2023
NCT 3115346

Protocol 16-16 HSRD (Goodney)

Alignment of Treatment Preferences and Repair Type for Veterans with AAA

Funding Agency: HSR&D

Principal Investigator/Study Chair: Philip P. Goodney, MD

[Version Number 1.2]

Abstract

Nearly 5,000 Veterans undergo abdominal aortic aneurysm (AAA) repair each year in VA hospitals. Randomized trials, including the VA-based Open Versus Endovascular Repair (OVER) Trial, have found endovascular AAA repair (EVAR), is associated with lower perioperative morbidity and mortality, less pain, and shorter length of stay than open surgical repair (OSR). However, OSR is more durable, has fewer long-term complications such as late rupture, and Veterans treated with EVAR and OSR have similar survival within two years following surgery. Given these tradeoffs, controversy remains as to which method is best suited for an individual Veteran who AAA repair, and preliminary analyses needs have found broad variations across VA hospitals in how Veterans are treated for AAA.

Treatment decisions for AAA need to be aligned with Veterans' preferences. For example, a Veteran for whom a rapid recovery is of primary importance and long-term durability a lesser concern has a treatment preference which aligns most closely with EVAR. Similarly, a Veteran who wishes to avoid repeated follow-up visits and late re-interventions has a treatment preference that aligns most closely with OSR. However, while AAA treatment type varies across VA hospitals, it is unknown if these treatment variations occurs as a result of Veterans preferences, or independent of Veterans' preferences. Surgeon preferences for repair type have been poorly described, especially for surgeons treating Veterans.

In preliminary work, we have performed observational analyses, surveys, and cognitive interviews. This work has demonstrated variation in AAA repair type in VA and refined qualitative methods to better understand Veterans' and surgeons' treatment decisions. In this proposal, in a cohort of Veterans who are candidates for either repair type (OSR or EVAR), we will use a survey explore Veterans' knowledge and preferences for AAA repair, and determine if Veterans who receive a decision aid as well as the survey are more likely to receive their treatment choice.

We describe a cluster-randomized trial comparing two ways to better align Veterans' preferences and treatments for AAA: (1) a validated decision aid describing AAA repair types with a survey measuring Veterans' preference for repair type -- versus (2) the survey alone. Enrolled Veterans will be candidates for either endovascular or open repair, and be followed at VA hospitals by vascular surgery teams who regularly perform both types of repair. In Aim 1, we will determine Veterans' preferences for endovascular or open repair and identify domains associated with each repair type. In Aim 2, we will compare agreement between Veterans' preferences and repair type between the decision aid+survey and survey-alone groups. We will identify factors associated with agreement. Our findings will be reported to the National Surgery Office Vascular Surgery Advisory Board to help ensure Veterans' preferences remain at the center of AAA treatment decisions. We have recruited 20 VA Medical Centers and their vascular surgery teams who are anxious to participate in this important trial to help Veterans make the best decisions.

List of Abbreviations

AAA: Abdominal aortic aneurysm

LSI: Local Site Investigator

NIH: National Institute of Health

NHLBI: National Heart, Lung and Blood Institute

PHI: Protected Health Information

TDI: The Dartmouth Institute for Health Policy & Clinical Practice

SVS: Society for Vascular Surgery

VISN: Veterans Integrated Service Network

Table of Contents

Contents

1.	Introduction.....	7
2.	Study Team	11
3.	Study Sites	14
4.	Study Design	16
5.	Study Committees	22
6.	Coding Guide and Data Management Plan	22
7.	Data Analysis	23
8.	References	27

Appendices

1. Site Enrollment Guide
2. Survey Instruments for Intervention and Control Groups
3. International Patient Decision Aid Standards Criteria Checklist
4. Shared Decision Making Training Course Summary
5. Study Introduction Script

1. Introduction

Background

Abdominal aortic aneurysm is the 14th leading cause of death among men over age 60, and a common condition among United States Veterans.^{4, 5}

Approximately 250,000 Veterans have AAA, and nearly 5,000 patients are treated for AAA annually to prevent rupture.^{1, 6-9}

Before the advent of endovascular devices in the late 1990s, open surgical repair of AAA was the only treatment option for patients with AAA. In open surgical repair, a large abdominal incision is necessary, and clamps are applied to the aorta - the largest blood vessel in the body. Surgical reconstruction is performed as shown in Figure 1. The risk of perioperative death is 3-5% for open AAA repair, even in hospitals skilled in this major operation. The chance of major complications such as bleeding, need for further surgery, or heart attack, can approach 20% within the first year.¹⁰⁻¹³

The development of endovascular AAA repair (called EVAR) in the 1990s changed the treatment options available for patients with AAA¹⁴. Stent-grafts could be placed through small incisions in the groins to exclude the aneurysm from blood flow, without any need for a large abdominal incision or aortic clamping (Figure 2). Short term recovery was now much simpler, and vascular surgeons rapidly adopted this new technique.

Equipoise between repair types for AAA:

Endovascular repair and open surgery have been compared extensively in a variety of settings, including large randomized trials within VA^{1-3, 9}. In these studies, the less-invasive nature of endovascular repair demonstrated several advantages: lower rates of perioperative mortality (less than 2% versus 5%), shorter length of stay (2 versus 7 days), and better patient quality of life earlier after AAA treatment¹⁵. However, endovascular repair had clear disadvantages as well. For example, Veterans treated with EVAR commonly develop leaks around their graft called endoleaks, which can require secondary procedures, and can result in late aneurysm rupture¹⁶⁻²¹.

These tradeoffs have made it difficult to find a clear “winner” between endovascular repair and open surgery. While the randomized trials gave surgeons and Veterans important information about the short and long-term outcomes of each approach, they failed to identify a single AAA repair type that would be best for all Veterans with AAA. Because of these tradeoffs, equipoise still remains as to the optimal AAA repair type.

Variation in treatment type for AAA: This equipoise in AAA repair type has led to variation in AAA repair type across VA hospitals (Figure 3). While many have studied changes in AAA repair type in Medicare patients³⁹⁻⁴¹, variation in repair type in VA hospitals has received less attention. Therefore, to explore this variation, we performed preparatory-to-research analyses⁴². Our work demonstrated four-fold variation in repair type across different VISNs. For example, in 2009, nearly 80% of AAAs were

Figure 1: Open AAA Repair

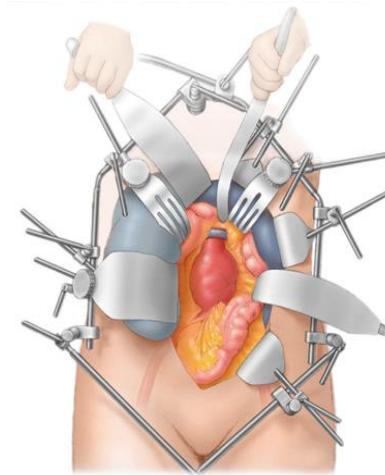
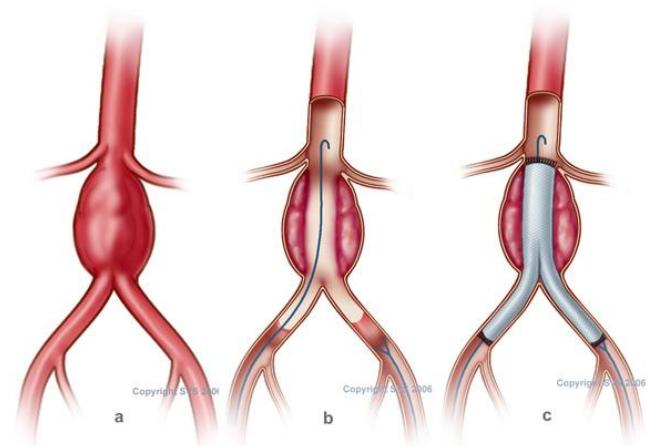


Figure 2: Endovascular AAA Repair



repaired with open surgery in VISN 8, and 20% underwent endovascular repair (Figure 3).

However, in VISN 1, the opposite was true – fewer than 20% of AAAs were repaired using open repair, and more than 80% were repaired with endovascular repair. The results seen at the VISN level were similar in a recent survey of the twenty sites in our study. Preliminary analyses also showed us that measuring AAA repair within the VA itself is necessary. For example, we measured the proportion of AAA treated with open repair in VA in the last five years. We found that the proportion of AAA repaired with open repair declined by 3% in absolute terms, from 36% to 33%⁴². When compared to patients treated at non-VA hospitals, using data from the Society for

Vascular Surgery⁴³, the decline in open repair was 19% in absolute terms (from 40% to 21%). These data suggest that treatment preferences for Veterans differ from non-Veteran populations. As such, using data from non-Veterans is unlikely to be a good substitution, and it would be best to learn about our Veterans' preferences directly – from our Veterans themselves.

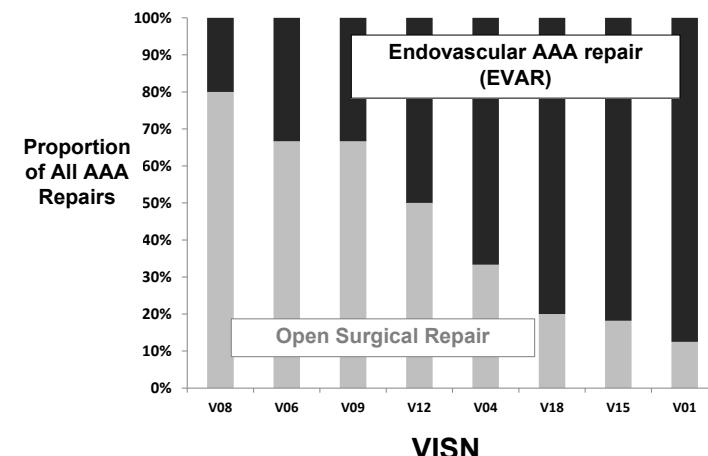
Why we need to understand Veterans' preferences: After our preparatory-to-research analyses, two findings were clear: (1) high-quality randomized trials have demonstrated that outcomes such as aneurysm-related mortality and overall mortality are equivalent between endovascular and open repair, and (2) significant variation in AAA repair type exists across VA. One might ask, why does it matter if there is variation in AAA repair type if the two repair types are similar, based on traditional procedure-related outcomes?

The best answer to this question integrates three important concepts: the disparate nature of the two repair types, the risks inherent to each repair type, and the need to align treatment for AAA with Veterans' preferences. Open repair requires a large abdominal incision, a greater physiologic challenge during surgery, and a more prolonged recovery when compared to endovascular repair, but is more durable than endovascular repair. A Veteran who must travel long distances for appointments, for whom reliable follow-up is not possible, or who has chronic worry and anxiety, has treatment preferences likely to align with open repair. Conversely, endovascular repair, while less invasive, requires close follow-up with multiple imaging tests for several years after repair, with the potential for late complications years following the initial treatment. A Veteran who needs to return to work quickly to ensure that his or her job is not endangered by a prolonged recovery has a treatment preferences likely to align with endovascular repair. Therefore, aligning Veteran preference and repair type is necessary to achieve the best patient-centered outcomes.

Have Veterans' preferences for AAA repair type been examined before? Significant attention has been dedicated towards determining the comparative effectiveness of endovascular and open repair. However, less attention has been given to understanding Veterans' preferences for repair type. In fact, other than measuring quality of life metrics in the context of VA randomized trials²³, to the best of our knowledge, Veterans' preferences for repair type remain undescribed. Three studies outside of VA – two surveys of National Health Service beneficiaries in England^{44, 45} and a report of six focus groups in Canadian patients⁴⁶ – have begun to study patient preferences for AAA repair type. However, these findings may, or may not, represent the preferences seen in US Veterans. These preliminary analyses suggest studies within the VA are necessary.

Why would a Veteran receive an AAA repair type that is not aligned with his/her preference? To better understand why a Veteran might receive a repair that was not aligned with his or her preferences, we performed two preliminary cognitive interviews with Veterans who underwent endovascular or open repair in recent years. Findings from these interviews led us to develop a theoretical model built upon

Figure 3: Variation in Repair Type in VA Hospitals in 2009



two well-known theories outlined by experts in shared decision making: a lack of informed choice (described by Fowler⁹ and Weinstein^{47, 48}) and an overestimate or underestimate of risks (described by Barry and Elwyn^{5, 6, 8}).

Lack of informed choice: First, the Veteran may not have a preference because he or she was never given the opportunity to clearly understand the options for treatment^{47, 48}. If the Veteran has not been fully apprised of the treatment options, he or she is not capable of making a truly “informed” decision.

For example, during our interview, one Veteran at our center described his interaction:

The surgeon simply told me, “Your aneurysm needs to be repaired, and it is best for us to fix it using the new way, endovascular.” I never knew there was a choice, and they never gave me an option”

Given the time constraints of current surgical practice, surgeons often use paternalistic care patterns to assign patients with the treatment the surgeon feels is “best” – without reviewing other options with patients. Surgical decisions, especially those made in the context of cardiovascular diseases which require time tradeoffs and competing risks, can be especially difficult for physicians to explain^{6, 49, 50}. Therefore, this *lack of informed choice* does little to foster shared decision-making with Veterans about ways to repair AAA^{48, 49}.

- *Overestimate or underestimate risks:* Even if a physician actually attempts to engage a patient in sharing knowledge about a health care decision, two tendencies can “derail” the process of shared decision making. First, the description can be biased in a way that reflects the providers’ beliefs and assumptions, rather than the patients⁵¹. Second, patients may not understand the magnitude of the risks, as patients tend to overestimate benefits and underestimate risks^{6, 49, 50}. These tendencies can result in providers following the “letter of the law” in shared decision-making, but still ending up with a decision that is unlikely to be aligned with the Veterans’ preferences for treatment.

My surgeon explained, “Your aneurysm is now large enough that we should repair it. While there are two ways to fix the aneurysm, the better choice for you is an endovascular, because you will recover more quickly.” But I ended up having to come back for many visits over the years, because of leaks. I even needed a second procedure. Maybe it would have been better to just fix it the old-fashioned way.”

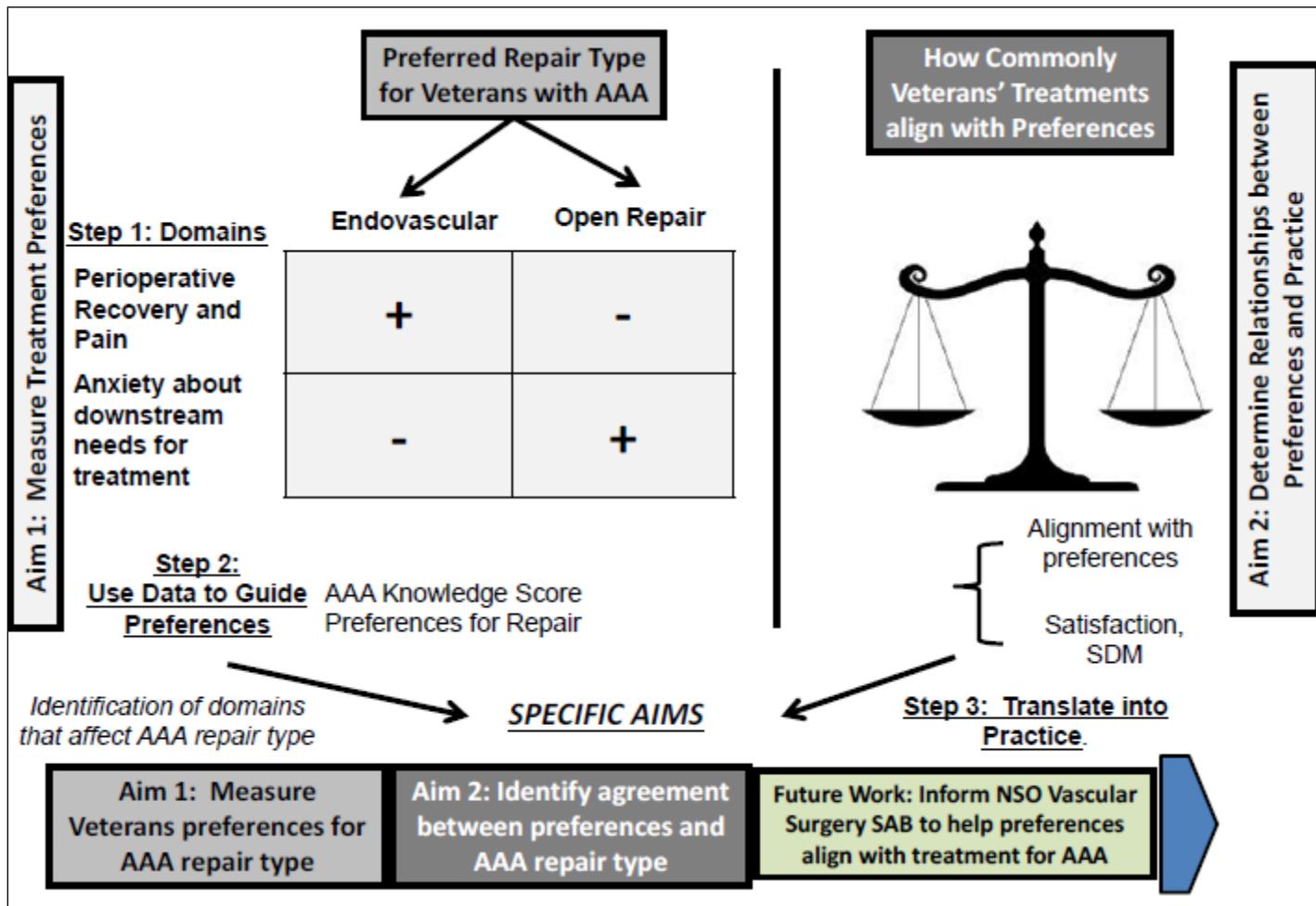
How considering Veterans’ preferences will help to improve outcomes: Misalignment of treatment preferences can result in poorer satisfaction with surgery^{52, 53}. This dissatisfaction can have real effects for Veterans. For example, Veterans treated with open repair may have more complications, more work loss, greater rates of depression, and more social isolation because of the longer recovery time^{32, 54-56}. Similarly, for Veterans treated with endovascular repair, the need for continued surveillance with radiation-based CT scans, worries about complications, and the need for family support can have deleterious effects as well^{24, 25, 40}.

Shared decision-making is an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options to achieve informed preferences^{57, 58}. The Veterans Health Administration has urged the adoption of shared decision-making for decisions facing elderly Veterans, such as decisions for long-term care⁵⁹. These efforts in VA were developed along with the Informed Medical Decisions Foundation, which is led by Dr. Michael Barry. Dr. Barry is a Co-Investigator in this proposal, and represents an important link to the VA’s existing work in shared- decision making¹⁰. Our proposal will help advance this science by determining how to best use shared decision-making models in the treatment of Veterans with vascular disease in VA. Poor decision satisfaction and limited shared decision-making are likely to result when treatment decisions are made without considering patient preferences^{60, 61}. We hypothesize that *overestimating or underestimating risk* may result in poor alignment between Veterans’ preferences and the repair type they receive for treatment of their AAA.

Specific Aims

We describe a cluster-randomized trial comparing two ways to better align Veterans' preferences and treatments for AAA: (1) a validated decision aid describing AAA repair types with a survey measuring Veterans' preference for repair type -- versus (2) the survey alone. Enrolled Veterans will be candidates for either endovascular or open repair, and be followed at VA hospitals by vascular surgery teams who regularly perform both types of repair. The conceptual framework for our study is illustrated in Figure 4.

Figure 4: Conceptual Model



Aim 1: To identify Veteran and surgeon factors associated with preference for endovascular or open repair. We will use validated survey instruments to determine repair type preference (endovascular or open) for Veterans and surgeons, and identify domains in our survey associated with each repair type.

Hypothesis (H1): We hypothesize Veterans who prioritize concerns about pain or disability will prefer endovascular repair, and Veterans who prioritize concerns about durability will prefer open repair.

Aim 2: To determine the effect of the decision aid on agreement between preference and repair type. AAA growth rate estimates suggest 85% of our cohort will undergo repair within our two – year study period. Among patients in the intervention and control groups who undergo repair, we will compare how commonly Veterans receive the repair type they indicated as their preference. We will study potential explanatory variables from our survey, such as AAA knowledge, between the intervention and control groups. Patient satisfaction and shared decision making will be assessed in both the intervention

and control groups.

Hypothesis (H2): Our intervention will be associated with better agreement between preference and treatment type for Veterans with AAA, as well as higher post-operative satisfaction and greater shared decision-making.

2. Study Team

Dr. Goodney, the Principal Investigator, is a VA vascular surgeon and Co-Director of the VA Outcomes Group in White River Junction. A current NIH K08 awardee in health services research, he is experienced in conducting multicenter, cluster-randomized clinical trials^{61, 62}. He is currently the Principal Investigator of a multicenter cluster-randomized trial of a smoking cessation quality improvement intervention funded by the Society for Vascular Surgery⁶². Dr. Goodney has assembled a team (Table 1) with extensive expertise in survey research (Dr. Sirovich), shared decision-making (Dr. Barry), and analyzing outcomes in VA (Drs. West and Mackenzie). Finally, Dr. Goodney and his team members have worked together before in several projects^{63, 64}, many of which have studied physician practice⁶⁴⁻⁶⁶, so they are well prepared to collaborate effectively in this study. Their team, including 20 site PIs, have collaborated on several projects which have studied physician practice⁷¹⁻⁷³ and each has significant time dedicated towards the proposal.

Table 1: Key Personnel

Team Member	Role	Skill Set	Task Aims
Philip Goodney, MD, MS	Principal Investigator	Vascular surgery, quantitative analyses, cluster-randomized trials	Overall project execution 1, 2
Brenda Sirovich, MD, MS	Co-Investigator	Assessing physician practice, preference-sensitive care using surveys	Interpret survey results in Aim 1 1
Michael Barry, MD	Co-Investigator	Shared Decision-Making, decision aids	Interpret survey results in Aim 1 and Aim 2 1,2
Alan West, PhD	Co-Investigator	Statistician and Epidemiologic Support, VA data architecture	Implementation of pilot trial, randomized trial design, VINCI data 2
Todd Mackenzie, PhD	Co-Investigator	Biostatistics, observational dataset analyses, cluster trial design	Observational analyses, cluster trial design, statistical 1,2

KEY PERSONNEL

Philip P. Goodney, MD, MS Principal Investigator. Dr. Goodney is an Associate Professor of Vascular Surgery and Co-Director of the VA Outcomes Group at the White River Junction VA. He is an affiliated faculty at The Dartmouth Institute for Health Policy & Clinical Practice (TDI) at the Geisel School of Medicine at Dartmouth. He received a Career Development Award in 2010 from the National Heart, Lung and Blood Institute (NHLBI) (K08HL05676) and the 2011 Lifeline Award from the Society for Vascular Surgery (SVS) to study variation in treatment and intensity in vascular care. In 2012, he was appointed Director of Surgical Outcomes Research at Dartmouth-Hitchcock Medical Center, and in 2013 he was named the Co-Director of the VA Outcomes Group at the White River Junction VA. In 2014, he received the Multicenter Trials Planning Grant from the SVS, and in 2015 he received funding from PCORI and FDA for patient-centered research. He has experience in studying the delivery of vascular care, surgical quality improvement efforts, and cluster- randomized trials in patients with vascular disease. In this study, Dr. Goodney will lead the team's efforts in a cluster-randomized trial that will compare the effect of two different strategies (decision aid plus survey versus survey alone) in helping determine the best ways to align Veterans' preferences for repair type in abdominal aortic aneurysm with their treatment. Dr. Goodney will devote 3.6 calendar months of his time to the project in each of the four years.

Brenda Sirovich, MD, MS Co-Investigator / Survey Research and Veterans' Preferences. Dr. Sirovich is Co- Director of the VA Outcomes Group at the White River Junction VA Medical Center (in partnership with Dr. Goodney). She is also Associate Professor of Medicine and Community and Family Medicine at Geisel School of Medicine at Dartmouth. With funding from HSR&D and the National Institutes on Aging, she is a nationally recognized researcher studying clinical practice intensity – a measure of practice patterns of physicians, with a focus on their thresholds to make invasive and non-invasive treatment decisions. Her work examining Pap smear screening practices and geographic variation in physician practice has been cited widely in the medical and lay media, and has been included in CME training programs. She has led research teams conducting two large successful national physician surveys, and has served on the VISN1 Specialty Consult Utilization Council. Given her broad expertise in survey research, she will assist Drs. Goodney, Barry, West, and MacKenzie in the development and execution of the cluster-randomized trial. She will devote 3.6 calendar months of her time in each of the four years of the project.

Michael Barry, MD (IPA) Co-Investigator / Decision Aids and Shared Decision-Making. Dr. Barry is the President of the Foundation for Informed Medical Decisions, the Chief Scientific Officer of Healthwise, and an internationally recognized expert on decision aids and shared decision-making. He has extensive experience in the development, testing, and implementation of decision aids to foster shared decision-making, especially regarding treatments related to surgery. He has collaborated with Dr. Goodney in prior work on the Dartmouth Atlas of Healthcare, and will extend these collaborations to this work as well. Specifically, he will work closely with Dr. Goodney to implement the survey and decision aid. He will subsequently analyze and interpret the results of the cluster-randomized trial. He will share his expertise in determining the domains that influence patient preferences. He will also be instrumental in interpreting findings related to the agreement between patient preferences and treatments and will help shape the recommendations that emanate from these findings. He will not have access to PHI. Dr. Barry will dedicate .6 calendar months in year 1, .3 calendar months in years 2 and 3, and 1.2 calendar months in year 4 of the project.

Alan N. West, PhD Co-Investigator / Quantitative Research. Dr. West is an experienced health services researcher who has been awarded three HSR&D IIR awards examining practice patterns in VA and non-VA healthcare, especially in comparison to Medicare claims (HSR&D IR 11-319, 07-233, and 04-306). Dr. West was Deputy Director of the Veterans Rural Health Resource Center (Eastern Region) and has published widely on health care access and utilization among VA patients. Given his extensive knowledge of VA administrative and clinical datasets, Dr. West will collaborate with Dr. Goodney to perform the cluster-randomized trial as outlined in Aim 1 and Aim 2, and will construct secure infrastructure for the conduct and receipt of study-related datasets. Dr. West will devote 1 calendar month of his time in all four years of the project.

Todd A. MacKenzie, PhD Co-Investigator / Biostatistician (IPA). Dr. MacKenzie, a Senior Biostatistician at Geisel School of Medicine at Dartmouth, has a long history of collaboration with Dr. Goodney, Dr. West, and other VA HSR&D investigators. He has extensive expertise in providing statistical collaboration in clinical trials and multilevel hierarchical modeling. Further, he has previously collaborated with Dr. Goodney and his team on analyses incorporating large observational datasets, including VA datasets, Medicare claims and clinical registry data. Specifically, he has served as a biostatistician on Dr. Goodney's NHLBI career development award, and they currently collaborate on a cluster-randomized trial funded by the Society for Vascular Surgery. In this study, in collaboration with Dr. Goodney and Dr. West, Dr. MacKenzie will oversee the implementation of statistical analyses, especially in the multilevel models described in Aim 1, as well as any weighted kappa calculations that are necessary in Aim 2. Dr. MacKenzie will devote 1.2 calendar months of his time in all four years of the project.

OTHER PERSONNEL

Cory Gaudette Central Study Coordinator: Our cluster-randomized trial entails the need for extensive coordination, oversight, and technical support for the study participants. To most effectively accomplish this goal, we will use a Central Study Coordinator. The Central Study Coordinator will be responsible for maintaining IRB approval of the Study Protocol, coordinating training meetings for Site Study Coordinators, implementing the randomization scheme, and overseeing enrollment and follow-up goals at each of the study sites. Further, the Central Study Coordinator will work with each of the Site Study Coordinators to receive and catalogue survey data forms and case report forms. As the survey data forms will contain the first initial of patients' last name and last 4 digits of their SSN, Ms. Gaudette will have access to this PHI. The Central Study Coordinator will also work with Dr. Goodney in coordination of study processes files between the study participants, assist in project analyst supervision, and coordinate the editorial process for manuscripts and reports. Ms. Gaudette is ideal for this role, having managed several large projects in her role as the Administrative Officer of the VA Outcomes Group, and she coordinated the study sites for this proposal. Ms. Gaudette will devote 6 calendar months of her time in all four years of the project. She will retain her VA appointment at the White River Junction VA Medical Center.

Amy Voorhees, MS Programmer / Analyst. Amy Rose is a program analyst at the White River Junction VA and currently works within the VA Outcomes Group. Ms. Rose has several years of experience designing research protocols and analyzing complex administrative and clinical databases in the Department of Veterans Affairs and in the private sector. Her analytic skills include proficiency in SAS programming, and she is highly knowledgeable regarding VHA databases. Ms. Rose will access and construct the VA analytic files and work with Dr. Goodney and Dr. West to construct analytic datasets from the study information within Aim 1 and Aim 2. Ms. Rose will also be responsible for data analyses. Ms. Voorhees will devote 2.4 calendar months of her time in all four years of the project.

Kayla Moore, MPH Research Project Director. Kayla Moore is a seasoned program manager with ten years' experience coordinating federal and privately funded health programs at academic and nongovernmental organizations. She currently works with Dr. Goodney and other surgical investigators at The Dartmouth Institute for Health Policy and Clinical Practice to operationalize surgical health services research projects. For this study, she will be responsible for managing start-up and administrative operations and facilitating IRB approval. Ms. Moore is in the process of receiving a VA WOC appointment at the White River Junction VA Medical Center. She will not have access to PHI.

To Be Named Central Research Nurse Coordinator. Our cluster-randomized trial will also require a Central Research Nurse Coordinator. The Central Research Nurse Coordinator will also help to support each of the Site Study Coordinators for clinical support. Specifically, the Central Research Nurse Coordinator will partner with the Central Study Coordinator to perform biweekly support calls and assist Site Coordinators with measuring study outcomes, especially measuring outcomes pertinent to Aim 2 (i.e., determining when Veterans undergo AAA repair). The Central Research Nurse Coordinator will dedicate 4.2 calendar months of their time in all four years of the project.

OTHER PERSONNEL: LOCAL SITE INVESTIGATORS AND SITE STUDY COORDINATORS FOR TWENTY STUDY SITES

Each Local Site Investigator, named in Table 2 below, is a vascular surgeon in active practice at one of the 20 local VA hospitals participating in the study. Each Local Site Investigator regularly performs the procedures studied in this trial in routine practice. They will lead enrollment activities at their local site and will provide administrative support to the Site Study Coordinator in all four years of the project. Each Local Site Investigator will dedicate .6 calendar months in years 1 and 2, and .3 calendar months in years 3 and 4 of the study.

To Be Named The Site Study Coordinator is a role that will be filled by a portion of a research nurse, physician assistant, nurse, or nurse practitioner at each site. The Site Study Coordinator will be responsible for IRB submission, patient enrollment and consent, study intervention, and data submission from each site. Each Site Study Coordinator will identify and follow twelve Veterans from each site and receive specific training and biweekly oversight from the Principal Investigator and the study team. The Site Study Coordinator will dedicate 1.2 calendar months in each year of the study.

Who will have access to protected health information

Local Site Investigators and Site Study Coordinators will have access to protected health information (PHI) for participants only at their sites during recruitment for eligibility screening and during follow-up data collection. They will also have access to patient's records for care received while undergoing treatment for AAA that is not part of this research. Local Site Investigators and Site Study Coordinators will not have access to study data or PHI from any study sites other than their own. Ms. Cory Gaudette, the Central Study Coordinator who receives and catalogues the surveys will also have access to PHI. On the PI team, Dr. West will have access to PHI for the purpose of assigning unique study IDs to code study data. All VA protocols for maintaining privacy and confidentiality of PHI will be strictly adhered to and the study key will be maintained behind VA firewalls and accessible only to VA credentialed personnel.

CONSULTANTS

Michael Barry, MD, Co-Investigator will be hired as a consultant. As described on page 10 above, his role is to provide expertise regarding the implementation of the survey and decision aid and interpretation of results. As stated on page 10, he will not have access to PHI.

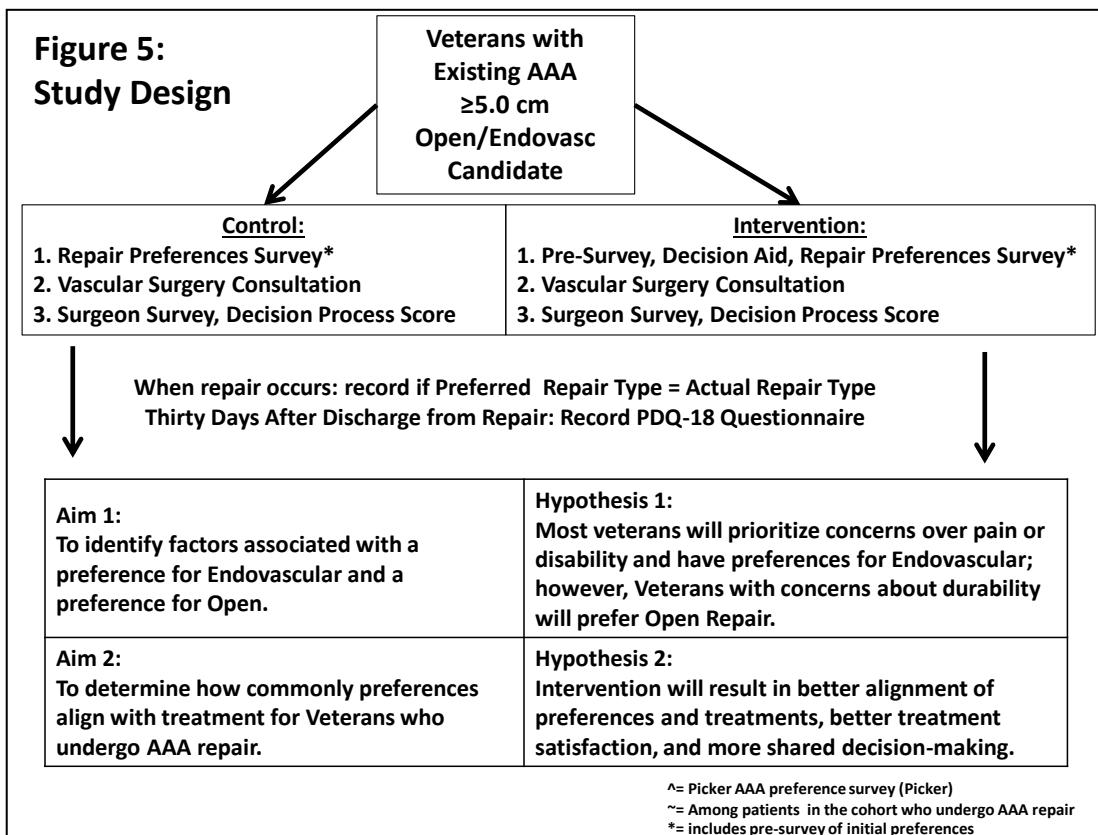
3. Study Sites

We have recruited a nationally representative sample from twenty VA hospitals across the country (Table 2). Our preparatory-to-research analyses indicate that hospital volumes in AAA repair have been constant (varied by <10% in the last five years), suggesting that our findings will be applicable towards treatment decisions for Veterans with AAA for several years in the future. In a pre-proposal survey, as well as assessment using CDA data, we confirmed that each study site performs at least five aortic repairs and fifteen endovascular repairs (or similar) per year, ensuring adequate ability at these sites to perform either repair type for Veterans. Contact information on each of the sites is listed below.

Table 2 Local Sites

<u>Surgery Site</u>	<u>City/State</u>	<u>Complex/Intermediate</u>	<u>Site Investigator</u>	<u>Contact Information</u>	<u>Annual AAA Volume (Direct) FY 2014</u>	<u>Annual AAA Volume (Endovascular) FY 2014</u>
VA Western New York Healthcare System at Buffalo	Buffalo, NY	Complex	Dr. Hasan Dosluoglu	(716) 862-8937	4	39
Valley Division - Sacramento VA Medical Center	Mather, CA	Complex	Dr. Eugene Lee	(916) 843-7202	0	21
VA Boston Healthcare System, West Roxbury Campus	West Roxbury, MA	Complex	Dr. Joseph Raffetto	(857) 203-6200	27	42
VA Ann Arbor Healthcare System	Ann Arbor, MI	Complex	Dr. Peter Henke	(734) 845-5939	21	33
VA Puget Sound Health Care System, Seattle Division	Seattle, WA	Complex	Dr. Gale Tang	(206) 764-2245	13	18
Durham VA Medical Center	Durham, NC	Complex	Dr. Leila Mureebee	(919) 681-2800	9	27
Michael E. DeBakey VA Medical Center	Houston, TX	Complex	Dr. Panagiotis Koulias	(713) 791-1414	2	49
VA Palo Alto Health Care System	Palo Alto, CA	Complex	Dr. Wei Zhou	(640) 849-0507	2	27
Omaha VA Medical Center	Omaha, NE	Complex	Dr. Jason Johanning	(402) 995-3607	4	14
Atlanta VA Medical Center	Decatur, GA	Complex	Dr. Shipra Arya	(404) 321-6111	4	30
Malcom Randall VA Medical Center	Gainesville, FL	Complex	Dr. Salvatore Scali	(352) 376-1611	19	37
White River Junction VA Medical Center	White River Junction, VT	Intermediate	Dr. David Stone	(802) 295-9363	0	11
VA Connecticut Healthcare System, West Haven Campus	West Haven, CT	Complex	Dr. Alan Dardik	(203) 932-5711	2	15
Jesse Brown VA Medical Center	Chicago, IL	Complex	Dr. Melina Kibbe	(312) 569-8387	3	9
VA Pittsburg Healthcare System	Pittsburg, PA	Complex	Dr. Ulka Sachdev	(412)-802-3333	7	33
Phoenix VA Health Care System	Phoenix, AZ	Complex	Dr. Vivienne Halpern	(602) 277-5551	7	36
Minneapolis VA Health Care System	Minneapolis, MN	Complex	Dr. Steven Levin	(612) 725-2000	4	94
VA Greater Los Angeles Healthcare System, West Los Angeles Medical Center	Los Angeles, CA	Complex	Dr. Jessica O'Connell	(310) 268-3445	3	14
George E. Wahlen VA Medical Center	Salt Lake City, UT	Complex	Dr. Benjamin Brooke	(801) 582-1565	0	15
James A. Haley Veterans Hospital	Tampa, FL	Intermediate	Dr. Peter Nelson	(813) 972-2000	11	71

4. Study Design



Study Design: Our cluster-randomized trial has two Specific Aims. First, we will test the effect of an intervention (decision aid + survey) versus the survey alone on preferences for repair type (Aim 1). We hypothesize that the intervention will be associated with a greater preference for open repair among Veterans who value long-term durability in their repair type.

In Aim 2, we will test the effect of the intervention (decision aid +survey) versus the survey alone on agreement between Veterans' preference and actual treatment (Aim 2). We hypothesize that the intervention will be associated with greater agreement between Veterans preferences and the repair type they receive.

Our instrument – both the decision aid and survey- was developed and validated by the Picker Institute in England²⁸. We modified to use United States English language (Appendix 1). In preparatory-to-research work, we pilot-tested the instrument in two cognitive interviews at White River Junction and administered the instrument to five patients at three sites. We will test the effect of our intervention (versus control) on the following outcomes: (1) Veteran preference for repair type, and the domains associated with preference for each repair type, (2) the agreement between Veterans' preferences and their actual repair type, and (3) the Decision Regret Scale, administered 30 days after repair to assess decision satisfaction.

Definition of "Usual Care": In both the intervention and control groups, Veterans will have "usual care" for the treatment of their AAA. This is defined as a routine outpatient consultation with a VA vascular surgeon for their AAA and AAA repair at the discretion of the surgeon during the study period. Estimates from the MASS trial⁸⁰ and RESCAN meta analyses^{81, 82} suggest that 85% of enrollees will progress to repair during the study. In this study, usual care will be provided by the study team.

Study Location: Our study will be based in the VA Outcomes Group in White River Junction, Vermont. We

will use our secure VA Research Server under the direction of Dr. West as the Study Data Core. All study related committees will meet at the offices of the VA Outcomes Group, either in person or using existing secure teleconference facilities. Web-based study team meetings will be held every other week, and will use videoconference to minimize expense. Two study meetings will be held at the annual meetings of the Association of VA Surgeons and at the Society for Vascular Surgery during each year of the study. This will serve as a cost-effective way for our group to meet biannually during the study period.

Characteristics and selection of the study population: Our study population will be Veterans and vascular surgeons enrolled at the ten intervention sites and ten control sites in our cluster-randomized trial. The inclusion criteria for patients will be Veterans with a >5.0 cm AAA that are candidates for endovascular and open repair. Step C of the Study Procedures describe the recruitment procedures and inclusion criteria in detail.

STUDY PROCEDURES

Step A: Recruitment of Surgeons Twenty VA hospitals that currently perform both endovascular and open repair are the study sample. Each local site investigator has been interviewed and their credentials vetted by the PI, and has accepted to participate in the study. Local site investigators may invite one or two additional surgeons whom they work with at their site to participate in the study. Site Study Coordinators will provide surgeons the Study Invitation and Information Sheet at the start of the study period and document the date. A waiver of documentation of informed consent for surgeons will be requested since the surgeon's participation involves no procedures other than completion of a survey and presents no more than minimal risk.

Step B: Selection of Intervention Centers: In Aim 1, we will conduct the intervention in 120 patients across 10 VA hospitals randomly assigned to the intervention arm. We will have a 9:1 stratified randomization scheme, so that we have a similar proportion of Complex and Intermediate Surgical VA hospitals in the intervention and control arms. These are the only two types of VA hospitals that perform AAA repair. Sites will be randomized at IRB approval in a rolling fashion. Site specific Study Coordinators will use the Study Protocol to facilitate IRB approval.^{3, 15}.

Step C: Recruitment of Patients: *We are requesting a waiver of informed consent for recruitment since potential participants will be identified through the screening process described as follows.*

- i. **Potential candidate referred to VA vascular surgery clinic.** The first contact with potential participants will occur when a referring physician indicates that they should be seen by a vascular surgeon for treatment of their AAA, and the patient is given an appointment for a consultation with a vascular surgeon at a study site.
- ii. **Identification of 12 Veterans with a >5.0 cm AAA who are candidates for endovascular and open repair.** The Site Study Coordinator will screen all new consultations made to VA vascular surgery clinics for Veterans with AAA that meet size criteria of ≥ 5.0 cm. Baseline audits at three clinics indicate ~15 new AAA referrals per vascular surgeon per month, and 60% of Veterans have an AAA that meets size criteria. Assuming a refusal rate of 50%, we anticipate we will enroll fully three months after enrollment begins, with a screening rate of 8 patients per site per month and an enrollment rate of four patients per site per month.
- iii. **Ensuring Veterans with AAA are candidates for both endovascular and open surgical repair.** Radiologic reports for new AAA consultations will be reviewed by the Study Coordinator according to the Site Recruitment Guide (Appendix 1). If a patient has an AAA that meets these size criteria (≥ 5.0 cm in diameter, the Study Coordinator will contact the Site Principal Investigator. The Site Principal Investigator will review imaging tests and the Veteran's electronic health record to ensure the Veteran is a candidate for endovascular and open repair using anatomic and clinical criteria defined according the Instructions for Use for each individual aortic endoprosthesis. These criteria derive from the Instructions-For-Use protocols determined by the

Food and Drug Administration⁸³. Site Principal Investigators will have discretion in interpretation for placement of an endovascular prosthesis outside of IFU guidelines. If the Veterans meets criteria for both open and endovascular repair, the Site Principal Investigator will inform the Study Coordinator.

- iv. Inviting Veterans who are candidates to participate in the study: Once a candidate has been identified, the Study Coordinator will note the time of the Veteran's appointment. When the Veteran arrives for their appointment, they will check in as usual and proceed to the waiting room. The first contact with potential participants will be made by The Study Coordinator or other Study Team member who will take the Veteran to a consult room. Once in the consult room, the Study Coordinator or other Study Team Member will use the Study Introduction Script (Appendix 5), to describe the intervention to the Veteran (decision aid and survey) and invite them to participate. Veterans will be offered some time to review the consent form. If they wish to have more time to discuss it with their family and friends, they may reschedule their appointment and return on a later day. The Veteran will be informed that they will be remunerated \$50 at the completion of their first appointment for their time spent completing study documents and surveys.
- v. Consent process: Once a Veteran has expressed interest in the study, the Study Coordinator or other Study Team Member will review the consent form with them, answer any questions, and obtain consent. For any Veterans who are unable to read, the study coordinator will read the consent form to them in the presence of a witness. A witness is required to be present during the entire consenting process for illiterate participants and the witness will sign the informed consent to indicate he/she witnessed the participant "making their mark" consenting to be in the study. After consent has been obtained by the study coordinator, the Veteran will be taken through the survey process.

Step D: Survey administration at intervention and control sites:

Process at the Intervention Sites:

Step 1: The Pre-Survey will be administered with the Veteran by the Study Coordinator. (2 minutes)

Step 1a: The Study Coordinator will review the Decision Aid with the Veteran. (5-10 minutes)

Step 1b: The Study Coordinator will administer the Survey. (10 minutes)

Step 2: The Study Coordinator will escort the patient to the visit with the vascular surgeon.

Step 3: After the Visit, the Study Coordinator will complete the Decision-Process Score with the Veteran. (5 minutes)

Step 4: Thirty days after AAA repair, the Study Coordinator will complete the PSQ-18 with the Veteran. (5 minutes).

The decision aid is available in English and Spanish.

The patient will be remunerated at completion of the enrollment visit. Data will be recorded securely by the Site Study Coordinator.

The Veteran will be thanked for their participation by the study team via a formal letter mailed from the Principal Investigator.

Process at the Control Sites:

Step 1: The Study Coordinator will administer the Survey. (10 minutes)

Step 2: The Study Coordinator will escort the patient to the visit with the vascular surgeon.

Step 3: After the Visit, the Site-Specific Research Coordinator will complete the Decision-Process Score with the Veteran. (5 minutes)

Step 4: Thirty days after AAA repair, the Study Coordinator will complete the PSQ-18 with the

Veteran. (5 minutes)

The patient will be remunerated at completion of the enrollment visit. Data will be recorded securely by the Site Study Coordinator.

The Veteran will be thanked for their participation by the study team via a formal letter mailed from the Principal Investigator.

Surgeon survey administration at both the intervention and control sites:

Step 1: The Study Coordinator will administer the Pre-Visit Survey to the surgeon (1 minute, according to pilot testing at four sites in the trial, and two sites outside the trial).

Step 2: The surgeon will have the clinic visit with the Veteran.

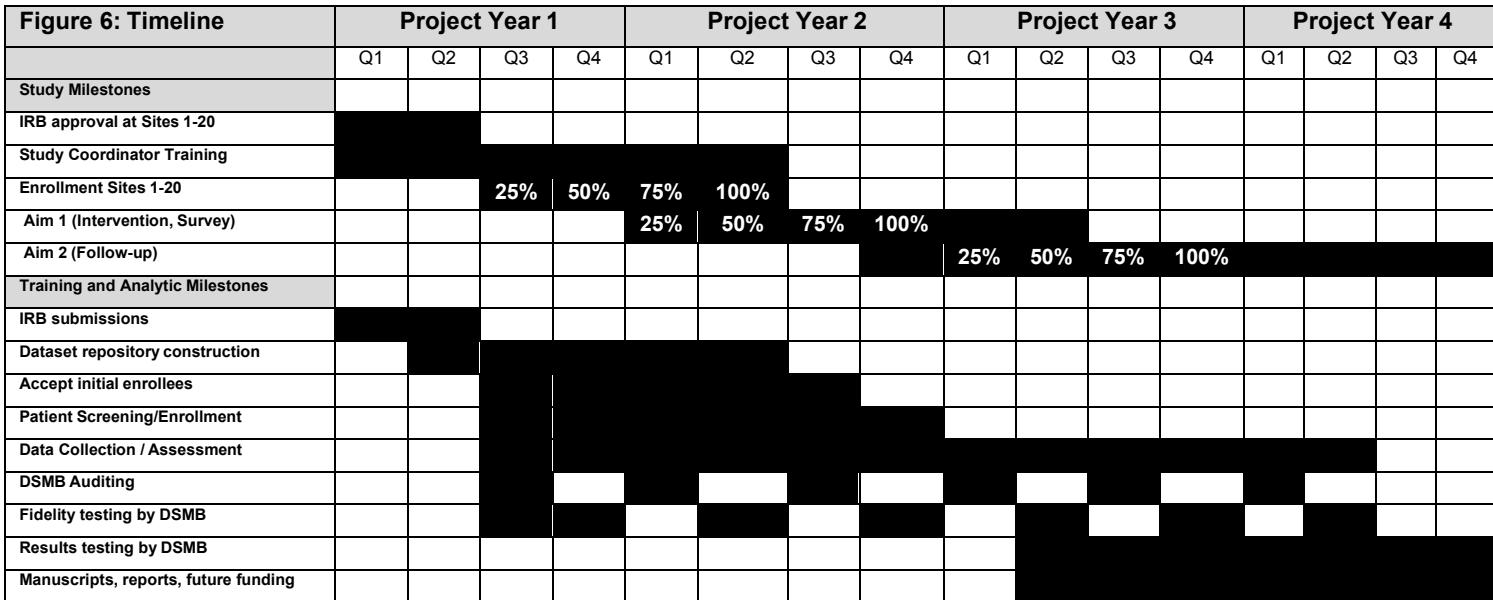
Step 3: After the Visit, the Study Coordinator will complete the Post-Visit Survey with the surgeon (1 minute).

Data will be recorded securely by the Study Coordinator.

Recruitment Target: We will recruit 12 Veterans per site (4 Veterans per site per month for 3 months) at 10 sites in the intervention arm for a total of 120 Veterans in the intervention arm. We will recruit 12 Veterans per site (4 Veterans per site per month for 3 months) at 10 sites in the control arm for a total of 120 Veterans in the control arm. The unit of analysis will be the Veteran. Randomization will occur at the site level, in a stratified 9:1 randomization scheme, based on the VA hospital's Surgical Complexity designation. We will enroll 8 Complex and 2 Intermediate sites per arm. Randomization will occur at the time of IRB approval. Weekly conference calls with Site Study Coordinators will assess study enrollment rates and help with problem-solving.

Exclusion Criteria: Veterans with AAA who are not a candidate for both endovascular and open surgical repair will be excluded. Veterans who have already undergone AAA repair will be excluded. We will include Veterans who speak English and Spanish, using a translated survey instrument (Appendix 2). Veterans who cannot read will be offered participation by allowing the Site Study Coordinator to administer the survey.

Time Frame: Our study timeline is shown in Figure 6. IRB approval and site randomization will occur during the first 0-3 months of Project Year (PY1). Enrollment will begin at PY1 Month 3, and will be completed by the end of PY1 at all sites (a conservative estimate). After two-year follow-up on all sites in our cohort during PGY2-3, we will examine our final outcomes and complete reports and manuscripts in PY4.



Risk to Subjects (Veterans and Surgeon Participants).

Human Subjects Involvement and Characteristics.

Aim 1: Cluster-Randomized Trial of a Decision Aid and Survey (versus Survey alone) for different types of AAA Repair

In our study, we will identify Veterans presenting to Vascular Surgery Clinic with abdominal aortic aneurysms who are candidates for endovascular or open repair.

Sources of Materials.

Aim 1 and Aim 2 Survey Results

The materials for Aim 2 will be the results from our survey administered as described in Aim 1 and Aim 2. In accordance with our Data Management Plan, all will be coded to protect PHI, with study entrants being assigned a study identifier throughout the data management process. The study key that allows identification between individual study patients and their protected health information (PHI) will remain behind VA firewalls and will not be routinely used as part of the study analyses. We will create individual random identifiers for each study patient, and all study dates will be removed and replaced with time-to-event variables to limit any potential PHI contained in study datasets.

Potential Risks for Veterans.

Decision Aid and Survey

Our cluster-randomized trial will compare the effect of a patient educational tool (the decision aid) on survey responses describing patients' preferences for different types of AAA repair. Both types of AAA repair are commonly performed across VA, and both are commonly accepted alternatives for the treatment of AAA.

The intervention consists of provision of standardized information to patients, compared to taking the survey alone. Given that the intervention consists only of a standardized delivery of information that is commonly shared with patients during a routine vascular surgery clinic consultation, there are minimal risks to the Veterans who will participate in our survey. All sites and surgeons will be assigned unique study IDs in our dataset, and indexed only through anonymous identifiers. Further, our data will be stored on VA servers, behind VA firewalls.

Potential Risks for Surgeons.

Surgeon Survey

In both the intervention and control groups, we will examine surgeon preferences for repair type for each Veteran. The surgeon's name associated to a randomly generated identifier, and a key at each site will be kept to allow the surgeon to remain unidentifiable in research datasets.

All surgeons participating in the study will receive the Study Invitation and Information Sheet from the Site Study Coordinator at the time of study initiation. We anticipate IRB approval for a waiver of documentation of informed consent.

For Veterans, there is an control arm (survey alone) and intervention arm (survey + decision aid). For surgeons, however, all will receive the same surgeon survey. This is simply a validated survey which records the factors they use to make their decisions. Given that the intervention consists only of a standardized delivery of information that is commonly shared with patients during a routine vascular surgery clinic consultation, there are minimal risks to the surgeons who will participate in our survey. No identifiable data will be made available, placing no risk on study surgeons. All sites and surgeons will be assigned unique study IDs in our dataset, and indexed only through anonymous identifiers. Further, our data will be stored on VA servers, behind VA firewalls.

Adequacy of Protection from Risk.

Recruitment and Informed Consent.

For our survey, we will perform recruitment at the 20 sites, as described in our study procedures. Our Site Study Coordinator will obtain consent prior to administering the intervention. Explanation of the anonymous nature of the interviews will be provided to the subjects. Informed consent will be logged electronically and secured at our central server behind the VA firewall.

Protection Against Risk.

The risk of a confidentiality breach is minimized by the fact that these data will be maintained on the White River Junction VAMC's dedicated research server, behind the VA firewall. Only summary statistical analyses are ever exported from the server. Data analysts for this project will use only the anonymous study IDs to distinguish individual subjects; they will not have access to any other personal identifiers, nor will they be able to convert Study IDs to SSNs. The risk of a data breach that will compromise personal information is minimal.

Potential Benefits of Research to Subjects and Others.

There are no direct benefits to Veterans or surgeons participating in this research. There is a potential benefit for Veterans enrolled in the intervention arm of this study, which is clearer pathway for communicating their preferences about their abdominal aortic aneurysm to the surgeon treating their aneurysm. Further, the information to be derived will be of great value for the planning of future interventions and resource allocation to provide Veterans the best access to the highest quality care for high-risk surgical interventions such as AAA repair.

Importance of Knowledge to be Gained.

This study will yield new information about outcomes for expensive and high-risk conditions/ procedures to support the planning of optimal resource allocation. It will distinguish VA facilities that achieve the best outcomes for further study, and it will identify the components of inpatient services that yield the best outcomes for Veterans with AAA. The knowledge to be gained will help VA planners improve access to care for patients with high-risk surgical conditions, and the benefits will greatly outweigh the limited risks to confidentiality and patient safety.

Data and Safety Monitoring Plan.

As this study involves a survey only, we do not anticipate any serious adverse events related to the research, and that any adverse events which occur during the study period are likely to be related to underlying, pre-existing medical conditions, and/or the surgery. Therefore, we will not routinely collect any data to assess harms. The Data and Safety Monitoring Committee will be responsible for ensuring that data conduct is commensurate with any potential benefits or harms evident in quarterly analysis of study datasets. **Any unanticipated problems which may arise involving risks to subjects or others, related to research (including data integrity/security issues) will be documented and reported to the IRB within 5 business days after becoming aware of the event, in accordance with VHA Handbook 1058.01 Paragraph 6.** This study will adhere to the **VA Central IRB Table of Reportable Events.** Data accuracy and integrity will meet the standards for VA or Medicare administrative treatment files.

5. Study Committees

We have established a study committee structure as outlined below, consisting of three central committees: A Steering Committee, A Data Safety Monitoring Board, and a Publications Committee. The committees are staffed by Key Personnel and six experienced, VA-funded surgical investigators (Zhou, Nelson, Johanning, Raffetto, Dardik, and Henke). Each Committee will meet quarterly during the study period.

AAA Survey Study Steering Committee,

Philip Goodney,

Brenda Sirovich,

Michael Barry,

Alan West,

Wei Zhou,

Peter Nelson,

Jason Johanning,

Joseph Raffetto,

Alan Dardik

Peter Henke

AAA Survey Study Data Safety Monitoring Board

Alan West

Todd Mackenzie

Richard Powell (external auditor)

AAA Survey Study Publications Committee:

Philip Goodney

Brenda Sirovich

Michael Barry

6. Coding Guide and Data Management Plan

Procedures for managing the flow of information from participating sites is detailed below. Any deviation from these procedures that might be relevant to participant protection will be reported to the PI within 24 hours. The PI will have 24 hours to investigate the occurrence and convey the information to the VA Central IRB. All study

team members must adhere to the **VA Central IRB Table of Reportable Events** all documented VA security policies and protocols. Removal of access to research study data will be accomplished for study personnel when they are no longer part of the research team.

Step 1:

Each completed survey and consent form will be completed by the Veteran under the supervision of the site-specific Study Coordinator.

Step 2:

A PDF of the survey document will be created and sent via secure email to a file maintained on our Research Server by the Data Coordinating Center (led by Dr. West and Dr. Goodney at White River Junction).

Step 3:

After confirming secure receipt and upload of the PDF onto our Research Server, the Site Study Coordinator will store the original documents in a locked file until study conclusion. Original documents will be destroyed in accordance with the VA Records Control schedule.

Step 4:

The survey data will be extracted by our Central Study Coordinator and imported into analytic software files (SAS) to allow for analysis by Drs. West and Mackenzie. A Coordinating Center Research Nurse will facilitate this effort as well, and hold biweekly technical support calls with the Central Site Study Coordinator with all sites during the study period. All research datasets will be destroyed in accordance with the VA Records Control Schedule.

Long term follow-up Data Collection:

To inform the agreement between preferences and repair type, we will compare the preference identified for each Veteran in Aim 1 and the actual AAA repair type the Veteran receives.

This will be done at each site by the Site Study Coordinator who will have access to PHI of participants enrolled only at their site for the purpose of follow-up. They will not have access to study data or PHI from any other study sites.

Every three months during the Study Period, each site-specific Study Coordinator will audit CPRS for each enrolled Veteran at that site.

If no record of repair exists, the Site Coordinator will contact the enrolled patients via phone to ensure repair has not been performed outside of VA.

Patients who do not undergo repair or who die prior to repair will be excluded from this step in the analysis.

7. Data Analysis

(Please note: The following sections are described separately for Aim 1 and Aim 2).

Aim 1: To identify Veteran and surgeon factors associated with preference for endovascular or

open repair.

Aim 1. Dependent and Independent Variables: The main dependent variable in Aim 1 is the preference for repair type (endovascular or open) as expressed by Veterans and surgeons in their respective survey instruments. Each survey instrument has a validated coding algorithm which will be used to categorize survey responses into preference for endovascular or open repair (Appendix 2)⁴⁴. Independent variables, such as age, gender, race, ethnicity, and other descriptive variables are recorded as part of the survey instrument by the Site Study Coordinator. Hospital and surgeon characteristics such as annual hospital and surgeon volume of endovascular and open repair for each participating site will be collected via VINCI by Dr. West. These variables will be measured at the hospital level, as in prior analyses.^{65, 97-100}

Aim 1: Data analytic strategy: tests, strengths, limitations, and alternative approaches: In Aim 1, our main outcome variable will be Veteran and surgeon preference for repair type (endovascular or open repair). The preference will be defined as either preference for endovascular or preference for open repair. Repair type preference will be categorized from several questions in our survey instruments. Several questions allow for differing degrees of choice (e.g., strongly/slightly favor open repair). For these responses, we will use variables that allow this category. We will use a coding algorithm (Appendix 2) which deconstructs survey questions into components that generate binary outcomes (i.e., preference for open or endovascular repair) and allows sensitivity analyses using the gradients. We will compare the proportion choosing each repair type in the intervention and control groups to test the effect of the decision aid on repair type preference. The proportions preferring each repair type will be compared between the two groups accounting for clustering of patients within center and/or surgeon; in particular, we will use the Mantel-Haenszel test (for stratified contingency tables, equivalent to partial likelihood ratio test from fixed effects logistic regression) or a mixed effects logistic regression with fixed effect of group, and random intercept for center effects.

Aim 1 Data Collection Strategy: potential problems and solutions Refer to Section 6 of this Protocol Coding Guide and Data Management Plan.

To identify patient characteristics (such as survey responses) associated with preference for endovascular or open repair we will use multivariable mixed effects logistic regression. The use of mixed effects is to account for clustering within individual VA centers using a random intercept, e.g. $\text{logit } \text{Pr}[Y_{ij}=1]=X_{ij}\beta+\mu_i$ where Y_{ij} is the binary preference variable in subject j from cluster i , X_{ij} is a vector of characteristics, μ_i is a random intercept from a zero mean distribution with standard deviation to be estimated (e.g. normal), and β is a vector of coefficient(s). We will explore the feasibility (e.g. convergence) and sensitivity of findings of patient characteristics of using either a random intercept for surgeon, or for center, or for surgeon nested within center. We will report both unadjusted and adjusted estimates, after identifying one or more models to adjust for using for instance stepwise regression or LASSO. Stata (e.g., xtmelogit) and/or R (library lme4 or nlme) software will be used. Dr. MacKenzie has extensive experience in these strategies.

Missing Data: To accommodate missing data where justified (e.g. the variable with missing data is predictive and deserves to be adjusted for, and furthermore the data is believed to be missing at random) we shall use multiple imputation methods, such as implemented in the Stata *mi* routine.

Power Analysis: Comparing the effect of the decision aid on repair type preference. Because the decision aid will inform Veterans more fully about the long-term disadvantages of endovascular repair, we hypothesize that the decision aid will reduce the proportion of Veterans who prefer endovascular repair by 25%, based on similar decision aids studied in surgical settings in breast cancer and back pain¹⁶⁻¹⁸.

Table 3 Sample size and power calculations (assuming a 90% baseline rate of EVAR preference)

Number of clusters	Number of patients per cluster	Total Number of Patients	Proportion Choosing Endovascular Repair At	Decision Aid Effect Size (in relative decline in preference)	Proportion Choosing Endovasc Repair at	Power To detect significant difference	Power To detect significant difference	Power To detect significant difference
--------------------	--------------------------------	--------------------------	--	--	--	--	--	--

Intervention	Control	Intervention	Control	Intervention	Control	Control Sites for endovascular	Intervention Sites	(ICC 0.01)	(ICC 0.05)	(ICC 0.10)
10	10	12	12	120	120	0.9	0.25	0.68	0.96	0.86
10	10	12	12	120	120	0.9	0.20	0.73	0.88	0.75
10	10	12	12	120	120	0.9	0.15	0.78	0.71	0.50

We adjusted our sample size calculations for our cluster-randomized trial to account for intra-cluster correlation, and allow for variable enrollment size within each cluster. As shown in Table 8, we anticipate that we will have 96% likelihood of detecting a 25% effect size, assuming an ICC of 0.01. Sensitivity analyses around our ICC assumption of 0.01 demonstrate that even if our ICC is ten times higher (ICC=0.10), our sample size would still yield an 81% likelihood of detecting a 25% effect size between intervention/control.

Aim 2: To determine the effect of the decision aid on agreement between preferences and repair type.

Aim 2 Dependent and Independent Variables: After identifying Veterans' preference for endovascular or open repair, we will determine the agreement between their preferences and the repair types they receive. The dependent variable will be the kappa statistic (κ), measuring agreement between the preferred repair type and the repair type the Veteran ultimately receives. Cohen's kappa will be compared between the intervention and control groups. Kappa will be calculated overall and by hospital (using a weighted sum of the kappas for each hospital in that arm). As a secondary outcome, Site Study Coordinators will administer two surveys to the Veteran. These two surveys will examine patient satisfaction (PDQ-18) and shared decision making (Decision Process Score, or DPS)^{87, 104}. Our group has used these or similar instruments in prior work^{104, 105}. A survey administration training guide for each Site Study Coordinator has been developed. The DPS will be administered at the end of the visit, and the PDQ-18 will be completed at 30-day follow-up visits which are already standard practice after AAA repair for both repair types. Completing the surveys in this context will not require any extra visits by Veterans, an important strength given the elderly population of patients involved in our proposal.

Aim 2 Data Collection Strategy: potential problems and solutions: To inform the agreement between preference and repair type, we will compare the preference identified for each Veteran and the actual AAA repair type the Veteran receives at each site. We anticipate that 85% of Veterans will undergo repair within three months after the study visit in which they are enrolled. However, we estimate that 15% of patients will not undergo repair within 3 months of enrollment. Therefore, to ensure we capture the repair type for these patients, each Site Study Coordinator will audit CPRS every three months during the study period. At the end of the two years of audits, the site specific Site Study Coordinator will contact the enrolled patients via phone to ensure repair has not been performed outside of VA. Patients who do not undergo repair or who die prior to repair will be excluded. Sample size calculations incorporate a dropout rate of 10% for this effect. Re-survey will occur for a delay in repair greater than 3 months, if the pre-survey shows a change in Veteran repair preference from the original enrollment survey.

Aim 2 Data analytic strategy: After we have measured the necessary elements for agreement (preferences for repair type and the actual repair type), we will then calculate Cohen's kappa. We will stratify these analyses for surgeon agreement with the actual repair type (surgeon-preferred repair type matches the actual repair type, surgeon-preferred repair type does not match the actual repair type, and surgeon has no preference in repair type). Of note, Question #8 in the Decision Process Score allows us to measure incidents where discussion with the surgeon changed the Veteran's preference after the survey. We will perform sensitivity analyses including and excluding Veterans who changed preferences. To account for possible agreement of preference and choice with age, gender and race, we will estimate the association of choice with preference in a multivariable binary regression model that includes age, gender and race, and report the odds ratio (via logistic link) and rate ratio (via Poisson link). The fitted value from the logistic regression model will be used to calculate the four proportions used in the calculation of Kappa agreement using the method of average predictions (fitted values). Bootstrapping methods, as described by Efron and Tibshirani¹⁰⁶, will be performed if individual hospital samples are small.

Power analysis in Aim 2: We hypothesized that Veterans who receive the decision aid will be 25% more likely to have a treatment that aligns with their preferences, based on effect sizes seen in similar decision aids¹⁶⁻¹⁸. This would increase kappa from a baseline of $\kappa=0.7$ in the control group to $\kappa=0.88$ in the treatment group. Using a nomogram by Sim and Wright¹⁰⁷, we assumed a 2-tailed test for a null value of $\kappa=0.7$ in the control group, and $\kappa=0.88$ in the intervention group. We would have 80% power to detect a difference assuming a 50% positive response rate at 101 patients in each arm. Our sample of 120 patients is powered to detect a difference in kappa, accounting for dropout (10%) and patients who do not undergo repair (15%).

8. References

1. Faggioli G, Scalzone L, Mantovani LG, et al. Preferences of Patients, Their Family Caregivers and Vascular Surgeons in the Choice of Abdominal Aortic Aneurysms Treatment Options: The Prefer Study. *Eur J Vasc Endovasc Surg.* 2011;42(1):26-34. PMID: 21334928.
2. Elwyn G, O'Connor A, Stacey D, et al. Developing a Quality Criteria Framework for Patient Decision Aids: Online International Delphi Consensus Process. *BMJ.* 2006;333(7565):417. PMID: 16908462;
3. Volk RJ, Llewellyn-Thomas H, Stacey D, et al. Ten Years of the International Patient Decision Aid Standards Collaboration: Evolution of the Core Dimensions for Assessing the Quality of Patient Decision Aids. *BMC Med Inform Decis Mak.* 2013;13 Suppl 2:S1. PMID: 24624947; PMCID: 4044280.
4. Elwyn G, O'Connor AM, Bennett C, et al. Assessing the Quality of Decision Support Using the International Patient Decision Aid Standards. *PLoS One.* 2009;4(3):e4705. PMID: 19259269; PMCID: 2649534.
5. Elwyn G, Frosch D, Thomson R, et al. Shared Decision Making: A Model for Clinical Practice. *J Gen Intern Med.* 2012;27(10):1361-7. PMID: 22618581; PMCID: 3445676.
6. Barry MJ, Edgman-Levitin S. Shared Decision Making--Pinnacle of Patient-Centered Care. *N Engl J Med.* 2012;366(9):780-1. PMID: 22375967.
7. Barry M, Levin C, MacCuaig M, et al. Shared Decision Making: Vision to Reality. *Health Expect.* 2011;14 Suppl 1:1-5. PMID: 21323818.
8. Barry MJ. Health Decision Aids to Facilitate Shared Decision Making in Office Practice. *Ann Intern Med.* 2002;136(2):127-35. PMID: 11790064.
9. Wagner EH, Barrett P, Barry MJ, et al. The Effect of a Shared Decisionmaking Program on Rates of Surgery for Benign Prostatic Hyperplasia. Pilot Results. *Med Care.* 1995;33(8):765-70. PMID: 7543638.
10. The Veterans Administration Makes Shared Decision Making Resources Available to Help with Long Term Care Choices: The Informed Medical Decisions Foundation; [cited 2014]. Available from: <http://www.informedmedicaldecisions.org/2013/03/28/the-veterans-administration-makes-shared-decision-making-resources-available-to-help-with-long-term-care-choices/>.
11. Veterans' Administration Website for Shared Decision Making 2015. Available from: (http://www.va.gov/geriatrics/guide/longtermcare/Shared_Decision_Making.asp).
12. Legare F, Thompson-Leduc P. Twelve Myths About Shared Decision Making. *Patient Educ Couns.* 2014;96(3):281-6. PMID: 25034637.
13. Legare F, Politi MC, Drolet R, et al. Training Health Professionals in Shared Decision-Making: An International Environmental Scan. *Patient Educ Couns.* 2012;88(2):159-69. PMID: 22305195.
14. Wexler R, Editor. Providers Benefit from Online Shared Decision Making Skills Course. ISDM/ISEHC Conference in Sydney, 2015; 2015; Sydney, Australia.
15. Volk RJ, Shokar NK, Leal VB, et al. Development and Pilot Testing of an Online Case-Based Approach to Shared Decision Making Skills Training for Clinicians. *BMC Med Inform Decis Mak.* 2014;14:95.
16. Weinstein JN, Lurie JD, Tosteson TD, et al. Surgical Vs Nonoperative Treatment for Lumbar Disk Herniation: The Spine Patient Outcomes Research Trial (SPORT) Observational Cohort. *JAMA.* 2006;296(20):2451-9. PMID: 17119141; PMCID: 2562254.
17. Weinstein JN, Tosteson TD, Lurie JD, et al. Surgical Vs Nonoperative Treatment for Lumbar Disk Herniation. *JAMA.* 2006;296(20):2441-50. PMID: 17119140; PMCID: 2553805.
18. Whelan T, Levine M, Willan A, et al. Effect of a Decision Aid on Knowledge and Treatment Decision Making for Breast Cancer Surgery: A Randomized Trial. *JAMA.* 2004;292(4):435-41. PMID: 15280341.
19. Birkmeyer NJ. Improving Patient Decisions About Bariatric Surgery. PCORI Grant for Decision Support in Bariatric Surgery (<https://www.clinicaltrials.gov/ct2/show/NCT02364128>).
20. Goodney PP, Newhall KA, Farber A, et al. Characteristics of Patients Enrolled in a Cluster- Randomized Trial of a Smoking Cessation Intervention. *J Vasc Surg.* 2015;(in press).
21. Newhall KA, Farber A, Goodney PP. Smoking Cessation Counseling in Vascular Surgical

Practice Using the Results of Interviews and Focus Groups in the VAPORTrial. *J Vasc Surg.* 2015;(in press).

22. O'Malley J, Goodney PP, Mackenzie TA, et al. Advancing Patient Centered Outcomes Research in Survival Data with Unmeasured Confounding. Patient Centered Outcomes Research Institute (PCORI); 2015.

23. Lederle FA, Freischlag JA, Kyriakides TC, et al. Long-Term Comparison of Endovascular and Open Repair of Abdominal Aortic Aneurysm. *N Engl J Med.* 2012;367(21):1988-97. PMID: 23171095.

24. Lederle FA, Freischlag JA, Kyriakides TC, et al. Outcomes Following Endovascular Vs Open Repair of Abdominal Aortic Aneurysm: A Randomized Trial. *JAMA.* 2009;302(14):1535-42. PMID: 19826022.

25. Lederle FA, Johnson GR, Wilson SE, et al. The Aneurysm Detection and Management Study Screening Program: Validation Cohort and Final Results. Aneurysm Detection and Management Veterans Affairs Cooperative Study Investigators. *Arch Intern Med.* 2000;160(10):1425-30. PMID: 10826454.

26. Eliason JL, Upchurch GR, Jr. Endovascular Abdominal Aortic Aneurysm Repair. *Circulation.* 2008;117(13):1738-44. PMID: 18378627.

27. Ailawadi G, Eliason JL, Upchurch GR, Jr. Current Concepts in the Pathogenesis of Abdominal Aortic Aneurysm. *J Vasc Surg.* 2003;38(3):584-8. PMID: 12947280.

28. De Martino RR, Goodney PP, Nolan BW, et al. Optimal Selection of Patients for Elective Abdominal Aortic Aneurysm Repair Based on Life Expectancy. *J Vasc Surg.* 2013;58(3):589-95. PMID: 23642927.

29. Newton WB, 3rd, Shukla M, Andrews JS, et al. Outcomes of Acute Intraoperative Surgical Conversion During Endovascular Aortic Aneurysm Repair. *J Vasc Surg.* 2011;54(5):1244-50; discussion 50.

30. Beck AW, Goodney PP, Nolan BW, et al. Predicting 1-Year Mortality after Elective Abdominal Aortic Aneurysm Repair. *J Vasc Surg.* 2009;49(4):838-43; discussion 43-4. PMID: 19341875.

31. Parodi JC, Criado FJ, Barone HD, et al. Endoluminal Aortic Aneurysm Repair Using a Balloon- Expandable Stent-Graft Device: A Progress Report. *Ann Vasc Surg.* 1994;8(6):523-9. PMID: 7865389.

32. Lederle FA, Wilson SE, Johnson GR, et al. Design of the Abdominal Aortic Aneurysm Detection and Management Study. ADAM VA Cooperative Study Group. *J Vasc Surg.* 1994;20(2):296-303. PMID: 8040955.

33. Aljabri B, Al Wahaibi K, Abner D, et al. Patient-Reported Quality of Life after Abdominal Aortic Aneurysm Surgery: A Prospective Comparison of Endovascular and Open Repair. *J Vasc Surg.* 2006;44(6):1182-7. PMID: 17145419.

34. Jackson RS, Chang DC, Freischlag JA. Comparison of Long-Term Survival after Open Vs Endovascular Repair of Intact Abdominal Aortic Aneurysm among Medicare Beneficiaries. *JAMA.* 2012;307(15):1621-8. PMID: 22511690.

35. Schermerhorn MIL, O'Malley AJ, Jhaveri A, et al. Endovascular Vs. Open Repair of Abdominal Aortic Aneurysms in the Medicare Population. *N Engl J Med.* 2008;358(5):464-74. PMID: 18234751.

36. Goodney PP, Tavris D, Lucas FL, et al. Causes of Late Mortality after Endovascular and Open Surgical Repair of Infrarenal Abdominal Aortic Aneurysms. *J Vasc Surg.* 2010;51(6):1340-7 e1. PMID: 20385469.

37. Park BD, Azefor NM, Huang CC, et al. Elective Endovascular Aneurysm Repair in the Elderly: Trends and Outcomes from the Nationwide Inpatient Sample. *Ann Vasc Surg.* 2013. PMID: 24189191.

38. Chadi SA, Rowe BW, Vogt KN, et al. Trends in Management of Abdominal Aortic Aneurysms. *J Vasc Surg.* 2012;55(4):924-8. PMID: 22226189.

39. Sethi RK, Henry AJ, Hevelone ND, et al. Impact of Hospital Market Competition on Endovascular Aneurysm Repair Adoption and Outcomes. *J Vasc Surg.* 2013;58(3):596-606. PMID: 23684424.

40. Ng TT, Mirocha J, Magner D, et al. Variations in the Utilization of Endovascular Aneurysm Repair Reflect Population Risk Factors and Disease Prevalence. *J Vasc Surg.* 2010;51(4):801-9, 9 e1.

41. Shah H, Kumar SR, Major K, et al. Technology Penetration of Endovascular Aortic Aneurysm Repair in Southern California. *Ann Vasc Surg.* 2006;20(6):796-802. PMID: 17136631.

42. Goodney PP, West A. Prepatory to Research Analyses (Personal Communication) 2014.

43. The Vascular Quality Initiative (VQI) 2013. Available from: www.vascularqualityinitiative.org.
44. The Picker Institute. Survey of Patient Preference for Method of Abdominal Aortic Aneurysm Repair.
45. Winterborn RJ, Amin I, Lyratzopoulos G, et al. Preferences for EVAR or Open repair among Patients with Abdominal Aortic Aneurysms under Surveillance. *J Vasc Surg.* 2009;49(3):576-81 e3. PMID: 19268761.
46. Dubois L, Novick TV, Power AH, et al. Identification of Patient-Derived Outcomes after Aortic Aneurysm Repair. *J Vasc Surg.* 2014;59(6):1528-34. PMID: 24447539.
47. Weinstein JN, Clay K, Morgan TS. Informed Patient Choice: Patient-Centered Valuing of Surgical Risks and Benefits. *Health Aff (Millwood).* 2007;26(3):726-30. PMID: 17485750; PMCID: 2918374.
48. Weinstein JN. Partnership: Doctor and Patient: Advocacy for Informed Choice Vs. Informed Consent. *Spine (Philadelphia, PA 1976).* 2005;30(3):269-72. PMID: 15682004.
49. Barry MJ. Shared Decision Making: Informing and Involving Patients to Do the Right Thing in Health Care. *J Ambul Care Manage.* 2012;35(2):90-8. PMID: 22415282.
50. Barry MJ, Roberts WC. Michael John Barry, Md: A Conversation with the Editor on Shared Decision Making. *Proc (Bayl Univ Med Cent).* 2012;25(4):383-8. PMID: 23077396; PMCID: 3448587.
51. Barry M. Six Steps of Shared Decision-Making: The Foundation For Informed Decision Making. Available from: <http://www.slideshare.net/fimdm/six-steps-of-shared-decision-making>.
52. Lantz PM, Janz NK, Fagerlin A, et al. Satisfaction with Surgery Outcomes and the Decision Process in a Population-Based Sample of Women with Breast Cancer. *Health Serv Res.* 2005;40(3):745-67.
53. Katz SJ, Lantz PM, Janz NK, et al. Patient Involvement in Surgery Treatment Decisions for Breast Cancer. *J Clin Oncol.* 2005;23(24):5526-33. PMID: 16110013.
54. Malas MB, Freischlag JA. Interpretation of the Results of over in the Context of Evar Trial, Dream, and the Eurostar Registry. *Semin Vasc Surg.* 2010;23(3):165-9. PMID: 20826293.
55. Parodi JC. Endoluminal Stent Grafts: Overview. *J Invasive Cardiol.* 1997;9(3):227-9. PMID: 10762904.
56. Lederle FA, Stroupe KT, Open Versus Endovascular Repair Veterans Affairs Cooperative Study G. Cost-Effectiveness at Two Years in the Va Open Versus Endovascular Repair Trial. *Eur J Vasc Endovasc Surg.* 2012;44(6):543-8. PMID: 23116986.
57. Elwyn G, Laitner S, Coulter A, et al. Implementing Shared Decision Making in the NHS. *BMJ.* 2010;341:c5146. PMID: 20947577.
58. O'Connor AM, Wennberg JE, Legare F, et al. Toward the 'Tipping Point': Decision Aids and Informed Patient Choice. *Health Aff (Millwood).* 2007;26(3):716-25. PMID: 17485749.
59. Guihan M, Hedrick S, Miller S, et al. Improving the Long-Term Care Referral Process: Insights from Patients and Caregivers. *Gerontol Geriatr Educ.* 2011;32(2):135-51. PMID: 21598147.
60. Brehaut JC, O'Connor AM, Wood TJ, et al. Validation of a Decision Regret Scale. *Med Decis Making.* 2003;23(4):281-92. PMID: 12926578.
61. O'Connor AM. Validation of a Decisional Conflict Scale. *Med Decis Making.* 1995;15(1):25-30.
62. Powell JT, Sweeting MJ, et al. Endovascular or Open Repair Strategy for Ruptured Abdominal Aortic Aneurysm: 30 Day Outcomes from Improve Randomised Trial. *BMJ.* 2014;348:f7661.
63. Becquemin JP. The Ace Trial: A Randomized Comparison of Open Versus Endovascular Repair in Good Risk Patients with Abdominal Aortic Aneurysm. *J Vasc Surg.* 2009;50(1):222-4; discussion 4.
64. Sheldon H, Garratt E. Patient Preferences for Alternative Surgical Techniques for Abdominal Aortic Aneurysm Repair: Report of a Patient Survey2008.
65. Nallamothu BK, Gurm HS, Ting HH, et al. Operator Experience and Carotid Stenting Outcomes in Medicare Beneficiaries. *JAMA.* 2011;306(12):1338-43. PMID: 21954477; PMCID: 3208144.
66. Goodney PP, Lucas FL, Birkmeyer JD. Should Volume Standards for Cardiovascular Surgery Focus Only on High-Risk Patients? *Circulation.* 2003;107(3):384-7. PMID: 12551859.
67. Goodney PP, Lucas FL, Stukel TA, et al. Surgeon Specialty and Operative Mortality with Lung Resection. *Ann Surg.* 2005;241(1):179-84. PMID: 15622006; PMCID: 1356861.
68. Goodney PP, Travis LL, Malenka D, et al. Regional Variation in Carotid Artery Stenting and Endarterectomy in the Medicare Population. *Circ Cardiovasc Qual Outcomes.* 2010;3(1):15-24.

69. Eslami MH, Doros G, Goodney PP, et al. Using Vascular Quality Initiative (Vqi) as a Platform for Organizing Multicenter, Prospective, Randomized Clinical Trials: Overpar Trial. *Ann Vasc Surg.* 2014.
70. SVS Multicenter Clinical Trials Planning Grant 2013. Available from: <http://www.vascularweb.org/about/SVSFoundation/Pages/Grant-recipients.aspx>.
71. Goodney PP, Goodman DC, Barry M. Variation in the Care of Surgical Conditions: A Dartmouth Atlas Report. Hanover, NH: 2014 June 1, 2014.
72. Goodney PP, Woloshin S, Schwartz LM. Fractional Flow Reserve-Guided Pci in Stable Coronary Disease. *N Engl J Med.* 2012;367(24):2355; author reply 6. PMID: 23234520.
73. Birkmeyer JD, Stukel TA, Siewers AE, et al. Surgeon Volume and Operative Mortality in the United States. *N Engl J Med.* 2003;349(22):2117-27. PMID: 14645640.
74. Lederle FA, Johnson GR, Wilson SE, et al. Rupture Rate of Large Abdominal Aortic Aneurysms in Patients Refusing or Unfit for Elective Repair. *JAMA.* 2002;287(22):2968-72. PMID: 12052126.
75. Lederle FA, Kane RL, MacDonald R, et al. Systematic Review: Repair of Unruptured Abdominal Aortic Aneurysm. *Ann Intern Med.* 2007;146(10):735-41. PMID: 17502634.
76. Rigberg DA, Zingmond DS, McGory ML, et al. Age Stratified, Perioperative, and One-Year Mortality after Abdominal Aortic Aneurysm Repair: A Statewide Experience. *J Vasc Surg.* 2006;43(2):224-9.
77. Cowan JA, Jr., Dimick JB, Henke PK, et al. Epidemiology of Aortic Aneurysm Repair in the United States from 1993 to 2003. *Ann N Y Acad Sci.* 2006;1085:1-10. PMID: 17182917.
78. VA Health Services Research and Development Website. Available from: http://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141698717#.UoaZP9Qo6M8
79. Bush RL, DePalma RG, Itani KM, et al. Outcomes of Care of Abdominal Aortic Aneurysm in Veterans Health Administration Facilities. *Am J Surg.* 2009;198(5 Suppl):S41-8. PMID: 19874934.
80. Westvik TS, Krause LK, Pradhan S, et al. Malnutrition after Vascular Surgery: Are Patients with Chronic Renal Failure at Increased Risk? *Am J Surg.* 2006;192(5):e22-7. PMID: 17071176.
81. Elwyn G, Tsulukidze M, Edwards A, et al. Using a 'Talk' Model of Shared Decision Making to Propose an Observation-Based Measure: Observer Option 5 Item. *Patient Educ Couns.* 2013;93(2):265-71.
82. Elwyn G, Lloyd A, Joseph-Williams N, et al. Option Grids: Shared Decision Making Made Easier. *Patient Educ Couns.* 2013;90(2):207-12. PMID: 22854227.
83. Couet N, Desroches S, Robitaille H, et al. Assessments of the Extent to Which Providers Involve Patients in Decisions: A Systematic Review Using the Option Instrument. *Health Expect.* 2013.
84. Schwartz LM, Woloshin S, Birkmeyer JD. How Do Elderly Patients Decide Where to Go for Major Surgery? Telephone Interview Survey. *BMJ.* 2005;331(7520):821. PMID: 16192286; PMCID: 1246083.
85. Suckow B, Goodney PP, Nolan B, et al. Domains That Determine Quality of Life in Vascular Amputees. *J Vasc Surg.* 2015;(in press).
86. Elwyn G, Edwards A, Wensing M, et al. Shared Decision Making: Developing the Option Scale for Measuring Patient Involvement. *Qual Saf Health Care.* 2003;12(2):93-9. PMID: 12679504; PMCID: 1743691.
87. Vrijhoef HJ, Berbee R, Wagner EH, et al. Quality of Integrated Chronic Care Measured by Patient Survey: Identification, Selection and Application of Most Appropriate Instruments. *Health Expect.* 2009;12(4):417-29. PMID: 19709315.
88. Schnurr PP. The Rocks and Hard Places in Psychotherapy Outcome Research. *J Trauma Stress.* 2007;20(5):779-92. PMID: 17955539.
89. Watts BV, Schnurr PP, Zayed M, et al. A Randomized Controlled Clinical Trial of a Patient Decision Aid for Posttraumatic Stress Disorder. *Psychiatr Serv.* 2014. PMID: 25322473.
90. Ronconi JM, Shiner B, Watts BV. Inclusion and Exclusion Criteria in Randomized Controlled Trials of Psychotherapy for Ptsd. *J Psychiatr Pract.* 2014;20(1):25-37. PMID: 24419308.
91. Hoagland TV. The Principles in Psychotherapy with Veterans. *J Mich State Med Soc.* 1952;51(1):62-4.

92. Littlewood C, et al. A Study to Evaluate the Clinical and Cost-Effectiveness of a Self-Managed Exercise Programme Versus Usual Physiotherapy. *BMC Musculoskelet Disord.* 2012;13:62. PMID: 22545990;
93. Thompson SG, Ashton HA, Gao L, et al. Final Follow-up of the Multicentre Aneurysm Screening Study (MASS) Randomized Trial of Abdominal Aortic Aneurysm Screening. *Br J Surg.* 2012;99(12):1649-56.
94. Thompson SG, Brown LC, Sweeting MJ, et al. Systematic Review and Meta-Analysis of the Growth and Rupture Rates of Small Abdominal Aortic Aneurysms: Implications for Surveillance Intervals and Their Cost-Effectiveness. *Health Technol Assess.* 2013;17(41):1-118. PMID: 24067626.
95. Collaborators R, Bown MJ, Sweeting MJ, et al. Surveillance Intervals for Small Abdominal Aortic Aneurysms: A Meta-Analysis. *JAMA.* 2013;309(8):806-13. PMID: 23443444.
96. Schanzer A, Greenberg RK, Hevelone N, et al. Predictors of Abdominal Aortic Aneurysm Sac Enlargement after Endovascular Repair. *Circulation.* 2011;123(24):2848-55. PMID: 21478500.
97. Goodney PP, Lucas FL, Travis LL, et al. Changes in the Use of Carotid Revascularization among the Medicare Population. *Arch Surg.* 2008;143(2):170-3. PMID: 18283142.
98. Goodney PP, Holman K, Henke PK, et al. Regional Intensity of Vascular Care and Lower Extremity Amputation Rates. *J Vasc Surg.* 2013;57(6):1471-79, 80 e1-3; discussion 9-80. PMID: 23375611;
99. Stone DH, Goodney PP, Kalish J, et al. Severity of Chronic Obstructive Pulmonary Disease Is Associated with Adverse Outcomes in Patients Undergoing EVAR. *J Vasc Surg.* 2013;57(6):1531-6.
100. Goodney PP, Beck AW, Nagle J, et al. National Trends in Lower Extremity Bypass Surgery, Endovascular Interventions, and Major Amputations. *J Vasc Surg.* 2009;50(1):54-60. PMID: 19481407.
101. West AN, Lee PW. Associations between Childbirth and Women Veterans' VA and Non-VA Hospitalizations for Major Diagnostic Categories. *Mil Med.* 2013;178(11):1250-5. PMID: 24183775.
102. Lee PW, Markle PS, West AN, et al. Use and Quality of Care at a VA Outreach Clinic in Northern Maine. *J Prim Care Community Health.* 2012;3(3):159-63. PMID: 23803775.
103. West AN, Weeks WB, Wright SM, et al. When VA Patients Have Non-VA Hospitalizations, Who Pays for What Services, and What Are the Research Implications? A New York Case Study. *Med Care.* 2008;46(8):872.
104. Fowler FJ, Jr., Gallagher PM, Bynum JP, et al. Decision-Making Process Reported by Medicare Patients Who Had Coronary Artery Stenting or Surgery for Prostate Cancer. *J Gen Intern Med.* 2012;27(8):911-6. PMID: 22370767; PMCID: 3403150.
105. Faerber AE, Horvath R, Stillman C, et al. Development of a Health Information Technology Tool for Patients with carotid stenosis. *BMC Med Inform Decis Mak.* 2015;15(1):20. PMID: 25890090;
106. Efron B, Tibshirani R. Improvements on Cross-Validation: The .632+ Bootstrap Method. *J Am Stat Assoc.* 1997;92(438):548-60.
107. Sim J, Wright CC. The Kappa Statistic in Reliability Studies: Use, Interpretation, and Sample Size Requirements. *Phys Ther.* 2005;85(3):257-68. PMID: 15733050.