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CONTINUING MEDICAL EDUCATION

Shared Decision-Making in Optimal Care of Psoriasis and Digital Tools: Making It Work in Practice

Thursday, February 14, 2019

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Joel M. Gelfand, MD, MSCE

Professor of Dermatology
Professor of Epidemiology
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Disclosures

- ***Research Grants (to the Trustees of the University of Pennsylvania):*** AbbVie Inc.; Celgene Corporation; Janssen Biologics, Inc.; Novartis Corporation; Pfizer Inc.; Ortho Dermatologics; Sanofi
- ***Consultant:*** Bristol-Myers Squibb Company; Boehringer Ingelheim; Janssen Biologics, Inc.; Novartis Corporation; Pfizer Inc.; Sanofi; UCB Data and Safety Monitoring Board (DSMB)

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Disclosures

- No relevant financial relationships to disclose

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Junko Takeshita, MD, PhD, MSCE

Assistant Professor of Dermatology
Assistant Professor of Epidemiology
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Case Presentation: JB

- 30 y/o female presenting with plaque psoriasis: scalp, trunk, elbows, knees, genitals, fingernail pitting and onycholysis
- BSA: 12%
- PGA: 3
- Has had symptoms for 5 years, has been self-medicating with OTC treatments
- Demanding job with long hours
- Pruritus resulting in sleep loss
- When asked about joint symptoms, she noted that her knees ache
- Obese

Audience Response

How would you treat JB?

A. Topical treatment
B. Methotrexate
C. Biologic
D. PDE4 inhibitor
E. Phototherapy
F. Not sure

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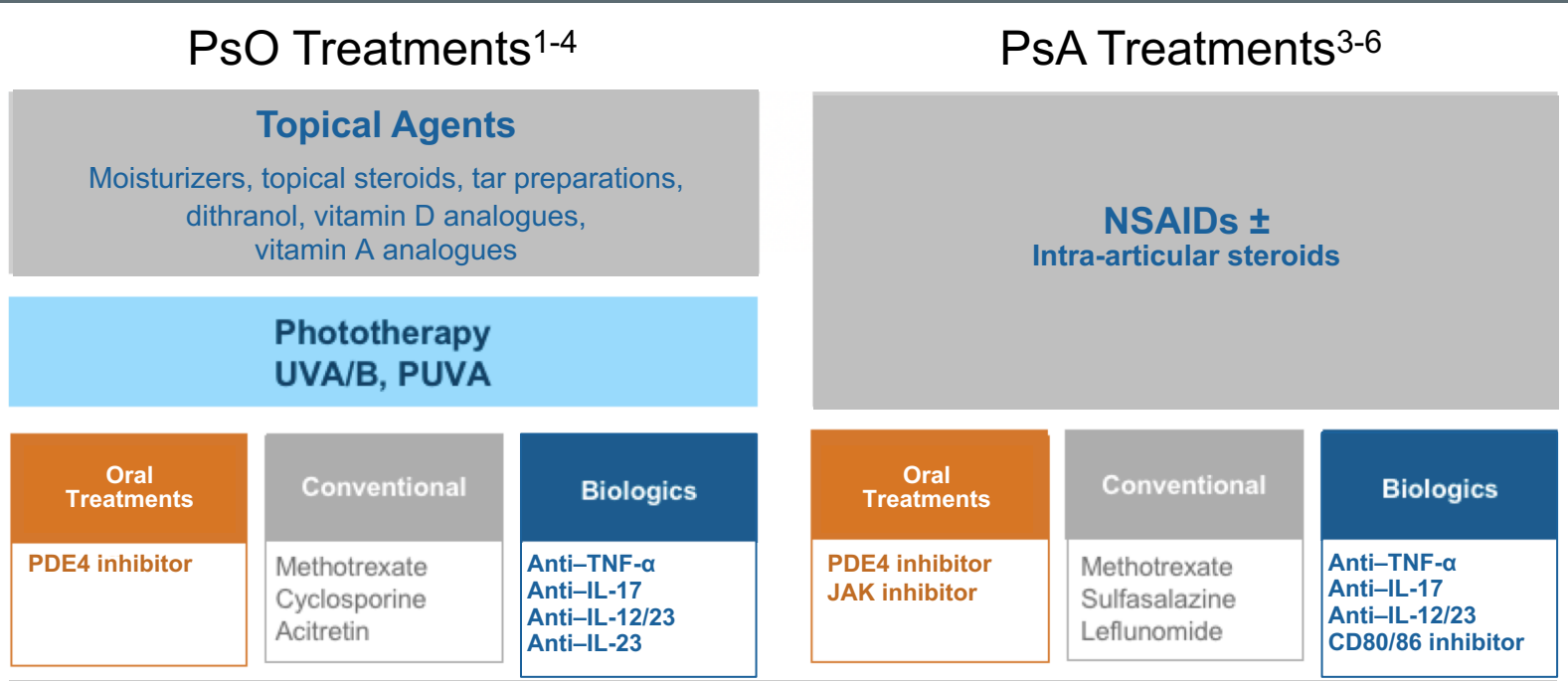
Learning Objective 1

Employ a proactive approach to the management of patients with moderate-to-severe psoriasis not responding to current treatments

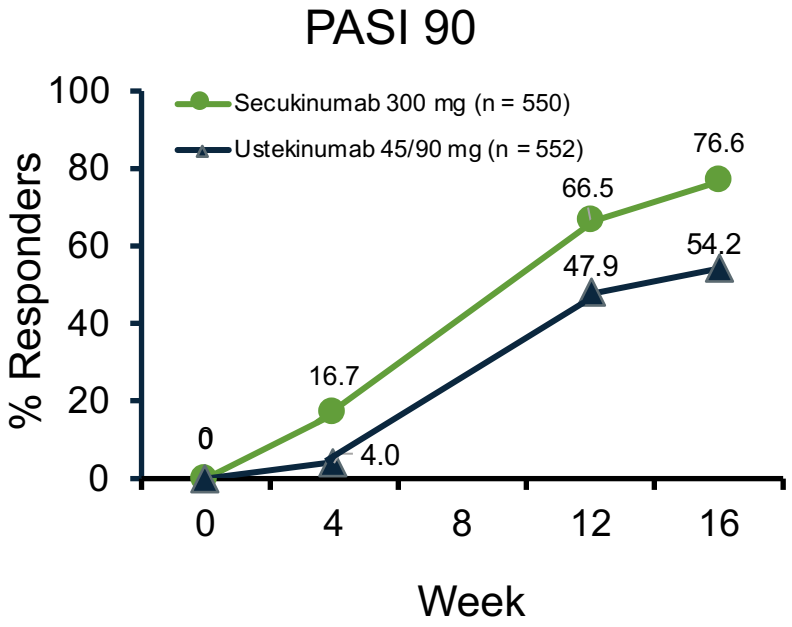
PsO and PsA Treatments

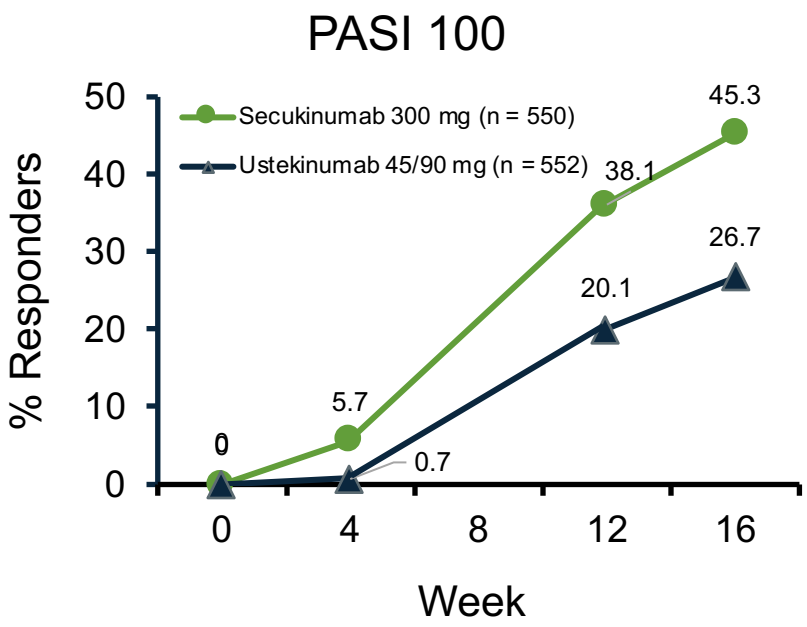


PDE4 = phosphodiesterase 4; UVA/B = ultraviolet A/B.

1. Adapted from Augustin M, et al. *J Eur Acad Dermatol Venereol.* 2012;26(suppl 4):1-16. 2. American Academy of Dermatology Work Group. *J Am Acad Dermatol.* 2011;65:137-174. 3. [Package Inserts]. Drugs@FDA Website. 4. National Psoriasis Foundation. https://www.psoriasis.org/files/pdfs/Treatment-Comparison-Chart.pdf. 5. Gottlieb A, et al. *J Am Acad Dermatol.* 2008;58:851-864. 6. Coates LC, et al. *Arthritis Rheumatol.* 2016;68:1060-1071.

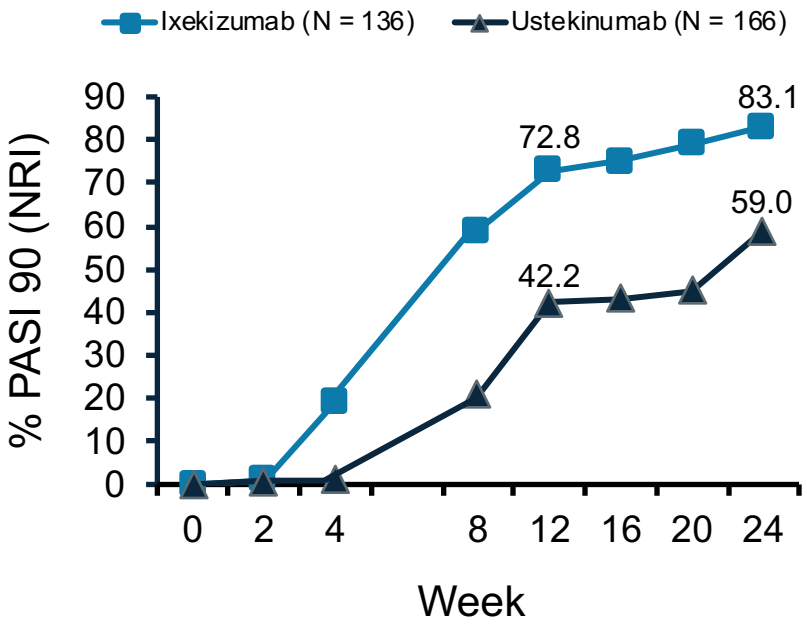
Secukinumab (CLARITY Study)[a,b]

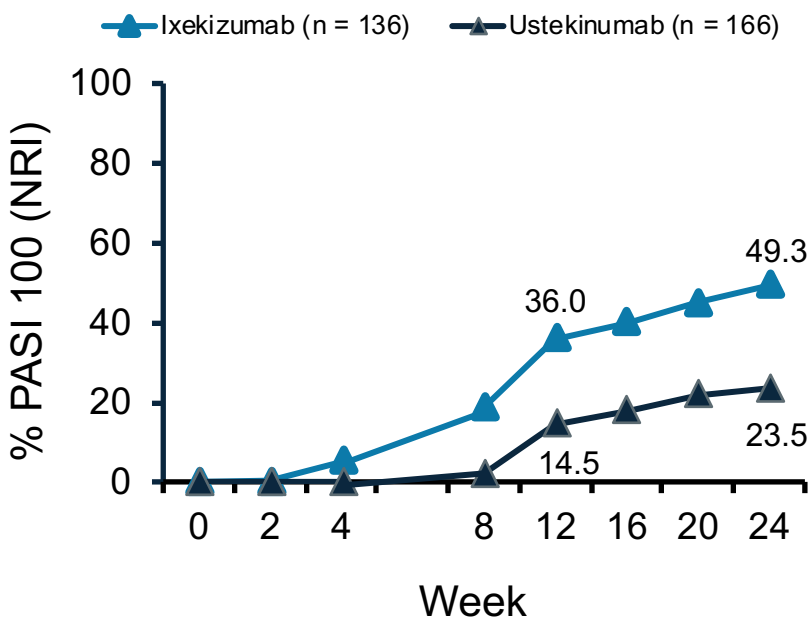




[a]Patients inadequately controlled by topical treatments, phototherapy, and/or previous systemic therapy.
[b]$p < .0001$ for secukinumab vs. ustekinumab at all timepoints.
Bagel J, et al. *Dermatol Ther (Heidelb).* 2018;8:571-579.

Ixekizumab (IXORA-S)[a,b]

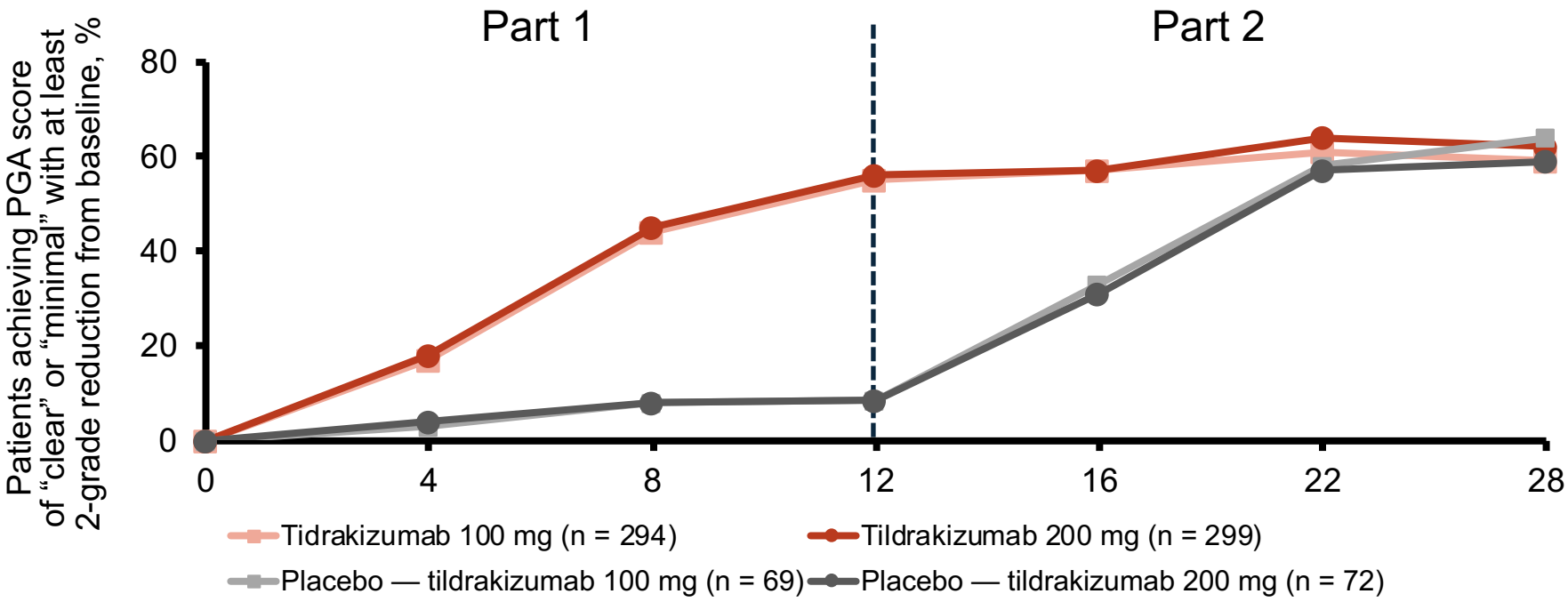




[a]Patients had previously failed or had a contraindication or intolerability to at least 1 systemic therapy (including cyclosporine, methotrexate, and phototherapy). [b]$p < .001$ for ixekizumab vs. ustekinumab at all timepoints.

Reich K, et al. *Br J Dermatol.* 2017;177:1014-1023.

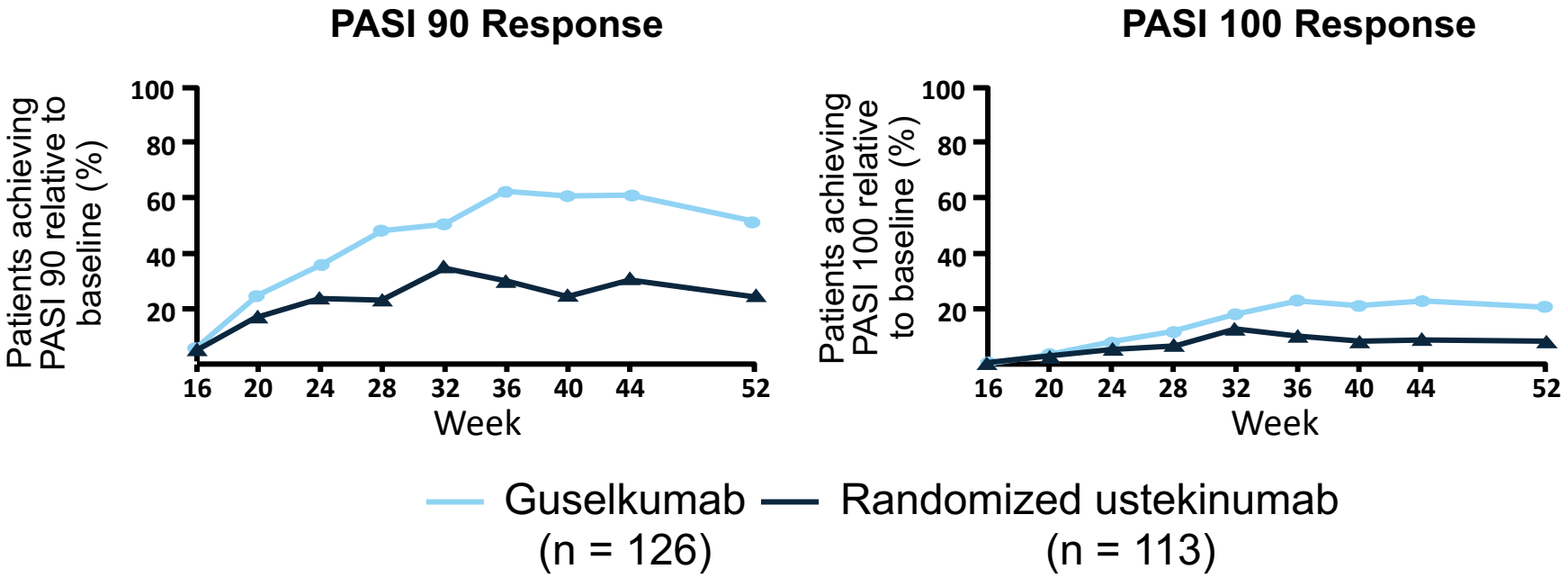
Tildrakizumab (reSURFACE 1)[a]



[a]Patients were candidates for phototherapy or systemic treatment.

Reich K, et al. *Lancet.* 2017;390:276-288.

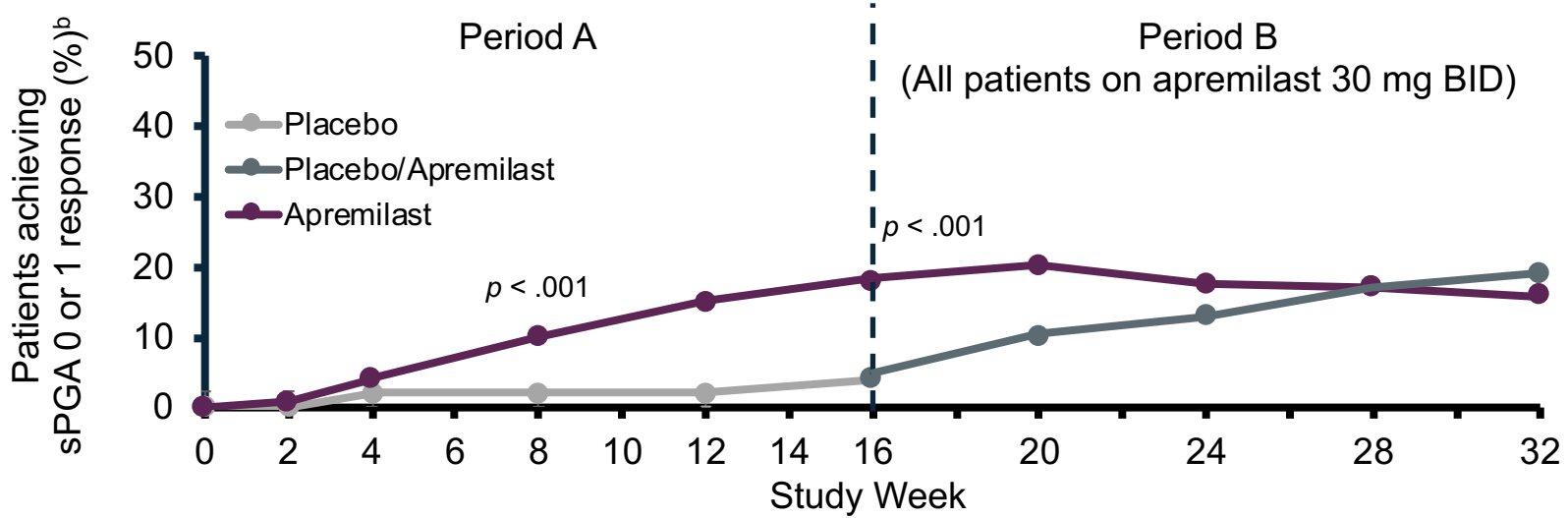
Guselkumab (NAVIGATE Trial)[a]



[a]Patients were candidates for phototherapy or systemic treatment.

Langley RG, et al. *Br J Dermatol*. 2018;178:114-123.

Apremilast (ESTEEM 2)[a]



Placebo, *n*	137	137	137	137	137	137				
Placebo/Apremilast, *n*							108	108	108	108
Apremilast, *n*	274	274	274	274	274	274	274	274	274	274

[a]Patients were candidates for phototherapy or systemic treatment. [b]sPGA 0 = clear, sPGA 1 = almost clear.
Paul C, et al. *Br J Dermatol.* 2015;173:1355-1356.

Selected Pearls from Hot Off the Press AAD-NPF Guidelines

Recommendation Number	Recommendation	Strength of Recommendation
1.4	Etanercept is recommended as monotherapy option in adult patients with moderate-to-severe plaque PsO affecting the scalp and nails	A
2.3	It is recommended that infliximab be administered at a shorter interval (more frequently than every 8 wk and as frequently as every 4 wk during the maintenance phase) and/or at a higher dose up to 10 mg/kg for better disease control in some adult patients.	B
3.3-3.5	Maintenance dose of adalimumab 40 mg/wk is recommended for better disease control in some patients. Adalimumab is recommended as monotherapy for adult patients with moderate-to-severe plaque PsO affecting the palms, soles (palmoplantar PsO), and nails.	A

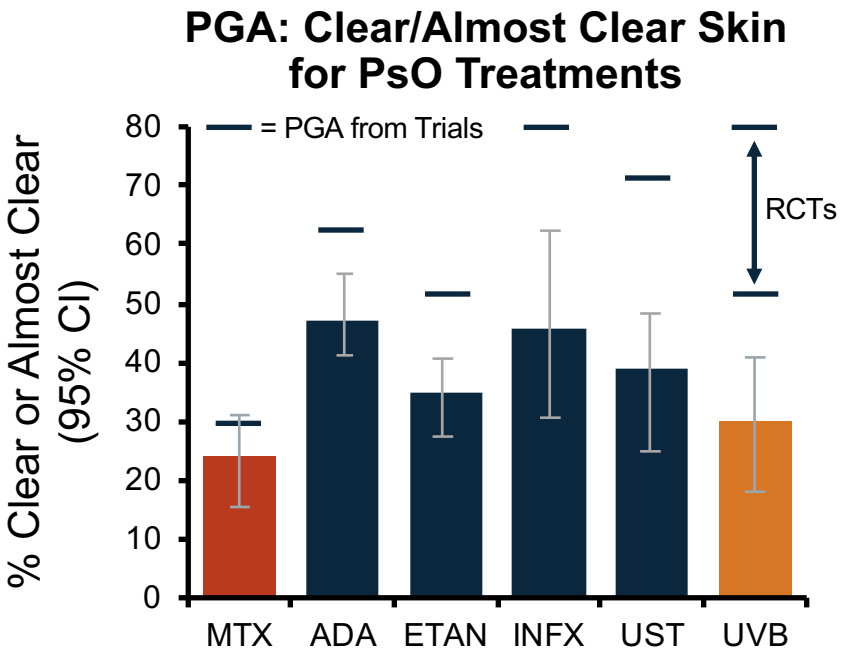
Elmets CA, et al. *J Am Acad Dermatol.* 2019. Published online February 13, 2019. doi.org/10.1016/j.jaad.2018.11.058.

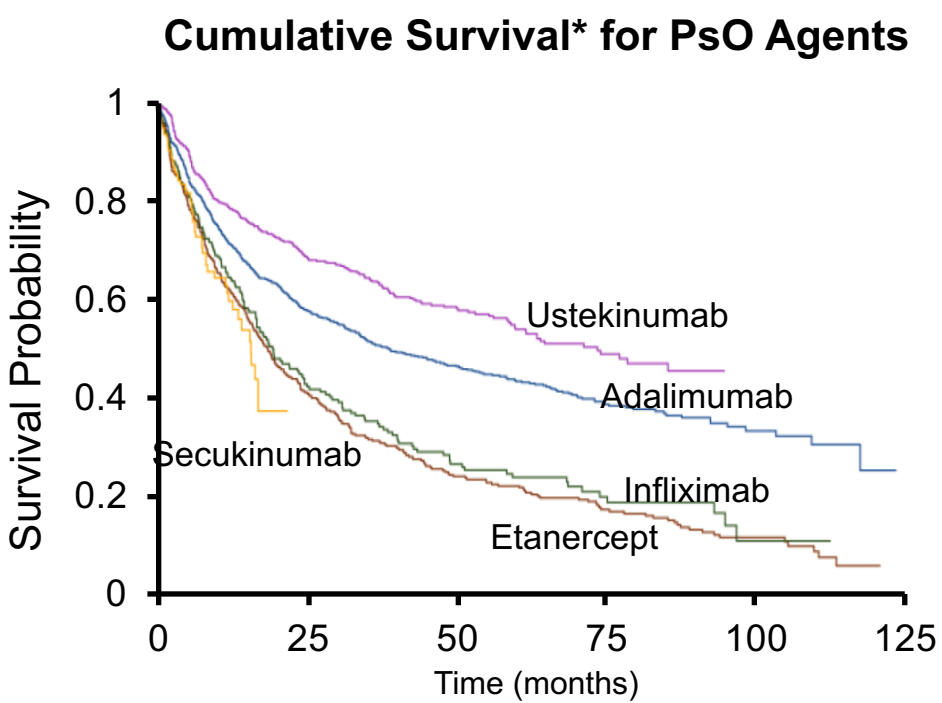
Selected Pearls from Hot Off the Press AAD-NPF Guidelines

Recommendation Number	Recommendation	Strength of Recommendation
4.3	Recommended alternate dosage for ustekinumab is administered at higher dose (90 mg instead of 45 mg in patients weighing ≥ 100 kg) or at a greater frequency of injection (eg, every 8 wk in maintenance phase) for those with an adequate response to standard dosing.	A
5.6	Secukinumab is recommended as monotherapy in adult patients with moderate-to-severe plaque PsO affecting the nails and palmoplantar plaque PsO	A
8.3	Guselkumab is recommended as a monotherapy treatment option in adult patients with scalp, nail, and plaque-type palmoplantar PsO	A

Elmets CA, et al. *J Am Acad Dermatol.* 2019. Published online February 13, 2019. doi.org/10.1016/j.jaad.2018.11.058.

Real-World Effectiveness of Treatments for Moderate-to-Severe PsO[1-5]



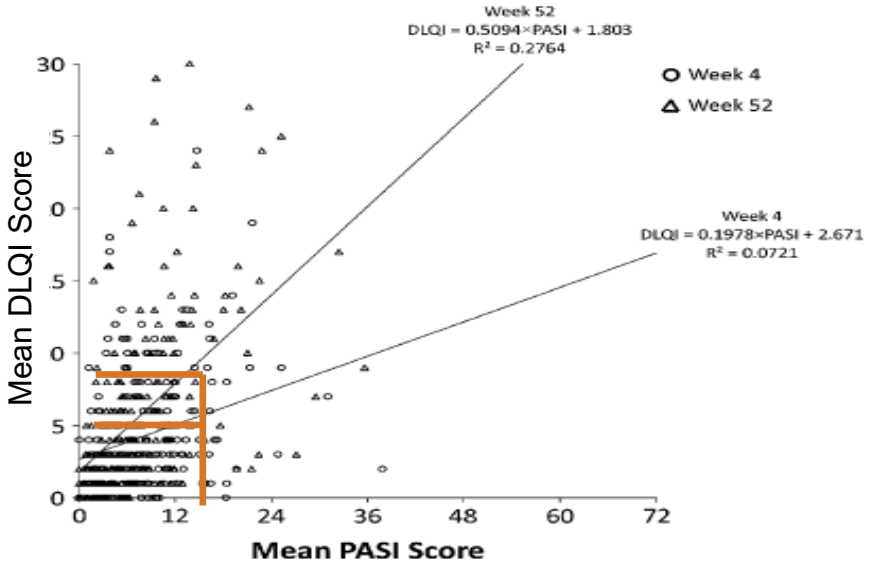


*Survival = time to drug discontinuation.

1. Gelfand JM, et al. *Arch Dermatol.* 2012;148:487-494. 2. Takeshita J, et al. *J Am Acad Dermatol.* 2014;71:1167-1175. 3. Saurat JH, et al. *Br J Derm.* 2008;158(3):558-566. 4. Egeberg A, et al. *Br J Dermatol.* 2018;178:301-302. 5. Adalimumab, etanercept, ustekinumab prescribing information. Slide courtesy of Joel M. Gelfand, MD, MSCE.

Psoriasis (PsO) Worsening Results in Disproportionately Negative Impact on Health-Related Quality of Life (QoL)

- Patients underwent protocol mandated discontinuation of adalimumab after achieving PASI 75 response
- An approximately two-fold disproportionately greater degree of worsening of DLQI score compared with the degree of worsening of PASI was observed while patients underwent discontinuation of therapy



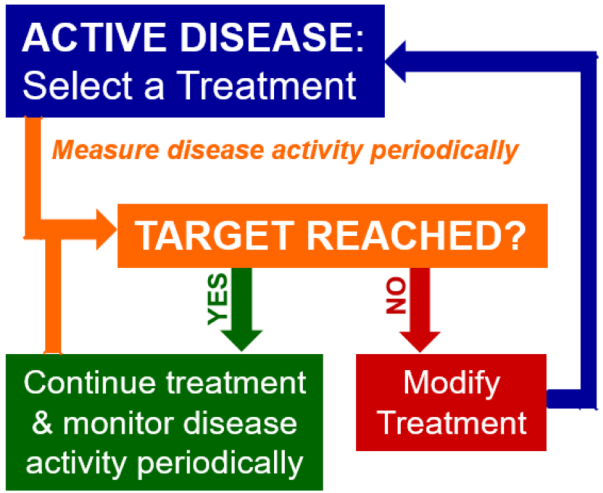
Scatter plot for week 4 and week 52 DLQI vs. PASI (LOCF; intent-to-treat population)

DLQI = Dermatology Life Quality Index; LOCF = last observation carried forward; PASI = Psoriasis Area and Severity Index.

Poulin Y, et al. Dermatol Ther (Heidelb). 2014;4(1):33-42. Slide courtesy of Joel M. Gelfand, MD, MSCE.

Treat to Target: What Is It?

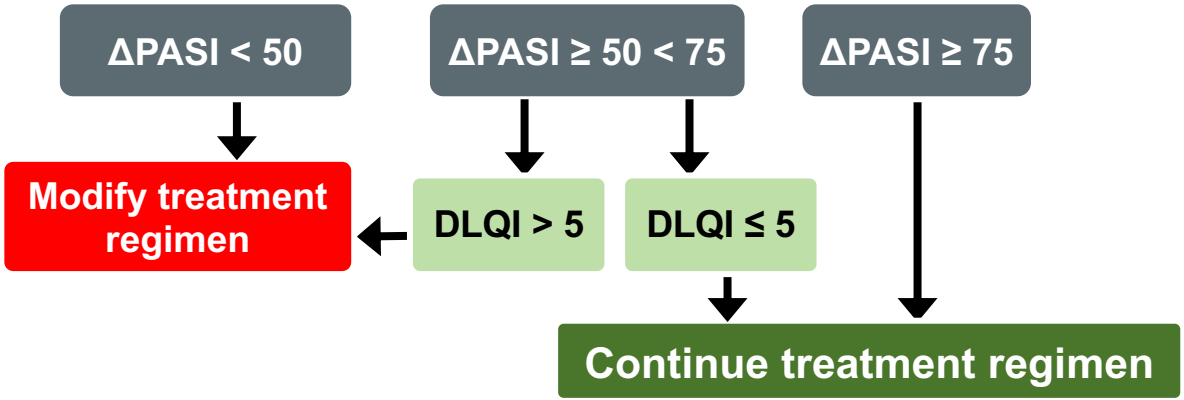
- Treat a disease until a prespecified clinically relevant measure is achieved
  - Ideally treatments have proven efficacy and safety data from randomized controlled trials
- Well-established in CV medicine (e.g., blood pressure, glucose targets)
- *Goal: Improve patient outcomes*



http://rawarrior.com/wp-content/uploads/2013/10/RPF-treat-to-target-diagram.png.
Slide courtesy of Junko Takeshita, MD, MSCE.

Clinical Practice: Nearly 20% of Almost-Clear Patients Meet DLQI Criteria for Treatment Change[1,2]

DLQI	Clear	Almost Clear	*p* Value
≥ Moderate effect (DLQI >5), N (%)	2 (2.1)	85 (19.4)	< .001



1. Mrowietz U, et al. *Arch Dermatol Res.* 2011;303:1-10. 2. Takeshita J, et al. *J Am Acad Dermatol.* 2014;71:633-641.
Slide courtesy of Junko Takeshita, MD, MSCE.

From the Medical Board of the National Psoriasis Foundation: Treatment targets for plaque psoriasis

April W. Armstrong, MD, MPH,[a] Michael P. Siegel, PhD,[b] Jerry Bagel, MD,[c,d] Erin E. Boh, MD, PhD,[e] Megan Buell,[b] Kevin D. Cooper, MD,[f] Kristina Callis Duffin, MD, MS,[g] Lawrence F. Eichenfield, MD,[h] Amit Garg, MD,[i] Joel M. Gelfand, MD, MSCE,[j] Alice B. Gottlieb, MD, PhD,[k] John Y. M. Koo, MD,[l] Neil J. Korman, MD, PhD,[f] Gerald G. Krueger, MD,[g] Mark G. Lebwohl, MD,[m] Craig L. Leonardi, MD,[n] Arthur M. Mandelin, MD, PhD,[o] M. Alan Menter, MD,[p] Joseph F. Merola, MD, MMSC,[q] David M. Pariser, MD,[r,s] Ronald B. Prussick, MD, FRCP,[t] Caitriona Ryan, MD,[p] Kara N. Shah, MD,[u] Jeffrey M. Weinberg, MD,[m] MaryJane O. U. Williams, MD,[a] Jashin J. Wu, MD,[v] Paul S. Yamauchi, MD, PhD,[w] and Abby S. Van Voorhees, MD[r]

- 25 PsO experts participated in Delphi process
- Recommended treatment target: **BSA ≤ 1%**
  - 3 months after treatment initiation and then every 6 months
- Acceptable treatment target at 3 months after initiation: BSA ≤ 3% OR BSA reduction ≥ 75%
- Treatment targets should **NOT** be used by payers to deny access to therapies if targets are not met.

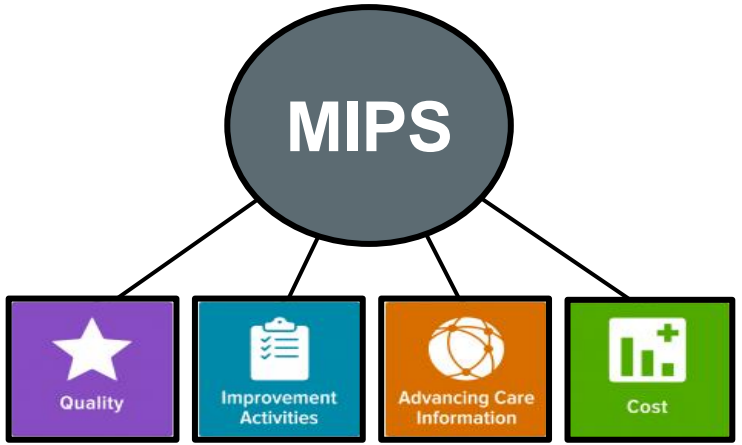
BSA = body surface area.

Armstrong AW, et al. *J Am Acad Dermatol*. 2017;76:290-298. Slide courtesy of Junko Takeshita, MD, MSCE.

MIPS (PQRS) 410 PsO: Clinical Response to Oral Systemic or Biologic Medications

- Only dermatology outcome measure in MIPS
- Outcome targets
  - PGA ≤ 2
  - BSA < 3%
  - PASI < 3
  - DLQI ≤ 5

- 2015 PQRS reporting data
  - 1,269 individuals reported
  - 69.7% performance rate

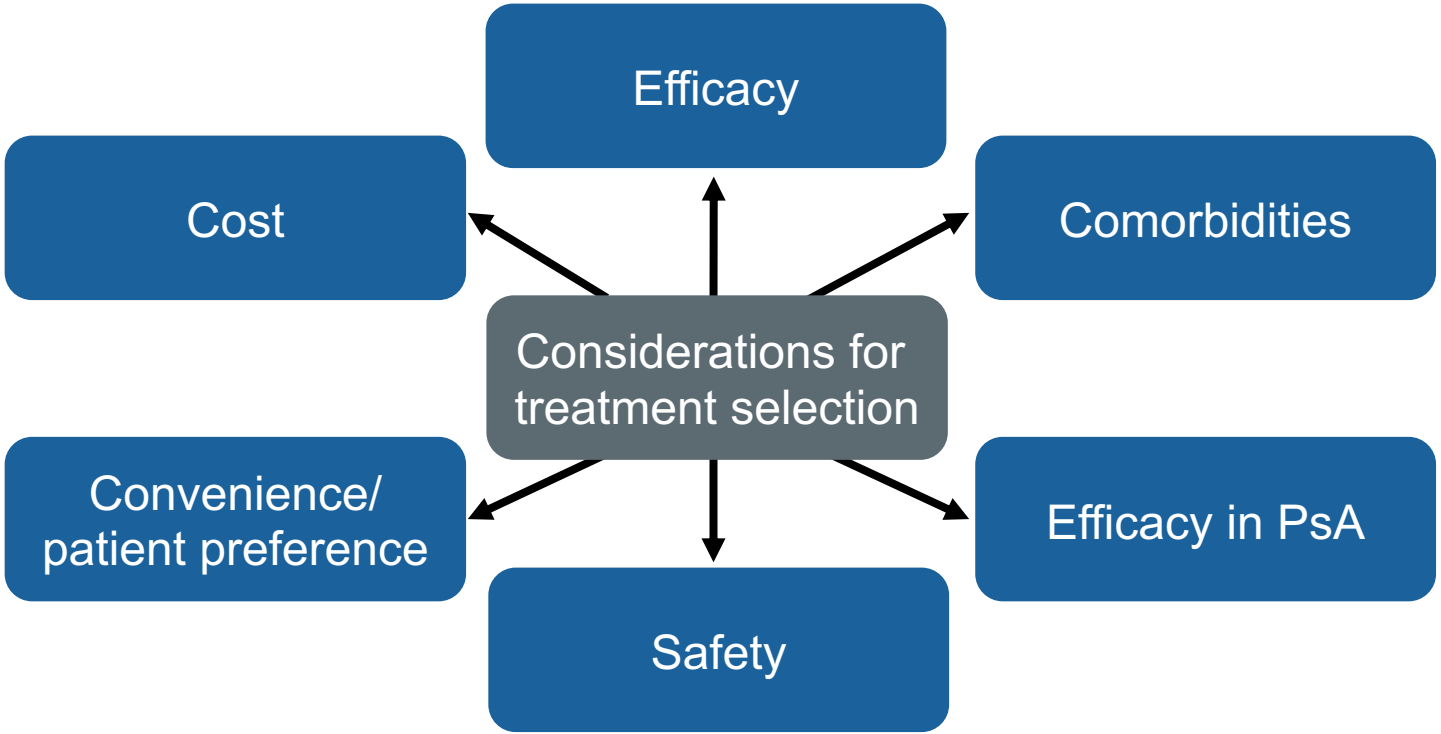


MIPS = merit-based incentive payment system; PGA = physician global assessment; PQRS = Physician Quality Reporting System.
http://healthmonix.com/mips_quality_measure/2018-mips-quality-measure-410/.
Slide courtesy of Junko Takeshita, MD, MSCE.

When considering options for patients with moderate-to-severe psoriasis, how successful would your online community say that dermatologists are in aligning treatment strategies with the long-term goal of total plaque clearance?

"I would say that the treatment has been very successful. I know that new techniques are being used that have been more effective than the techniques in the past."

Which Biologic/Small Molecule Should You Choose First?



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Learning Objective 2

Ensure management of comorbid conditions in patients with psoriasis through screening and appropriate referral when necessary.

Audience Response

How often do you check blood pressure in patients with psoriasis?

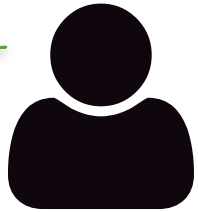
A. Never
B. Sometimes
C. Frequently
D. Always

Well-Established Comorbidities of Psoriasis[1-11]

- Heart attack, stroke, cardiovascular death
- Metabolic syndrome (obesity, insulin resistance, cholesterol abnormalities, and hypertension)
- Diabetes
- Psoriatic arthritis
- Mood disorders (anxiety, depression, and suicide)
- Crohn's disease
- T-cell lymphoma (rare)

1. Gelfand JM, et al. *JAMA.* 2006;296:1735-1741. 2. Gelfand JM, et al. *J Invest Dermatol.* 2006;126:2194-2201. 3. Langan SM, et al. *J Invest Dermatol.* 2012;132:556-562. 4. Kurd SK, et al. *Arch Dermatol.* 2010;146:891-895. 5. Armstrong AW, et al. *J Hypertens.* 2013;31:433-442. 6. Ma C, et al. *Br J Dermatol.* 2013;168:486-495. 7. Azfar RS, et al. *Arch Dermatol.* 2012;148(9):995-1000. 8. Yeung H, et al. *JAMA Dermatol.* 2013;149:1173-1179. 9. Mehta NN, et al. *Eur Heart J.* 2010;31:1000-1006. 10. Najarian DJ, et al. *J Am Acad Dermatol.* 2003;48(6):805-821. 11. NPF. https://www.psoriasis.org/about-psoriasis/related-conditions. Slide courtesy of Joel M. Gelfand, MD, MSCE.

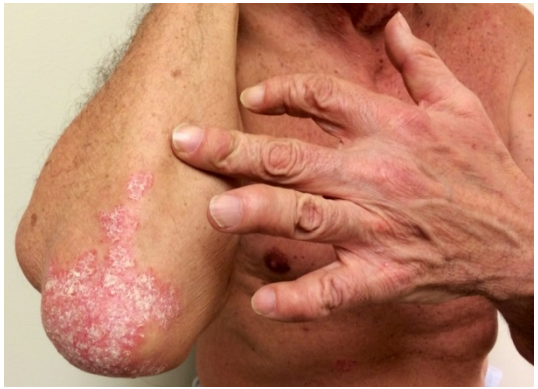
Speaking on behalf of your patient community, do dermatologists typically discuss comorbidities or other conditions commonly associated with psoriasis when speaking with their patients who have psoriasis?

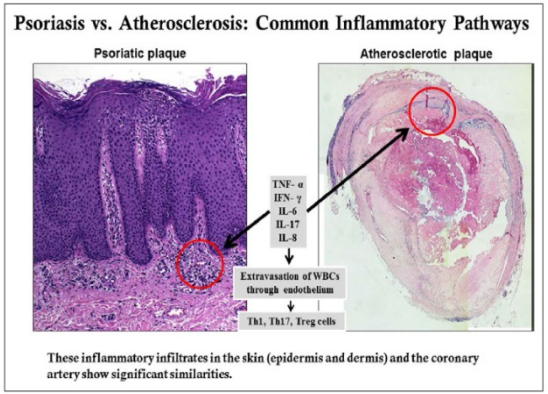


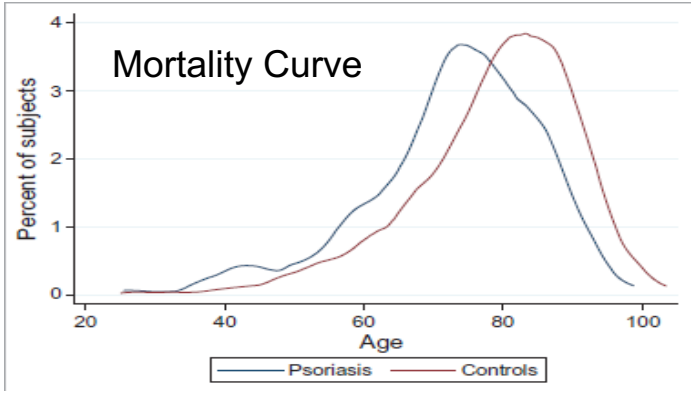
"I would say based on conversations in my community, dermatologists do not discuss co-morbidities with psoriasis. I find that new people to the group will ask a question about their psoriasis and will be surprised at the answer from a group member and will say wow my doctor never told me that. Or I didn't know that. Or the doctor didn't share that with me."

"It's been my experience that dermatologists typically want to just treat the skin and don't really discuss any other kinds of treatment."

Risk of Cardiometabolic Disease in PsO[1-4]



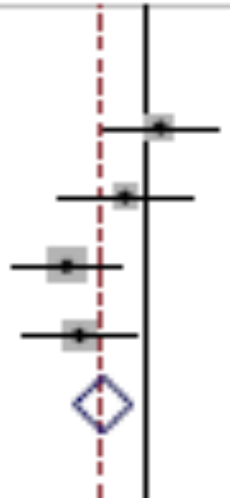




- Moderate-to-severe PsO is associated with an increased risk for major CV events and mortality independent of traditional risk factors, resulting in a 5-year reduction in life expectancy
- Chronic inflammation and metabolic abnormalities are common to PsO and CV disease

1. Azfar RS, Gelfand JM. *Curr Opin Rheum*. 2008;20:416-422. 2. Yang ZS, et al. *Clin Rev Allergy Immunol*. 2016;51(2):240-247. 3. Kivelevitch D, et al. *Circulation*. 2017;136:277-280. 4. Abuabara, K, et al. *Br. J. Dermatol.* 2010;163(3):586. Slide courtesy of Joel M. Gelfand, MD, MSCE.

TNF Inhibitors are Cardioprotective in PsO: Meta-analyses of Observational Studies



Year	Author	Follow_mon	RR (95% CI)	Weight
TNF Inhibitors vs. Topical/Phototherapy				
2010	Abuabara	42	1.10 (0.73, 1.66)	13.67
2012	Wu∆	52	0.86 (0.53, 1.38)	11.16
2012	Wu#	52	0.56 (0.37, 0.83)	23.10
2013	Wu	48	0.61 (0.41, 0.91)	22.84
Subtotal (I^2 = 56.2%, p = .077)			0.73 (0.59, 0.90)	70.77

TNF = tumor necrosis factor.

Yang ZS, et al. *Clin Rev Allergy Immunol*. 2016;51(2):240-247.

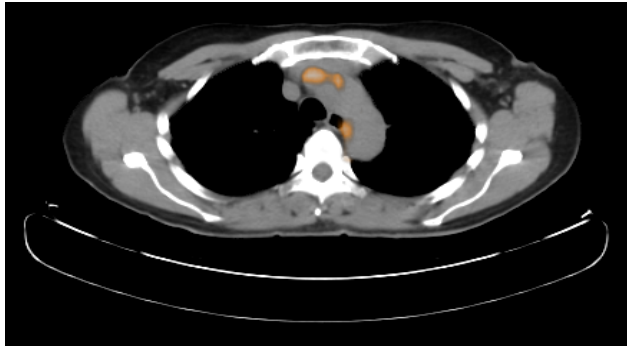
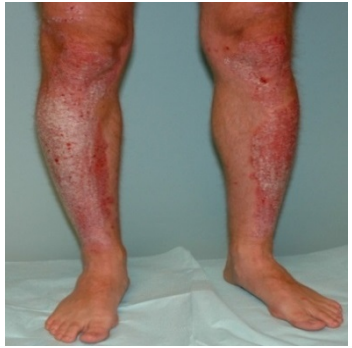
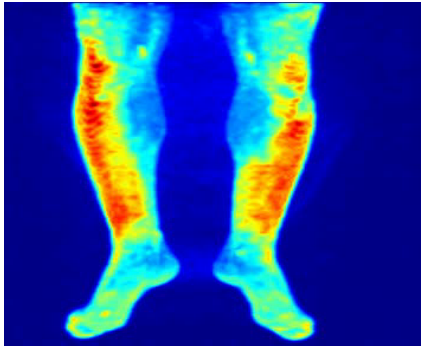
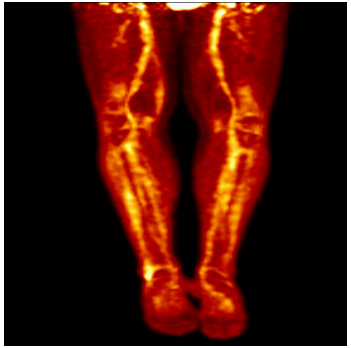
Slide courtesy of Joel M. Gelfand, MD, MSCE.

4 studies
HR myocardial infarction 0.73 (95% CI: 0.59 - 0.90)

Should PsO Be Aggressively Treated to Lower the Risk of CV Disease? We Don't Know for Certain

Vascular Inflammation in Psoriasis Trials (VIP): Assessing effects on vascular inflammation and lipid metabolism in moderate-severe PsO:

- RCT: adalimumab or phototherapy vs. placebo (NCT01553058)
- RCT: ustekinumab vs. placebo (NCT02187172)
- RCT: secukinumab vs. placebo (NCT02690701)
- Open label: apremilast (NCT03082729)

Slide courtesy of Joel M. Gelfand, MD, MSCE.

Effect of Adalimumab and Phototherapy on Vascular Inflammation and Blood Biomarkers

- Adalimumab has a neutral impact on aortic vascular inflammation
- Over 12 weeks adalimumab has neutral impact on markers of lipoprotein characterization and glucose metabolism, but *improves inflammation (CRP, TNF-alpha, IL-6, GlycA)*
- Over 12 weeks phototherapy *improves HDL-P*, has a neutral effect on glucose metabolism, *and improves inflammation (CRP, IL-6)*
- Over 52 weeks adalimumab is associated with *impairments in HDL function and HDL-P*, has neutral impact on insulin metabolism, and has mixed effects on inflammation (*CRP, TNF-alpha, GlycA improve, IL-6 goes up*)

Mehta NN, et al. *Circ Cardiovasc Imaging*. 2018;11(6):e007394. Slide courtesy of Joel M. Gelfand, MD, MSCE.

AAD-NPF Joint Guidelines: PsO and Cardiovascular Disease Comorbidity Strength of Recommendation

Recommendation Number	Recommendation	Strength of Recommendation
2.1	CV risk assessment (screening for hypertension, diabetes, and hyperlipidemia) with national guidelines is recommended for all patients with psoriasis.	B
2.2	Clinicians should consider early and more frequent screening for hypertension, diabetes, and hyperlipidemia in psoriasis patients who are candidates for systemic or phototherapy or who have psoriasis involving > 10% of the BSA.	B
2.3	Risk score models should be adapted for patients with psoriasis by introducing a 1.5 multiplication factor when patient with psoriasis meets either criteria: disease severity of BSA > 10% or candidate for systemic or phototherapy.	C
2.4	CV risk management in psoriasis for hypertension and dyslipidemia should be carried out according to national guidelines. Target for NP and lipid levels are based on risk calculated for psoriasis. Antihypertensives and statins may be used as in the general population. CV risk management should be performed by either a PCP or other HCP experienced in CV risk management or the dermatologist.	C

Elmets CA, et al. *J Am Acad Dermatol.* 2019. Published online February 13, 2019. doi.org/10.1016/j.jaad.2018.11.058.

AAD-NPF Joint Guidelines: Standard Screening Recommendations

Type	Criteria	Frequency
Hypertension	• Normal BP < 120/80 mmHg • Age 18-30 yrs, no risk factors, and BP < 130/86 mmHg • Age > 40 yrs and at increased risk for high BP (BP 130-139/85-89 mmHg, overweight/obese, black)	Every 3-5 yrs Yearly
Diabetes	• Adults aged 40-70 yrs with BMI ≥ 25 kg/m^2 • In those without any risk factors, testing should begin at age 45 yrs	Every 3 yrs
Cardiovascular Risk Assessment	• Adults aged 20-79 yrs with standard risk factors (including hypercholesterolemia, obesity) • Adults aged 40-79 yrs: estimate 10 yr risk	Every 4-6 yrs

BMI = body mass index; BP = blood pressure

1. Siu AL, USPSTF. *Ann Intern Med.* 2015;163:778-786. 2. Siu AL, USPSTF. *Ann Intern Med.* 2015;163:861-868. 3. Goff DC Jr, et al. (ACC/AHA 2013 guideline on assessment of CV risk). *J Am Coll Cardiol.* 2014;63:2935-2959.

Based on discussions within your online psoriasis community, do dermatologists routinely screen for and counsel patients about risks of cardiovascular disease and psoriatic arthritis?

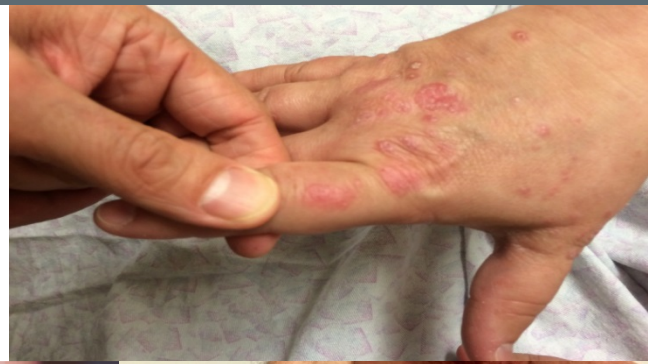
"Often dermatologists do not counsel their patients about cardiovascular health and psoriatic arthritis. However, there is becoming more of a push, and patients are becoming more aware on their own and talking to their dermatologists about these two conditions. And then the dermatologists typically will go further at that point. However, not very often will the dermatologist bring up these issues on their own.."

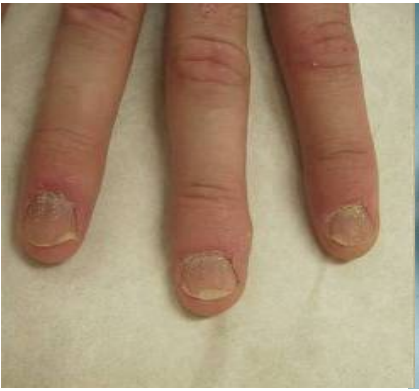
"I, personally, have not been screened for this at all. I didn't even know that psoriasis was related to cardiovascular health in any way. "

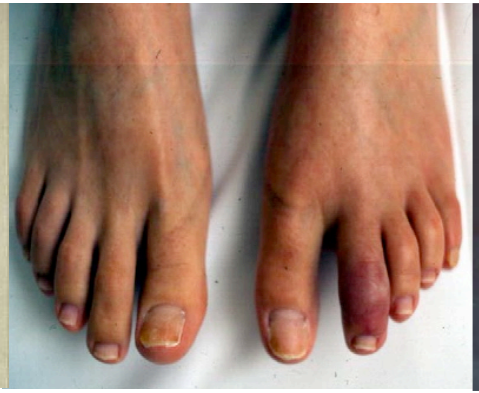
Screening for PsA in Clinical Practice

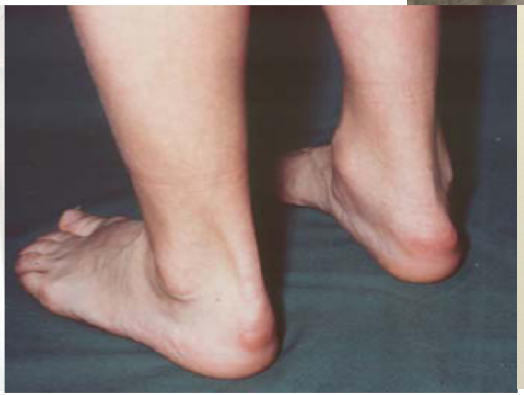
Identify symptoms/signs of PsA

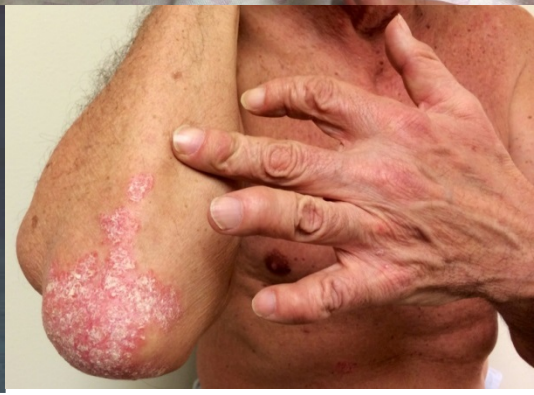
- Morning-joint stiffness
- Joint pain that improves with activity
- Swollen, tender joints; dactylitis; enthesitis; IBP; uveitis
- Check x-rays of affected joints and CRP, RF, CCP











CCP = cyclic citrullinated peptide; IBP = inflammatory back pain; RF = rheumatoid factor.

Gisondi P, et al. *J Eur Acad Dermatol Venereol*. 2017;31(12):2119-2123. Slide courtesy of Joel M. Gelfand, MD, MSCE.

Suggested Cancer Screenings

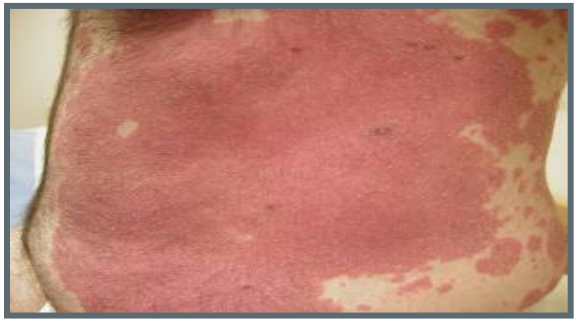
Cancer	Screening Recommendation
Breast Cancer	• Women age 50-74 yrs, average risk: mammogram every 2 yrs • Women aged 40-50 yrs, above average risk: consult with provider
Cervical Cancer	• Women age 21-65 yrs: annual Papanicolaou test
Colorectal Cancer	• Male and female patients age 50-75 years: screening • Male and female patients age < 50 yrs: at risk population • Male and female patients age > 75 yrs: consult with provider

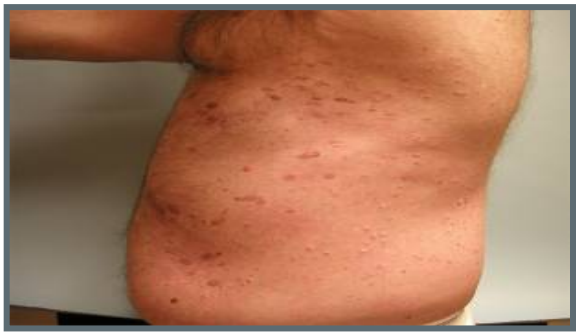
Lung Cancer	• Male and female patients age 55-80 yrs: low-dose computed tomography if:
	  • Smoking history of > 30 pack yrs and
	  • Currently smoke or have smoked within the past 15 yrs

Centers for Disease Control and Prevention, https://www.cdc.gov/cancer/dcpc/prevention/screening.htm.

Clinical Implications: PsO and Infection

- Patients with severe PsO are 65% more likely to die of infection (second highest excess risk)[1,2]
- Screen for streptococcal infection with guttate flares
- Screen for HIV in severe PsO
- Vaccination for:[3,4]
  - Influenza (annually)
  - Pneumonia (PCV13 and PPSV23)
    - Refer to CDC website for specific ages/schedules
  - Zoster (age ≥ 50)
    - Recombinant zoster vaccine recommended for adults age ≥50[5]
  - Hepatitis B
  - HPV (age 9-45)
    - 9-valent vaccine can be started at age 9

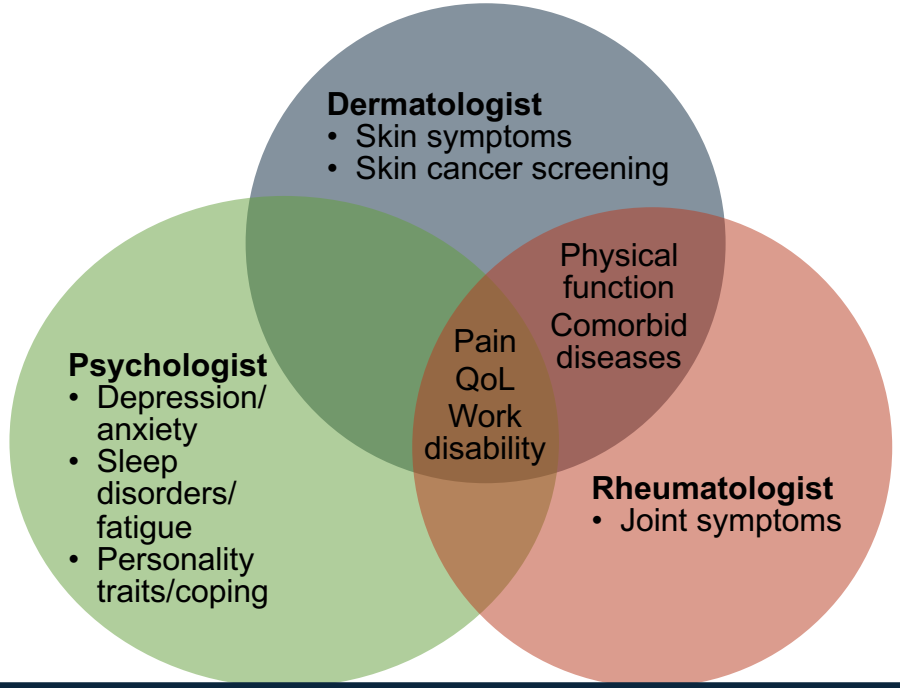




HPV = human papillomavirus; PCV = pneumococcal conjugate vaccine; PPSV = pneumococcal polysaccharide vaccine.
Slide courtesy of Joel M. Gelfand, MD, MSCE.

1. Abuabara K, et al. *Br J Dermatol*. 2010;163(3):586-592. 2. Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377-390. 3. Wine-Lee L, et al. *J Am Acad Dermatol.* 2013;69:1003-1013. 4. 2019 vaccination schedule. www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf. 5. CDC – Shingles Vaccination. https://www.cdc.gov/shingles/vaccination.html.

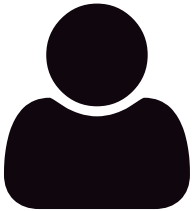
Members of the Management Team for Patients with PsO



Other professionals who may need to be involved:
primary care physician, gastroenterologist, cardiologist, weight management/bariatric surgeon

Adapted from Husni ME, et al. *Semin Arthritis Rheum*. 2017;47:351-360.

Speaking on behalf of your online community, how often do dermatologists typically coordinate with specialists such as rheumatologists, psychiatrists, endocrinologists, or other specialists about other conditions when treating a patient with psoriasis?



"I hate to say it, but my dermatologist has never, ever tried to hook me up with a psychiatrist, a counselor, endocrinologist or rheumatologist in reference to my psoriasis. These are subjects that he has never brought up to me. I'm trying to think if I ever brought them up to him, because when I first was diagnosed with psoriasis, and I had it very, very badly, it was a horrible experience for me and I probably did need to go to a counselor, but it was never given to me as an option."

Role of Nurse Practitioners (NPs) and Physician Assistants (PAs)

- Optimize PsO care by building strong long-term relationships with patients
- Help patients to have increased understanding of their disease
- Instill an appreciation for the need to adopt lasting healthy behaviors and adhere to therapy, and increase patient awareness of new options for care
- Increase access by hosting later office hours
- Help patients navigate at-home UVB therapy

Engaged patients are likely to have fewer complications with their disease or therapy as well as more realistic expectations about the benefits and risks of their treatment and how their disease and its treatment may change over time.

Aldredge L, et al. *J Dermatol Nurses Assoc.* 2016;8(1):14-26.

CME Outfitters
CONTINUING MEDICAL EDUCATION

Learning Objective 3

Integrate digital coaching into the management of patients with psoriasis to improve patient outcomes and treatment satisfaction.

Digital Health Tools

Citizen Pscientist (CP)[1,2]

- Created by the National Psoriasis Foundation (NPF) to promote patient-centered psoriatic disease research
- Patients with psoriatic disease were invited to enroll in CP and contribute health data to a cloud database by responding to a 59-question online survey
- Patients and researchers have the ability to analyze data

NPF PsO and PsA Pocket Guide[3]

- Provides updated treatment algorithms and management options for physicians

NPF Patient Navigation Center[4]

- First personalized support center for people with psoriatic disease
- Provides free guidance to help patients access care

1. Sanchez IM, et al. *Dermatol Ther (Heidelb).* 2018;8:405-423. 2. NPF. Citizen Pscientist. https://pscientist.psoriasis.org. 3. NPF. The Psoriasis and Psoriatic Arthritis Pocket Guide - Treatment Algorithms and Management Options. https://www.psoriasis.org/pocket-guide. 4. NPF. Patient Navigation Center. https://www.psoriasis.org/navigationcenter/resources.

Digital Health Tools: Apps for Psoriatic Disease

Apps for Managing PsO and PsA[1]

- **Skin Advocate** connects patients to advocacy and the support they may need
- **AAD PsO App** offers insights into PsO and treatment options
- **MyPsO** anonymously connects users in a virtual community where they can talk about their PsO and their treatment options
- **Track + React** helps individuals with PsA identity triggers for flares
- **CatchMyPain** is a digital pain diary for people with chronic pain conditions like PsA

Tracking Medications

- **RxmindMe** reminds patients to take their medication[1]
- Consult with medication manufacturer for resources and tools to help track medication adherence.

Staying Healthy[1]

- **TREAT** offers a personal nutrition coach for people living with PsO
- **MyFitnessPal** tracks exercise and caloric and nutrition intake
- **Microsoft HealthVault** is a place to store all of your and your family's medical, prescription, and insurance information
- Use **LiveHealth Online** to browse a menu of doctors and connect for a live consult 24/7 through video call from your smart device
- **Move Me** coaches users to do short, regular bursts of activity to help boost mood

Managing Anxiety and Depression[2]

- **Happify** provides games and exercises to help decrease negativity and build positive thoughts
- **Worry Knot** gives a guided tool to address specific problems you can't stop thinking about, as well as tips for coping with issues such as "tangled thinking"
- **Purple Chill** unwinds stress with relaxation and meditation exercises
- **Slumber Time** tracks how well you are sleeping and takes you through a nightly bedtime checklist to clear your mind before you go to sleep. You can also use it as alarm clock that wakes you with your choice of music or natural sounds.

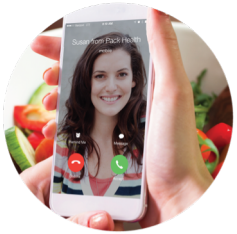
1. NPF. http://npf.awarenessmonthly.com/the-worlds-best-apps-for-psoriatic-disease/. 2. NPF. https://www.psoriasis.org/advance/best-apps-boost-your-mental-health?utm_medium=email&utm_campaign=Advance%20Weekly-%20115&utm_content=Advance%20Weekly-%20115+Version+A+CID_28a924ba8ebd3c5ee64791d2817cb20e&utm_source=email%20marketing&utm_term=READ%20MORE.

Patient Tools: Pack Health

Digital Health Coaching Program

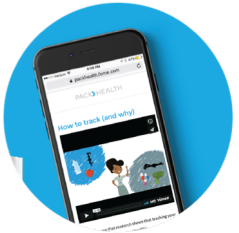
- A 12-week program to help patients access the right care and develop the self-management skills needed to improve their well-being
- Delivers personalized support via non-clinician Health Advisor across 20+ chronic conditions
- Efficacy data indicate an average of 17% increase in treatment adherence

Psoriasis Toolkit



Weekly calls

Text messages



Videos and activities

Efficacy of Pack Health on Patient-Reported Outcomes

- Statistically significant increases for both physical health (pre = 44.1 vs. post = 47.8, p = .012) and mental health (pre = 43.9 vs. post = 48.1, p = 0.003) through PROMIS
- Statistically significant increase in confidence to manage PsO symptoms (pre = 11% vs. post = 53%, p = .008)
- Reduction in the percentage of patients with severe psoriasis symptoms (pre = 44% vs. post = 30%)
- Increase in average hours of sleep per night, but this was not statistically significant (pre = 6.4 vs. post = 6.9, p = .078)
- Medication adherence improved from 61% to 75%, but this was not statistically significant

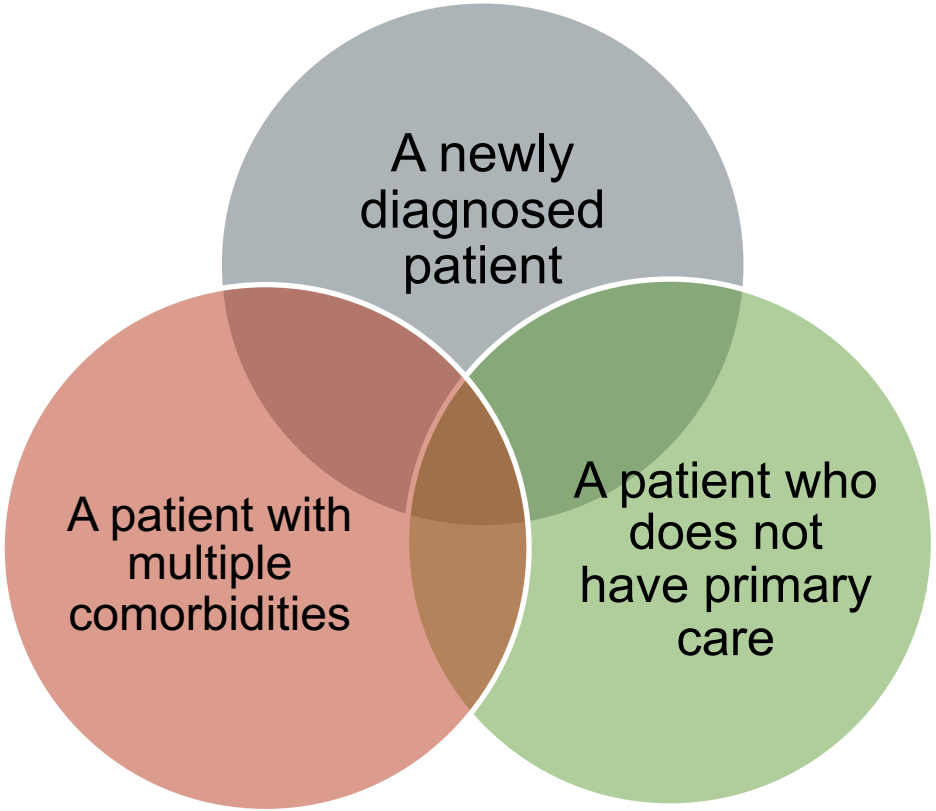
Following this activity, a total of 60 patients can enroll in Pack Health *free* for three months!

Visit *https://packhealth.com/cmeoutfitters/* to enroll.

N = 30

Reiter J, et al. Presented at Maui Derm for Dermatologists 2018.

Optimal Patients for Pack Health



SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

- Engage patients in decisions regarding their care and incorporate their preferences into treatment selection
- Screen for comorbidities
- Consider a treat-to-target approach to improve patient outcomes
- A multidisciplinary team is critical for the optimal management
- PAs and NPs can optimize management by building strong relationships with patients
- Digital health tools can have a role in improving overall outcomes

Additional Resources

Visit **cmeoutfitters.com**
for clinical information and
certified educational activities

Questions for Faculty

Use the "Q&A" widget on your screen

or

E-mail:
questions@cmeoutfitters.com

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After the live webcast, this activity will be available as a web archive at cmeoutfitters.com

Coming Up...

CME Outfitters

AFTER THE SHOW

CME Outfitters

AFTER THE SHOW

Questions & Answers

To receive CME/CE credits for this activity, participants must complete the post-test and evaluation online.

Click the *Apply for Credit* link found under the presentation slide window to complete the process and print your certificate.

Claim ABIM MOC Credit

3 Things to Do

1. Actively participate in the meeting by **responding to ARS** and/or **asking the faculty questions**
   (It's ok if you miss answering a question or get them wrong, you can still claim MOC)
2. Complete your post-test and evaluation at the conclusion of the webcast
3. Be sure to fill in your **ABIM ID number** and **DOB** (MM/DD) on the evaluation, so we can submit your credit to ABIM.

ABIM CME MOC ACCREDITED

Quality Payment Program (QPP)

How to Claim This Activity as a QPP Improvement Activity

- **Actively participate** by responding to ARS and/or asking the faculty questions
- Over the next 90 days, **actively work to incorporate improvements** in your clinical practice from this presentation
- **Complete the follow-up survey** from CME Outfitters in approximately 3 months

CME Outfitters will send you confirmation of your participation to submit to CMS attesting to your completion of a QPP Improvement Activity.