

NHL Patient Education — Shared Decision Making

On-Demand Branched Video Activity

Script Recommendations Document — Nodes 1–8

Prepared for: Blood Cancer United / Client Review

Source References: Source 1: Full Script (All Nodes) | Source 2: Lizette Figueroa Summary | Source 3: SDM Evidence-Based Primer | Source 4: Assumption Guidance

Status: **DRAFT — For client approval only. The original script (Source 1) must remain unaltered until changes are approved.**

Supporters: AbbVie, Eli Lilly, Genentech, Ipsen

TYPE A — Client Requested Changes

Changes requested by Lizette Figueroa and the Blood Cancer United content team (Source 2).

TYPE B — SDM Principle Gaps

Changes needed to ensure full coverage of SDM best-practice principles (Source 3 Evidence-Based Primer).

1. Purpose and Scope

This document identifies and describes recommended changes to the NHL Patient Education script (Source 1, dated March 31, 2026). It is organized into two distinct change types:

- **Type A — Changes explicitly requested by Lizette Figueroa and the Blood Cancer United content team, as captured in the meeting summary (Source 2, March 20, 2026).**
- **Type B — Changes identified as necessary to ensure the script fully embeds evidence-based Shared Decision Making (SDM) principles, as defined by the AHRQ SHARE Approach, Elwyn's Three-Talk Model, NICE NG197, and the Makoul-Clayman nine-element framework (Source 3).**

IMPORTANT: This document does not alter the original script. All recommendations contained herein require client review and written approval before any changes are made to Source 1.

The activity consists of 8 nodes across two parallel paths (iNHL — Indolent, and aNHL — Aggressive Non-Hodgkin Lymphoma). Recommendations address both paths where applicable, and are flagged specifically when they apply to only one path.

2. Executive Summary of Findings

The current script (Source 1) demonstrates strong foundational storytelling and a clear commitment to patient empowerment. The branched structure, Alex/Nate narrative arcs, and menu-driven learner choices are well-conceived. However, analysis against Sources 2, 3, and 4 identifies the following priority areas for improvement:

- Inclusion Architecture: The introductory branching does not yet accommodate the 80+ NHL subtypes, rare T/NK-cell lymphomas, or learners who don't know their subtype. (Source 2, Lizette priority item)
- Clinical Trials: No mention of clinical trials across all 8 nodes — a significant SDM gap and a Lizette-specific concern. (Source 2 + SDM P2)
- Relapse/Second-Line Planning: The script ends without adequately addressing what happens if first-line treatment fails, a key anxiety-reduction element for patients. (Source 2)
- NCI-Designated Centers & Second Opinions: While second opinions are mentioned briefly in Node 6, the concept of NCI-designated centers is absent, and guidance for community center patients is missing. (Source 2)
- Quantitative Risk Communication: Per NICE NG197 and AHRQ, risks and benefits should be communicated with numbers rather than vague qualitative terms. This is largely absent across the script. (Source 3, P2)
- Teach-Back / Comprehension Verification: The script includes some informal checking but lacks explicit teach-back moments across nodes, a core SDM requirement. (Source 3, P7 / E7)
- Values Clarification Tools: Node 5 covers personal values but lacks a structured values-clarification exercise, leaving this SDM principle only partially covered. (Source 3, P3 / IPDAS)
- Health Equity and Cultural Humility: The script's diverse cast is a strength, but explicit acknowledgment of cultural communication patterns, health literacy levels, and community center disparities is absent. (Source 2 + Source 3, P9)
- Deliberation Support and Deferred Decisions: The script does not explicitly offer formal decision aids, allow for deferred decisions, or encourage second consultations between menus and scenes. (Source 3, P5 / P6)
- Follow-up Planning: Most node conclusions do not explicitly establish a follow-up plan or monitoring schedule as part of the SDM cycle. (Source 3, P8 / E9)

3. Node-by-Node Recommended Changes

Each recommendation below is presented in the format: Node, Script Location, Type, Recommended Change, and Rationale. Changes are self-contained so they can be reviewed individually for client approval.

Node 1: Understanding Your Diagnosis

Node 1 — Rec 1.A [Lizette (Source 2)] — Expand Introductory Branching Architecture	
Script Location	Menu: Path Selection (before iNHL/aNHL branch) — Alex opening monologue
Applies To	All learners / All paths
Recommended Change	<p>Add a longer, interactive pre-branch sequence before the iNHL/aNHL split. This sequence should:</p> <ul style="list-style-type: none"> - Ask learners to identify their NHL category (slow-growing / aggressive / I don't know yet / other/rare type) - Include an "Unknown" and "Other/Rare" option that does not dead-end the learner but instead guides them to discuss subtype with their doctor - Add a brief context-setting pop-up or info box explaining that NHL has 80+ subtypes and that the program focuses on broad categories - Allow learners selecting "Other/Rare" to continue with whichever path most closely resembles their diagnosis

Rationale / SDM Basis	Lizette's primary structural ask: the program must accommodate the full NHL spectrum, not just the two most common subtypes. Learners with rare T-cell, NK-cell, or unknown subtypes need an entry point. Per SDM principle P1 (Choice Awareness), all decision points must acknowledge uncertainty and include all available paths — including "I don't know yet."
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Node 1 — Rec 1.B [Lizette (Source 2)] — Shift Language from Subtype-Specific to Broad Descriptors

Script Location	Menu: Path Selection — Button labels
Applies To	All learners / Both paths
Recommended Change	Replace any specific subtype names (e.g., DLBCL, follicular) in the main path selection menus with the broader descriptors "slow-growing (indolent)" and "aggressive." Specific subtypes may appear as examples within informational content but should not drive branching architecture.
Rationale / SDM Basis	Lizette specified that naming specific diagnoses in the main flow excludes the many patients who have rare or less common subtypes. Broader descriptors are more inclusive and ensure the content remains evergreen for the 2-3 year program lifespan (Source 4). This also supports SDM equity principle P9 (Cultural Humility / Health Literacy).

Node 1 — Rec 1.C [SDM Principles (Source 3)] — Add Explicit Choice Awareness Statement — Including 'No Treatment' as an Option

Script Location	Menu Node 1.5 Prompt — Shared Decision-Making interest question / Alex closing monologue
Applies To	All learners / Both paths
Recommended Change	When Alex explains shared decision-making to the learner, add an explicit statement that in SDM, options always include watchful waiting or no immediate treatment. Example addition: "Part of shared decision-making is knowing that your options aren't limited to just different treatments. Sometimes 'let's monitor closely before doing anything' is itself a valid option — and your doctor should walk you through all of them."
Rationale / SDM Basis	SDM Principle P1 requires that clinicians and decision-support tools explicitly communicate that a choice exists and that no treatment or watchful waiting is always on the table. This is currently missing from the SDM definition given to learners. Per AHRQ SHARE Step S: "Make clear that watchful waiting or no treatment is always an option."

Node 1 — Rec 1.D [SDM Principles (Source 3)] — Add Teach-Back / Comprehension Check by Dr. Patel

Script Location	Main Node 1.2 Scene — Dr. Patel's explanation of iNHL / aNHL
Applies To	iNHL and aNHL / Dr. Patel scenes
Recommended Change	After Dr. Patel's explanation of the diagnosis, add a structured teach-back moment. Dr. Patel should explicitly ask Alex to repeat back their understanding of the key concept. Suggested addition: PATEL: "Before I go further — can you tell me in your own words what you understand about what I just explained? I want to make sure this is landing clearly for you."
Rationale / SDM Basis	SDM Principle P7 (Check/Clarify Patient Understanding) and the Makoul-Clayman E7 element require that comprehension is verified at multiple points

using teach-back. NICE NG197 explicitly recommends teach-back. The current script checks for understanding informally through Alex's reactions but does not include structured teach-back, which is a distinct technique.

Node 2: Exploring Treatment Options

Node 2 — Rec 2.A [Lizette (Source 2)] — Add Clinical Trials as a Named Treatment Option	
Script Location	Main Node 2.3 Scene — Dr. Miller's explanation of treatment options (iNHL path)
Applies To	iNHL path / Dr. Miller scenes
Recommended Change	In Dr. Miller's treatment discussion, add an explicit mention of clinical trials. Clinical trials should be framed as a first-line consideration, NOT as a last resort. Suggested addition: MILLER: "I also want to make sure you know that clinical trials are an option worth discussing at any stage of treatment — not just if things don't work out. There are active trials for indolent lymphoma at various stages, and I can walk you through how to find out if you might be eligible." A reference to clinicaltrials.gov and nurse navigators should accompany this.
Rationale / SDM Basis	Lizette was explicit: clinical trials must be mentioned and specifically framed as not a last resort. This is also a requirement of SDM Principle P2 (Evidence-Based Information on All Options) — all available and evidence-supported options must be described. Omitting clinical trials is an incomplete options disclosure.

Node 2 — Rec 2.B [Lizette (Source 2)] — Add Clinical Trials to aNHL Treatment Conversation	
Script Location	Main Node 2.3 Scene — Dr. Miller's explanation (aNHL path)
Applies To	aNHL path / Dr. Miller scenes
Recommended Change	Mirror the clinical trials addition from Rec 2.A for the aNHL path. Add a brief but clear statement from Dr. Miller that clinical trials are available for aggressive lymphoma patients as well, and are a legitimate option — not a fallback. A reference to nurse navigators and clinicaltrials.gov should be included.
Rationale / SDM Basis	Same basis as Rec 2.A. Both paths must address clinical trials as an option per Lizette's direction and SDM P2.

Node 2 — Rec 2.C [Lizette (Source 2)] — Clarify That Radiation is a Valid Option for Some Indolent Lymphoma Patients	
Script Location	Main Node 2.3 Scene — Dr. Miller (iNHL path) — radiation section
Applies To	iNHL path / Dr. Miller scenes
Recommended Change	Strengthen Dr. Miller's discussion of radiation for iNHL. Currently, radiation is described as only used in "very specific situations" with a note that it's "less common." Add context that radiation is a valid first-line option for patients with isolated or localized indolent NHL (e.g., marginal zone lymphoma limited to one area). Suggested addition: MILLER: "Radiation can actually be a primary treatment for some patients whose lymphoma is in just one area of the body

	— for example, some cases of marginal zone lymphoma. It's not the right fit for everyone, but it's worth knowing it exists as a standalone option in the right circumstances."
Rationale / SDM Basis	Lizette specifically flagged that radiation should not be omitted. Per SDM P2, all evidence-based options must be described with appropriate balance. Framing radiation only as a conditional add-on understates its role for specific patient populations.

Node 2 — Rec 2.D [Lizette (Source 2)] — Add Explicit Relapse Planning and Anxiety-Reduction Language	
Script Location	Main Node 2.5 Scene — 'What happens if treatment stops working' (iNHL) / closing scenes (aNHL)
Applies To	Both paths / Dr. Miller or Dr. Patel scenes
Recommended Change	In both paths, add a moment where the treating physician explicitly tells the patient that a plan exists for relapse or treatment failure — even if they hope not to need it. Suggested addition (iNHL, Dr. Miller): "I also want you to know: we never treat first-line therapy as if it's the only option. If the lymphoma ever comes back or stops responding, we have a plan for that too. You don't have to wait and worry about 'what if' — there's a roadmap." This should not be presented as alarming, but as reassuring forward-planning.
Rationale / SDM Basis	Lizette specifically cited patient anxiety about relapse as a key content need. Addressing this proactively reduces decisional conflict (SDM P5). SDM Principle P8 (Collaborative Decision + Follow-Up) requires that a plan for monitoring outcomes and revisiting the decision is established. Explicitly naming a relapse contingency plan is a concrete expression of that principle.

Node 2 — Rec 2.E [SDM Principles (Source 3)] — Add Quantitative Risk/Benefit Language to Treatment Comparisons	
Script Location	Main Node 2.2 Scene — Dr. Miller treatment explanation (iNHL) — options overview
Applies To	iNHL path / Dr. Miller
Recommended Change	When Dr. Miller discusses rituximab and other options, replace vague qualitative descriptors ("generally well tolerated," "can be difficult to manage") with at least one example using numbers. For example: "Studies suggest that for patients with your type of indolent lymphoma, about [X in 10] people respond well to rituximab alone as a first treatment." Exact statistics should be sourced from current clinical data and verified by the content team before insertion.
Rationale / SDM Basis	NICE NG197 is explicit: "Numerical data should be used to describe risks and benefits rather than qualitative terms such as 'rare' or 'common.'" AHRQ SHARE Step H also specifies "communicate risks and benefits in numbers rather than vague terms." This is an IPDAS essential criterion for patient decision aids. The current script relies heavily on qualitative language.

Node 3: Weighing Benefits and Risks

Node 3 — Rec 3.A [Lizette (Source 2)] — Add Newer Therapy 'Buzzwords' to iNHL Discussion for Awareness	
Script Location	Mini Scene Response 3.1.1 (iNHL) — Dr. Lewis treatment rationale discussion
Applies To	iNHL path / Dr. Lewis
Recommended Change	In Dr. Lewis's options explanation for iNHL, add brief references to newer therapies by name so patients from community centers hear terms they may encounter elsewhere. Dr. Lewis should reference BTK inhibitors and bispecific agents by category name (not brand), ensuring sponsors (AbbVie, Eli Lilly, Genentech, Ipsen) feel represented without any therapy being over-weighted. Lizette's suggested framing: patients should be able to recognize these terms and feel empowered to ask their doctor about them.
Rationale / SDM Basis	Lizette was explicit about using known "buzzwords" so patients — especially those at community centers who may only be offered older therapies — have the language to ask about newer options. This is also an SDM equity issue (P9): patients in under-resourced settings are less likely to be offered cutting-edge options unless they ask.

Node 3 — Rec 3.B [SDM Principles (Source 3)] — Add Explicit Values Clarification Exercise	
Script Location	Mini Scene Response 3.2.2 (iNHL) / Node 3.4 Scene (aNHL) — Dr. Lewis / Alex reflections
Applies To	Both paths / Alex sidebar or menu prompt
Recommended Change	Add a structured values-clarification moment to Node 3. This can be embedded in the learner menu as a brief reflective prompt, or delivered by Alex as a sidebar. Example: "Before thinking about which treatment to choose, it can help to ask yourself: What matters most to me right now? Staying active? Minimizing side effects? Having a fixed end-date to treatment? Or something else? Knowing your priorities can help your doctor tailor the conversation to what matters most to you." A short on-screen list of common patient values could accompany this.
Rationale / SDM Basis	SDM Principle P3 (Values/Preferences) requires using open-ended questions or structured tools to elicit what matters most to the patient. The IPDAS standards specifically require "values clarification exercises (explicit tools for patients to weigh trade-offs)." The current script discusses preferences in conversation but does not include a structured values-clarification tool or prompt. This is a gap against both SDM P3 and IPDAS essential criteria.

Node 3 — Rec 3.C [SDM Principles (Source 3)] — Replace Qualitative Descriptors with Numeric Risk Examples	
Script Location	Mini Scene Response 3.1.1 and 3.1.2 — Dr. Lewis comparisons
Applies To	Both paths / Dr. Lewis
Recommended Change	In Dr. Lewis's side-by-side treatment comparison, add at least one concrete numeric example to illustrate risk/benefit trade-offs. For example: "For patients with your profile, studies show that about [X%] achieve a full response with this regimen in the first six months." All statistics must be verified by the clinical content team before insertion. This need not be comprehensive — even one or two data points materially improves SDM fidelity.
Rationale / SDM Basis	Same basis as Rec 2.E. NICE NG197 and AHRQ SHARE both require numerical risk communication. This is also an IPDAS essential criterion. Node

3 is the primary risk/benefit comparison node and is where numeric data would have the highest educational impact.

Node 4: Managing Side Effects

Node 4 — Rec 4.A [SDM Principles (Source 3)] — Strengthen the 'Poor SDM' Contrast Moment with Explicit Labeling

Script Location	Main Scene 4.1 — Dr. Patel's initial dismissive response
Applies To	Both paths / Alex direct-to-learner moment
Recommended Change	Node 4 opens with Dr. Patel being somewhat dismissive of Alex's symptoms. The scene includes a prompt noting this reflects a more dismissive provider. This label should be made explicit in Alex's direct-to-learner commentary — naming this as an example of what SDM failure looks like. Alex should articulate what the doctor is NOT doing: "Notice what just happened there. Dr. Patel didn't ask me to describe my symptoms in my own words. He didn't check whether I felt understood. He moved straight to reassurance without really listening. That's a missed opportunity for shared decision-making."
Rationale / SDM Basis	SDM Principle P4 (Bilateral Exchange) requires an explicit mechanism for the patient to ask questions and express concerns. The contrast between poor and good SDM practice is powerful pedagogically, but it needs to be named explicitly. Elwyn's Three-Talk model (Team Talk) emphasizes that clinicians must acknowledge the decision-making partnership — silence in the face of patient concern is a departure from that principle.

Node 4 — Rec 4.B [SDM Principles (Source 3)] — Add Explicit Follow-Up Plan / Monitoring Schedule

Script Location	Main Node 4.2 Scene — Dr. Patel clear plan discussion
Applies To	Both paths / Dr. Patel
Recommended Change	After Dr. Patel's symptom-management conversation, add a specific, structured follow-up plan rather than general reassurance. Dr. Patel should articulate: (1) the specific schedule for check-ins, (2) what will be monitored and how, (3) who Alex should contact for what types of issues, and (4) at what threshold they would reconvene to revisit the treatment plan. Example: "So here's our plan going forward: I'll see you in [X] weeks, your nurse line is available [hours], and if any of these red-flag symptoms appear, we escalate same day. We'll also recheck your labs at that appointment to see how things are tracking."
Rationale / SDM Basis	SDM Principle P8 (Collaborative Decision + Follow-Up) and Makoul-Clayman E9 (Arrange Follow-Up) both require that a specific follow-up plan be established. AHRQ SHARE Step E specifies: "Arrange follow-up. Confirm the patient understands the decision and its implications. Plan to monitor outcomes." The current script concludes the Node 4 arc with reassurance but lacks a concrete plan structure.

Node 5: Aligning with Your Values and Preferences

Node 5 — Rec 5.A [Lizette (Source 2)] — Strengthen Emotional Validation Language	
Script Location	Main Node 5.1.1 and 5.1.2 — Dr. Patel / Alex — daily life and support discussions
Applies To	Both paths / Dr. Patel
Recommended Change	In both the daily-life and support discussions, strengthen the emotional validation language. Dr. Patel's current responses are somewhat directive and logistical. Add a brief but genuine acknowledgment of the emotional dimension before moving to problem-solving. Example addition for Dr. Patel: "Before we talk through options — I want to say that everything you're describing is completely understandable. A diagnosis like this changes every part of your life, not just the medical part. Your feelings about that are not wrong." This should apply in both the iNHL and aNHL paths.
Rationale / SDM Basis	Lizette specifically asked for explicit emotional validation — telling patients their feelings are not wrong. SDM Principle P3 (Values/Preferences) includes affective and emotional dimensions. The Elwyn Three-Talk Team Talk step specifically requires that the clinician acknowledges the difficulty of the situation before moving to options discussion. Emotional acknowledgment also reduces decisional conflict (SDM P5).

Node 5 — Rec 5.B [Lizette (Source 2)] — Add Explicit Language for Older Patients and Culturally Diverse Learners	
Script Location	Menu Node 5.3 Prompt / Main Node Scene 5.4 — Personal values and cultural beliefs
Applies To	Both paths / Alex direct-to-learner
Recommended Change	In the values/beliefs discussion, add a brief moment where Alex speaks directly to learners from backgrounds where questioning doctors is not culturally normalized. Example: "For many of us — especially those from communities where we were taught to trust the doctor completely, or where speaking up can feel disrespectful — this part can feel uncomfortable. But your lived experience, your cultural practices, and how your body feels every day are forms of expertise your doctor needs. You are not questioning their authority by sharing them. You are helping them do their job better."
Rationale / SDM Basis	Lizette flagged that the target audience skews 50+ and includes culturally diverse patients — particularly Latino patients — who may not see questioning their doctor as culturally acceptable. SDM Principle P9 (Equity and Cultural Humility) requires that materials acknowledge and address cultural communication norms. This is also an AHRQ and NICE NG197 implementation requirement.

Node 5 — Rec 5.C [Lizette (Source 2)] — Add NCI-Designated Center Awareness Content	
Script Location	Node 5 — Transition from financial discussion to values discussion
Applies To	Both paths / Alex or Dr. Patel
Recommended Change	Add a brief educational moment — delivered by Alex or embedded in a menu info-box — that introduces the concept of NCI-designated cancer centers. Content should explain what an NCI designation means, why blood cancers benefit from treatment at high-volume specialized centers, and how to find

	<p>NCI-designated centers. Also add language specifically addressing patients who may be receiving care at community centers: "If you're being treated at a local community center, it's worth asking your doctor whether there are options available at a larger cancer center that specialize in blood cancers — and whether a second opinion there would make sense for your situation."</p>
Rationale / SDM Basis	<p>Lizette explicitly asked for: education about NCI-designated centers, encouragement to seek second opinions, and specific language for community center patients. Blood cancers are rare and community centers may offer outdated treatments. Per SDM P1 and P2, patients must be aware that all options exist. The current script addresses second opinions briefly in Node 6 but does not mention NCI-designated centers or community center disparities anywhere.</p>

Node 5 — Rec 5.D [SDM Principles (Source 3)] — Add Formal Deferred Decision Mechanism	
Script Location	Main Node Scene 5.4 — Personal values / Dr. Patel response
Applies To	Both paths / Dr. Patel
Recommended Change	<p>Add a moment where Dr. Patel explicitly names the option of taking time before deciding. Suggested addition: PATEL: "I also want you to know — you don't have to make any decisions today. If you want to sit with this information, talk to family, or come back with more questions before we finalize anything, that is completely okay and I will support that." This should be paired with a concrete mechanism: "We can schedule a follow-up in [X] days specifically to continue this conversation."</p>
Rationale / SDM Basis	<p>SDM Principle P5 (Deliberation Support) includes: allows time for deferred decisions and supports patient consultation with others before deciding. AHRQ SHARE Step R specifies: "Allow time for reflection — complex decisions may require a follow-up appointment." Currently the script moves from values discussion to plan formation without explicitly naming deferred decision as an option.</p>

Node 6: Communicating with Your Healthcare Team

Node 6 — Rec 6.A [Lizette (Source 2)] — Expand Second Opinion Guidance to Include NCI-Designated Centers	
Script Location	Main Node Scene 6.8 — Second opinions discussion
Applies To	Both paths / Alex
Recommended Change	<p>In Alex's second opinion discussion, add specific language about NCI-designated centers. Suggested addition: "One great resource when seeking a second opinion is an NCI-designated cancer center — these are hospitals and research centers recognized by the National Cancer Institute for their specialized expertise in treating cancers. Because blood cancers like NHL are relatively rare, getting input from a center that treats high volumes of patients with these diagnoses can be really valuable. You can find a list at cancer.gov." Also address that second opinions sometimes yield different but equally valid recommendations — and that this is normal and should not cause panic.</p>
Rationale / SDM Basis	<p>Lizette asked for NCI-designated center education and normalization of different provider opinions. Per SDM P5 and P6, decision support includes</p>

helping patients access expert consultation. The current Node 6 second opinion discussion is good but does not connect to NCI resources or address the reality that top specialists may recommend differently.

Node 6 — Rec 6.B [SDM Principles (Source 3)] — Strengthen Teach-Back as a Named, Learner-Actionable Technique

Script Location	Main Node Scene 6.5 — Communication strategies / teach-back examples
Applies To	Both paths / Alex
Recommended Change	In Alex's communication skills discussion, elevate teach-back from an implied technique to an explicitly named, taught strategy. Alex should say: "One of the most powerful things you can do in any appointment is what's called 'teach-back.' It means you briefly repeat back what you just heard in your own words, so both you and your doctor can confirm you're on the same page. Something like: 'So if I'm understanding correctly, what you're saying is... Is that right?' It sounds simple, but it changes everything about how much you actually take in from a visit."
Rationale / SDM Basis	Makoul-Clayman E7 and SDM P7 require that comprehension is verified using techniques such as teach-back. NICE NG197 explicitly recommends teach-back. The current script gestures at this concept but does not name it as a technique, explain its mechanics, or empower learners to use it proactively. Naming it gives learners a transferable tool.

Node 7: Building Your Support System

Node 7 — Rec 7.A [Lizette (Source 2)] — Add Blood Cancer United as a Named Resource with Specific Context

Script Location	Main Node Scene 7.5 — Dr. Miller support groups and resources
Applies To	iNHL path (aNHL already includes this) / Dr. Miller
Recommended Change	In Dr. Miller's discussion of support organizations, add an explicit reference to Blood Cancer United by name and position it as a primary resource for NHL patients specifically. Example: MILLER: "One organization I'd specifically recommend for NHL patients is Blood Cancer United — they have resources designed for patients and caregivers, including support groups, educational content, and connections to navigators who specialize in blood cancers." This mirrors the reference already included in the aNHL Node 3 scene but should be consistently present across both paths.
Rationale / SDM Basis	Blood Cancer United is the program sponsor's partner organization. Consistency requires that learners in both paths receive the same organizational referral. This also fulfills SDM P8 — the follow-up plan should include community resources, not just clinical referrals.

Node 7 — Rec 7.B [Lizette (Source 2)] — Add Nurse Navigator as a Named, Accessible Resource

Script Location	Main Node Scene 7.5 and 7.8 — Support services and navigator discussions
Applies To	Both paths / Dr. Miller or Alex

Recommended Change	In the support services and patient navigator discussions, add specific reference to nurse navigators as a named role. Suggested addition: "There's also a type of specialist called a nurse navigator or patient navigator — they help patients like you coordinate care, understand their diagnosis, understand clinical trial options, and connect to community resources. Your care team may have one, and if they don't, organizations like Blood Cancer United can connect you with navigation services." Also add a reference to clinicaltrials.gov in this section.
Rationale / SDM Basis	Lizette specifically named nurse navigators as a resource to be integrated into the program. Clinical trial matching and resource navigation are navigator-specific functions. Per SDM P5 (Deliberation Support), decision aids should reference consultation resources. This also directly connects to Lizette's goal of integrating nurse navigator services into the resource layer.

Node 7 — Rec 7.C [SDM Principles (Source 3)] — Name the SDM Failure Pattern in the Contrast Scene More Explicitly

Script Location	Main Node Scene 7.3 — Kate's emotional needs / Dr. Miller response (initial dismissal)
Applies To	Both paths / Alex direct-to-learner
Recommended Change	In Alex's commentary after the initial Dr. Miller dismissal of Kate's emotional needs, add a clearer SDM-specific diagnosis of what went wrong. Alex should name the specific SDM elements missing: "What we just saw was a missed opportunity for SDM in two ways: first, Dr. Miller didn't really listen to Kate's expressed need — he moved to a generic solution without checking what she actually wanted. And second, he didn't assess whether Kate had the support systems in place to carry out her care. Those two things — listening to what the patient says they need, and checking whether they can actually get it — are core parts of shared decision-making."
Rationale / SDM Basis	Makoul-Clayman E5 (Discuss Patient Ability and Self-Efficacy) requires that the clinician assesses whether the patient has the capability and support systems to carry out the chosen treatment plan. This is one of the most commonly overlooked SDM elements. Making the gap explicit gives learners a specific frame to recognize and address in their own care.

Node 8: Planning Next Steps and Coping

Node 8 — Rec 8.A [Lizette (Source 2)] — Add Explicit Second Opinion Encouragement in the Closing Node

Script Location	Main Node Scene 8.3 — Dr. Patel closing visit (iNHL) / Post-chemo recovery (aNHL)
Applies To	Both paths / Dr. Patel
Recommended Change	In the closing visit scene, add a brief moment where Dr. Patel proactively mentions second opinions as a normal and supported part of care — before the learner has to ask. Suggested addition: PATEL: "One more thing I want to bring up before we close: if at any point you want a second opinion — from another hematologist, or from an NCI-designated center — I fully support that. It's a normal part of making sure you feel confident in your care. Just let me

	know and I can help connect you or transfer your records." Proactive mention normalizes this far more than waiting for patients to raise it.
Rationale / SDM Basis	Lizette stressed that blood cancer patients should actively be encouraged to seek second opinions. The current Node 8 does not include second opinions. Proactive clinician endorsement of second opinions — rather than reactive permission-giving — is a stronger SDM model aligned with P5 (Deliberation Support) and P6 (Patient Decision Aids / Expert Consultation).

Node 8 — Rec 8.B [SDM Principles (Source 3)] — Establish an Explicit SDM Commitment Closing Moment	
Script Location	Main Node Scene 8.3 and 8.4 — Alex closing reflections / Learner check-in
Applies To	Both paths / Alex and learner
Recommended Change	Add a closing SDM commitment prompt where the learner is invited to identify one concrete action they will take as a result of this program. This can be a menu selection or a direct Alex prompt. Options might include: "I will write down my top three questions before my next appointment," "I will ask my doctor to walk me through my options side by side," "I will contact my care team's social worker this week," or "I will look into NCI-designated centers near me." Alex should validate any choice with a brief, specific affirmation.
Rationale / SDM Basis	AHRQ SHARE Step R (Reach a Decision Together) and Step E (Evaluate the Decision) both require that the SDM encounter concludes with a clear action plan. Makoul-Clayman E8 (Make or Defer a Decision) requires that a decision or next step is clearly identified. The current Node 8 closes with reflective and affirming content but does not drive a specific learner commitment — which is a gap in behavioral follow-through from the SDM process.

Node 8 — Rec 8.C [SDM Principles (Source 3)] — Add Disclosure of Funding/Supporter Information Per IPDAS Standards	
Script Location	Main Node Scene 8.5 — Alex final farewell
Applies To	Both paths / End-screen or Alex
Recommended Change	In the closing sequence, add a brief, transparent disclosure statement acknowledging that this program was developed with support from AbbVie, Eli Lilly, Genentech, and Ipsen, and that the content was developed to be balanced and independent. Example: "This program was made possible with support from AbbVie, Eli Lilly, Genentech, and Ipsen. The content was developed by Blood Cancer United to be balanced, evidence-based, and free from commercial influence." This can appear as an end-screen graphic or voiced statement.
Rationale / SDM Basis	IPDAS essential criteria require: "Conflicts of interest in development and funding are disclosed." This is a mandatory element of any patient decision aid that meets IPDAS standards. Given that four pharmaceutical companies are supporters, transparent disclosure is both ethically required and legally protective for Blood Cancer United.

4. SDM Principle Coverage Analysis

The table below maps each of the nine SDM core principles from Source 3 against the current script's coverage and the recommended additions.

Ref	SDM Principle	Current Script Status	Gaps	Rec(s) to Address
P1	Choice Awareness	Partial — decision exists is implied; watchful waiting mentioned but not as always-an-option	No explicit statement that no-treatment is always an option; no formal deferred decision mechanism	1.C, 5.D
P2	Evidence-Based Options	Partial — options described qualitatively; some depth in Nodes 2, 3; clinical trials absent	No quantitative risk data; clinical trials omitted; radiation scope understated for iNHL	2.A, 2.B, 2.C, 2.E, 3.C
P3	Values & Preferences	Partial — Node 5 covers values; Node 3 touches on daily life priorities	No structured values-clarification tool or exercise; emotional dimension underweighted	3.B, 5.A
P4	Bilateral Exchange	Moderate — menus give learner voice; Alex advocates throughout	Poor SDM contrast moments not always named explicitly; some dismissals pass without SDM diagnosis	4.A, 7.C
P5	Deliberation Support	Partial — second opinions covered in Node 6; no formal decision aids referenced	No deferred-decision mechanism offered; no reference to decision aids; nurse navigators absent	5.D, 6.A, 7.B
P6	Patient Decision Aids	Low — no reference to IPDAS-compliant tools	No decision aids referenced or offered anywhere in the 8-node sequence	5.D, 6.A
P7	Understanding Verification	Partial — informal checking present; no structured teach-back	Teach-back not named or taught as a learner technique; no systematic comprehension check	1.D, 6.B
P8	Collaborative Decision + Follow-Up	Partial — Node 8 closes with follow-up scheduling; relapse planning weak	No explicit follow-up plan structure in most nodes; relapse contingency absent	2.D, 4.B, 8.A, 8.B
P9	Equity & Cultural Humility	Low — diverse cast is a strength; no content addressing communication culture norms	No cultural communication content; NCI centers absent; community center disparity unaddressed	1.A, 5.B, 5.C

5. Consolidated Recommendations Quick Reference

Rec ID	Node	Type	Change Summary	SDM / Source Basis
1.A	1	Client (Lizette)	Expand introductory branching to include unknown/rare subtypes and 'I don't know yet' options	Source 2; SDM P1, P9
1.B	1	Client (Lizette)	Shift from subtype-specific naming to broad descriptors in path selection	Source 2

1.C	1	SDM Principles	Add explicit 'no treatment is always an option' statement in SDM definition	Source 3 P1; AHRQ SHARE-S
1.D	1	SDM Principles	Add structured teach-back by Dr. Patel after diagnosis explanation	Source 3 P7, E7; NICE NG197
2.A	2	Client (Lizette)	Add clinical trials (not as last resort) to iNHL treatment discussion	Source 2; SDM P2
2.B	2	Client (Lizette)	Add clinical trials to aNHL treatment discussion	Source 2; SDM P2
2.C	2	Client (Lizette)	Clarify radiation as a valid primary option for localized iNHL	Source 2; SDM P2
2.D	2	Client (Lizette)	Add relapse planning and anxiety-reduction language to both paths	Source 2; SDM P5, P8
2.E	2	SDM Principles	Replace qualitative risk language with at least one numerical example	Source 3 P2; NICE NG197; AHRQ SHARE-H
3.A	3	Client (Lizette)	Add newer therapy buzzwords (BTK inhibitors, bispecifics) to iNHL discussion	Source 2
3.B	3	SDM Principles	Add structured values-clarification exercise	Source 3 P3; IPDAS Essential
3.C	3	SDM Principles	Add at least one numeric risk/benefit example in Dr. Lewis comparison	Source 3 P2; NICE NG197
4.A	4	SDM Principles	Name poor SDM patterns explicitly in Dr. Patel contrast scene	Source 3 P4; Elwyn Three-Talk
4.B	4	SDM Principles	Add specific structured follow-up plan in Node 4 closing	Source 3 P8, E9; AHRQ SHARE-E
5.A	5	Client (Lizette)	Strengthen emotional validation before problem-solving in Node 5	Source 2; SDM P3
5.B	5	Client (Lizette)	Add explicit content for older/culturally diverse learners re: speaking up	Source 2; SDM P9
5.C	5	Client (Lizette)	Add NCI-designated center awareness and community center disparity content	Source 2; SDM P1, P9
5.D	5	SDM Principles	Add explicit deferred decision option offered by Dr. Patel	Source 3 P5; AHRQ SHARE-R
6.A	6	Client (Lizette)	Expand second opinion section to include NCI centers and differing expert opinions	Source 2; SDM P5, P6
6.B	6	SDM Principles	Name teach-back explicitly as a learner-actionable technique	Source 3 P7; NICE NG197
7.A	7	Client (Lizette)	Add Blood Cancer United as named resource consistently in iNHL path	Source 2
7.B	7	Client (Lizette)	Add nurse navigator as a named, accessible role with clinicaltrials.gov reference	Source 2; SDM P5
7.C	7	SDM Principles	Name specific SDM elements missing in Dr. Miller contrast scene	Source 3 P4, E5
8.A	8	Client (Lizette)	Add proactive second opinion endorsement by Dr. Patel in closing node	Source 2; SDM P5
8.B	8	SDM Principles	Add SDM commitment closing prompt with concrete learner action	Source 3 P8, E8; AHRQ SHARE-E
8.C	8	SDM Principles	Add IPDAS-required supporter disclosure statement	Source 3 IPDAS Essential

6. Evergreen Considerations and Sponsor Balance

Per Source 4, the program should remain evergreen for 2–3 years. The following principles should govern content additions:

- Avoid naming specific drug brands or dosages in the main simulation dialogue. Drug names may appear as clinical examples within Dr. Patel/Miller/Lewis scenes, as they do currently, but menu prompts and Alex narration should use category descriptors.
- Clinical trial language should reference the concept and the resource (clinicaltrials.gov) rather than specific trials, which will evolve over the program lifespan.
- The four supporters (AbbVie, Eli Lilly, Genentech, Ipsen) are each represented by drug categories currently present in the script. Any additions should maintain approximate balance across therapeutic areas. No single sponsor's therapy should be elevated in Alex's direct-to-learner commentary.
- Newer therapy categories (bispecifics, CAR-T, BTK inhibitors) are referenced by category name in the script — this is the correct level of specificity for evergreen content. Additions should follow the same convention.

7. Approval Process

This document is provided as a recommendation record only. The following approval workflow applies:

1. Client (Blood Cancer United / Lizette Figueroa) reviews and approves, modifies, or rejects each recommendation.
2. Approved items are flagged for incorporation into the script revision process.
3. Script revisions are submitted as a separate tracked-changes document against Source 1.
4. Final approved script is released for production.

End of Recommendations Document — Prepared April 2026

Source 1 script must not be altered without client approval. All recommendations herein are advisory only.