

Public Use of a Web-Based Treatment Decision Aid: The Personal Patient Profile – Prostate

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Attendees will be able to take our findings into consideration when planning deployment of a patient-facing, web-based intervention as open access (freely available through search engine or referral). Important metrics such as time spent on the intervention and acceptability of the interventions are not only important but relevant as to general usage.

The problem is focused on the lack of availability of evidence-based, open-access interventions for cancer treatment decision making.¹ Management of localized prostate cancer is one of the most preference sensitive decisions that exist in modern health care.² Such decision aids typically are available through clinical settings. The purpose of our project was to describe frequencies and explore relationships between user types, usage analytics, decision status and acceptability of the open-access, web-based Personal Patient Profile – Prostate (P3P).

We addressed this gap with the following methods: P3P, a web-based decision aid for localized prostate cancer (LPC), has been tested in two multicenter trials^{3,4} with diverse samples and is available in both English and Spanish. P3P significantly reduced self-reported one-month decisional conflict associated with LPC treatment decisions. Additionally, at six months, Black men who used the P3P intervention benefited the most with regard to lower treatment regret than all others in the second randomized trial. P3P has been available outside of formal implementation sites as of 2017, listed in professional publications, promoted by a public service YouTube video and accessible by search engines. P3P is composed of a query component covering factors related to the decision, how close one is to making a decision, preferences for personal control of the decision, current symptoms and demographics. Answers to the queries populate the personalized, multi-media information and coaching intervention with video personalized to race, ethnicity and language (English/Spanish). Analyses were conducted on users' demographic characteristics and decision status (no decision vs close/made decision) plus usage metrics and Acceptability E-scale (AES) items (overall satisfaction; information value). Due to system limitations, we calculated intervention time spent only for users who completed the AES. Identifying data were not collected. Median times to complete through the AES were categorized into slow, fast completers using a median split. Fisher's exact tests were used to explore relationships.

Results: Between 11/2017 and 11/2019, 130 users, unaffiliated with any implementation site, entered the P3P website. Median age 66 (min 27, max 86); the majority (83.5%, n=108) reported married/partnered status, 17 (13.1%) reported being Hispanic and/or Black. Median time to complete the query component was 8.0 minutes (range 1.0-106.2). 122/130 of the users entered intervention components at least once and 36/130 of the participants entered more than once. Twenty-five users (19%) completed the AES allowing us to calculate time spent on the intervention: median 22.0 minutes (range 3-74). Of these 25 users, 22 (88.0%) reported being satisfied/very satisfied and 21 (84.0%) found the information valuable/very valuable. Users with no treatment decision spent significantly more time in the intervention ($p = .047$) than those who

were close/decided. No significant differences were found between fast and slow completers with regard to race/ethnicity or satisfaction and value.

Conclusions: P3P users outside of formal clinical implementation sites completed the assessment and intervention components in a reasonable amount of time. Users without a final LPC treatment decision likely spent more time in the site as the information and coaching was most pertinent, and the application acceptable and valuable.

Attendee's Take-away Tool



References

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