PhD Dissertation Pilot Data Planning

Protocol Alterations

* Could have a very simplified version of our protocol, with less options, less choices total needed to be made.
  + Could provide each element with a full description of what it entails in SIMPLE terms
    - Could be choose left or right (instead of 3 options)
  + Each element is provided with Paling Perspective Scale showing relative risks of problems in this category
    - Note that PPS usage primarily favors risks that are similar to the target and spatially closest, and the 3rd reference risk is much less important compared to the 1st or 2nd, thus ‘overloading’ information seems unlikely.
    - Alternatively, risk can be portrayed as a table with shared fixed denominator
    - Or, risk can be portrayed as ‘topline total expected cost’ for individual per year, based on % of occurrence and average cost of occurrence.
  + Each element is provided with estimated total cost per year that the problems would drain, and how much relative coverage per year each option could or would give.
    - This would let us see which of the relative sets of options is better at helping the less numerate comprehend what is happening and make better choices
* Could have similar version of our protocol, with ‘pre-set’ options meant to be aimed at different types of preferences and wants. Choosing or making a choice from a limited set of options that have clear differences in coverage and types of priorities.
* More complex version of protocol, with dollar-actuarial estimates of what each ‘peg’ costs (for example, 5$ per peg per month)
  + Directly asking what individuals think is worth having, letting them set-up total topline budgetary costs (could spend more, could spend less, etc.)
  + Would provide interesting data on care priorities and total spending patterns.

Do regardless?

* Order information s.t. most important items are either first or last
  + Ask people to rank order information (what care categories they care about)
    - Then present and weight each attribute by how much they care about them.
    - Specifically, what we can do with “TAILORING”
* Directly ask people to make choices based on the ASSUMPTION that the presented information is true
  + Is this a big ask, and will it/should it make a difference?
* Extrapolation, but is there any way to learn/know if the individual subjects are aware of what is objectively ‘good’ or ‘bad’ with regards to healthcare?
  + What kind of explanation can we provide to reach consensus?
  + Could consider going into MORE details on important concepts, and just cover less options/choices for less important concepts.
    - Perhaps reference elements/standards in other countries?
  + We can look at values around electronic health record (Brian Zikmund Fischer AND holly witteman)
    - What is a good range, what is how far out of range?
* Add clearer procedural instructions (if we alter the protocol significantly?)

Additional Measures?

* Could measure health literacy directly
  + Also measure how much individuals WANT to be involved in the decision-making process.
    - Note that lower-numeracy subjects tend to prefer more passive decision making, and in theory, are assumed to want educated professionals to make the choices, rather than themselves.
* Measure objective numeracy using measures from math field
  + Number-line mapping exercises (especially including fractions)
* Could measure math anxiety, but doesn’t seem strictly necessary
  + As it isn’t predictive of risk comprehension if you also control for objective math skills.