Comprehensive and Coordinated Patient-Centered Care in Psoriatic Arthritis

CME OUTFITTERS

CMEO Podcast Transcript

Allan Gibofsky:

Hello and welcome. On behalf of CME Outfitters, I would like to welcome and thank you for joining us for third in a series of three CMEOCast podcasts titled *Comprehensive and Coordinated Patient-Centered Care in Psoriatic Arthritis*. This is supported by an educational grant from Janssen Biotech, Inc. Administered by Janssen Scientific Affairs, LLC. I'm Allan Gibofsky, professor of medicine at Weill Cornell Medicine and attending rheumatologist and co-director of the Clinic for Inflammatory Arthritis of Hospital for Special Surgery in New York, New York. I'm joined today by Dr. April Armstrong, professor of dermatology at the Keck School of Medicine, University of Southern California, Los Angeles, California, where she's also the associate dean for clinical research and director of clinical research support for the Southern California Clinical and Translational Science Institute, vice chair and director of clinical trials and outcomes research and director of the psoriasis program for the Department of Dermatology at the Keck School of Medicine, part of the University of Southern California in Los Angeles, California. Welcome, April.

April Armstrong:

Thank you, Allan. It's a true pleasure to be here today.

Allan Gibofsky:

Today's activity is eligible for ABIM Maintenance of Certification credit, and also as a CME for the MIPS improvement activity of CMS. Please complete your post-test evaluation at the conclusion of the activity. You're to fill in your AIBM ID number and date of birth on the evaluation so your credit can be submitted to the ABIM. Now over the next 90 days, actively work to incorporate improvements in your clinical practice from this presentation and complete the follow-up survey from CMOO in approximately three months that you will receive. CME Outfitters will then send you confirmation of your participation that you can submit to CMS attesting to your completion of the CME for the MIPS improvement activity. Our goal for today's podcast is to collaborate with patients to optimize treatment regimens across the healthcare continuum. April, sometimes we as physicians just aren't on the same page with our patients and how they're affected by a chronic disease. Can you share some of the takeaways from this DISCONNECT study, which was a collaboration between colleagues in dermatology and colleagues in rheumatology at the Cleveland Clinic?

April Armstrong:

I will be happy to. First of all, I want to say that I was really tickled by the name DISCONNECT study. And I know a lot of the study investigators who are just really terrific and in terms of adhering to really great methodology in terms of carrying out this study. So this study looked at perceived bother of psoriatic disease manifestations, and it identified and compared patients and dermatologists. And then finally, the rheumatologists perceived bother of psoriatic disease manifestations.

So the study team essentially gave survey out to patients with both psoriasis as well as psoriatic arthritis. They also gave survey out to dermatologists and rheumatologists. So as you can see here, the derms are in red and rheums are in blue and the patients are in green. So first let's talk about where people did agree. So the patients and the physicians both agree that joint pain, soreness, and tenderness are among the most bothersome features of their psoriatic disease.

April Armstrong:

Where did people disagree? For patients, painful and inflamed or broken skin was actually more bothersome than joint pain, while both the dermatologists and rheumatologists consider painful skin much less bothersome than joint pain. I thought this was a surprise finding for me as well. Now, relative to the joint pain itself, rheumatologists were more likely to perceive other joint symptoms as bothersome, while dermatologists were more likely to perceive other skin symptoms as bothersome. So perhaps this particular observation is not quite as surprising just because we may be approaching the different systems with different perspectives here.

Now, what this study taught us is really the importance of understanding patients' perspective and the importance of engaging them in their care. When we think about ways of engaging our patients in terms of their psoriatic arthritis and their psoriasis care, it's really important to include our patients in personalized decision-making. And it's also important to educate them about their disease and treatment options.

As we know, when we put a patient on a long-term therapy, there may be a lot of updates regarding that therapy. So it's important that we keep our patients updated on the latest safety data or efficacy data on the therapy that we have put them on. And as we all do in terms of not just psoriatic diseases, but treating any disease and in terms of our approach to our patients, it's very important to treat our patients with respect and dignity through their disease journey. And it's important through all this is making sure that they feel involved in their treatment decision-making process because ultimately when patients feel engaged, they are more likely to adhere to their therapies and probably more likely to have a better outcome because of the better adherence to their treatment.

As clinicians, when we think about principles of psoriatic arthritis treatment, I think we probably all in general agree on the following principles. Number one, we need to be active and aggressive in terms of reducing joint pain in our patients with psoriatic arthritis. We want to make sure that the treatments that we have for their PSA also will improve their quality of life as well as function. It's very important that we also want to, to the extent that possible, choose therapies that can help prevent structural damage or complications because we know that structural damage is oftentimes irreversible and can lead to severe disabilities later on if untreated.

We want to be mindful of how to assemble a multidisciplinary team for patients that have multiple comorbidities. And again, engaging patients as stakeholders is very important in this particular decision share making process. And then finding those co-morbidities, identifying them and treating them both as a multi-disciplinary team as well as having individualized dialogues with our patients that would not only address their skin and joints, but also for example, their blood pressure, their diabetes is paramount in terms of treatment selection and also encouraging adherence.

Allan Gibofsky:

Well, April, we want all of our patients to be satisfied with their care. But does the impact of patient satisfaction reach even further than that?

April Armstrong:

So treatment satisfaction, Allan, as you know, is oftentimes defined as the degree to which patients perceive that the treatment fulfills their health needs. And I shall say that treatment satisfaction is different. For example, from patients' satisfaction about the healthcare process, for example, how easy it is to find parking near a physician's office. And when we think about treatment satisfaction, it oftentimes reflects on patients' personal experience with a particular therapy.

April Armstrong:

For example, how long they need to be on the therapy, what the efficacy is, whether they experience any side effects, and also frequency. Injection frequency, for example, the frequency of taking oral medication, those are all elements that can go into patient's assessment of treatment satisfaction.

And it's very important that when patients are satisfied with their medication, they're actually more likely to stick with it. And when they're dissatisfied with certain elements of the medication, for example, if they don't really like how frequently they need to take a medication, that dissatisfaction can oftentimes translate into nonadherence. And that can be problematic because when we are assessing our patients and try to think if a medication has really worked for them, if non-adherence is not addressed, it's really hard to really assess how this particular prescribed regimen has worked for these patients. When we're unsure whether the patients are taking this as directed. Now, Allan, we've talked about the importance of patient engagement in their care. Can you now talk about how that influences treatment decision-making?

Allan Gibofsky:

Well, in addition to the multiple factors that run through our mind in determining what to give to a particular patient or what therapy to recommend, the patient has some factors that we need to consider as well. What is our experience with an agent? What is the patient's experience with an agent that may be similar? What is the experience of members of the patient's family or members of the patient's community with a particular agent? What is the evidence for the use of that agent? How severe is their disease? What comorbidities do they have that may necessitate using one agent over another? What are the side effects? Some side effects are a particular concern to some patients and not to others. What route of administration does the patient prefer? How often does a patient prefer to take their medication? All of these go into a common funnel and there is no one-size-fits-all for all of our patients because every patient is an individual, and that's important.

It's important because we're often presented... and we ourselves discussed in these podcasts... data that was done on studies of cohorts, but every patient [inaudible 00:10:23] and all of these decision-making principles have to go into that decision. In fact, that leads us to the concept of shared decision-making. April, I think you alluded to the notion that our patients have to be engaged partners in the decision-making. And that's exactly what shared decision-making means. Fundamentally, we need to create a supportive environment for open discussion. We need to have a dialogue. The absence of a dialogue is in part what contributed to the disconnect that you so nicely outlined in the DISCONNECT study earlier in this discussion. We need to clarify the timeline needed for the patient to make the decision, including the opportunity to revisit the decision at subsequent visits, and where appropriate, engaging family or others as appropriate.

Not only is it not one-size-fits-all, but it's not one decision at all points in time. This needs to be a constant evaluation and re-evaluation every time we see the patient. We need to identify decision options and how outcomes may be affected by those options. We need to be certain that the patient understands everything involved in each option and each outcome and provide patient information as needed. What is necessary for one patient to make a decision may be entirely different from the information and the level of information for another. We need to be able to translate the evidence that we're trying to share to an individual patient's situation. So at all times, we'll be selecting the options and outcomes most relevant to that patient, and then communicating the expected probabilities of different outcomes for decision options. We're communicating probabilities. We're not communicating what will or will not happen, but what is likely or not likely to happen.

Allan Gibofsky:

And this is only going to be done in the context of engaging the patient in a discussion of his or her values and preferences so as to better achieve a shared interaction. We need to be supportive and offer advice as the patient requests it, all the information that the patient may need or require to inform the decision, and then whatever decision is made, support the patient in the selection of that option. We're not empowered to make decisions for patients. We are not wardens. We are going to offer the patient options and allow them to make the decision. We have evolved away from physician paternalism to patient autonomy. And that's the best way I can encapsulate the whole concept of shared decision-making.

April Armstrong:

Allan, thank you very much for that very thoughtful discussion on shared decision-making. Now, as you know, treat to target is a term that rheumatologists are very familiar with. So how does treat a target apply in the case of psoriatic arthritis?

Allan Gibofsky:

Well, the concept of treat to target probably comes last to rheumatology. Other disciplines of internal medicine have used it quite some time. By that, I mean that if you were treating a patient with hypertension, you know that your target is going to be 120 over 80 or whatever the latest guidelines recommend are the normal numbers, systolic and diastolic, for that patient. You know if you're treating a diabetic that you want to get them to a certain hemoglobin A1c. Unfortunately, rheumatology for many, many years has been qualitative and it's assessment rather than quantitative. And many of the charts of my forebears carried notes like, "The patient is doing well. The joints are less inflamed." Those are qualitative, not quantitative. The concept of treat the target means that you will identify a target and you will use a validated metric to assess disease activity at each visit. And then you will make changes in the therapeutic decision that you've made based on the number that you get from use of that validated metric until the patient reaches a target.

This has been widely demonstrated in rheumatoid arthritis with the so-called TICORA study. And several years ago, my good friend Laura Coates incorporated that into psoriatic arthritis with the tight control of psoriatic arthritis study. In other words, there were two populations of patients. One treated however the rheumatologists wanted to, and the other, according to a protocol. Measure disease activity, adjust disease activity according to whether or not the patient was reaching the target. And what you can appreciate is that if the patient was treated according to a schedule of tight control rather than qualitative assessment, the patients who were treated with the tight control regimen did better than the population who was treated with standard care.

All of these patients were treated by excellent rheumatologists. It was just that one group of patients were treated according to a mandated protocol based on measurement of disease activity and the other was assessed qualitatively. The other important concept here is that when using the treat to target protocol, it is treatment-agnostic. And by that, I mean, it doesn't matter what therapy you're using. You want to combine the use of a validated activity metric with the therapy in order to achieve the best outcome whatever that therapy is going to be. Turns out that we have a variety of FDA-approved agents for psoriatic arthritis and also for psoriasis. They're not all approved for both. Some are for psoriasis. Some are for psoriatic arthritis. But the agents that approve for psoriasis generally tend to come over into the psoriatic arthritis area after appropriate study.

Allan Gibofsky:

And so you can see on this chart that we have multiple classes that we can use for both diseases, fortunately, some for more than others. In the group of agents of the TNF inhibitors, we have five agents that can be used in both conditions. The IL-17A inhibitor, we have two that can be used for both and one only for psoriasis. For the IL-12/23 inhibitor, it can be used in both. The IL-23 inhibitor can be used in both. There are other IL-23 inhibitors being studied, one of which is currently approved for psoriasis but not for psoriatic arthritis. We have a T-cell activation inhibitor for psoriatic arthritis, but not for psoriasis. We have a PDE4 inhibitor, which is available for both. And we have a JAK inhibitor currently, which is available for psoriatic arthritis but not for psoriasis. And other agents of this class are being studied as well. So April, after all that illustration of the agents, tell me, are they interchangeable?

April Armstrong:

Great question. From my perspective, the short answer is really no. And that answer really comes from several head-to-head studies that have compared, for example, a TNF inhibitor versus an IL-17 inhibitor for the treatment of patients who have both moderate to severe plaque psoriasis as well as psoriatic arthritis. And in those studies, what was shown is that in general, the IL-17 medications, when you're looking at them, they are probably pretty comparable in terms of efficacy in PSA compared to the TNF inhibitors. But overall, in general, they also tend to be a bit better with regards to producing a greater skin response compared to the TNF inhibitors. In terms of our IL-23 inhibitors, I think we're still gathering additional information on the joint effects on some of the IL-23 inhibitor agents. And it's also important to note that while it's important to have the FDA indication, to be able to prescribe a medication on that indication while a medication may be awaiting for that particular approval, doesn't necessarily mean it doesn't have that effect.

So for example, if you are having a patient on IL-23 inhibitor that hasn't been approved yet for PSA but have PSA data that one can review, that's very helpful. It just means that perhaps the PSA indications will come later on, that it still has an effect on the joints based on the data. And then we'll see how the future data with regards to efficacy and safety may guide our treatment decision-making process. And so with that, I thought we can go on to think about some of the common comorbidities in psoriatic arthritis. And when we think about that, we can think about a few different categories that our patients with PSA tend to have in terms of these comorbidities. And these include ocular inflammation. So diseases such as uveitis, or iritis. In addition to that, we know that patients with PSA have increased prevalence as well as incidents of inflammatory bowel disease, especially Crohn's disease.

I think it's not a surprise to many of us practicing clinicians that patients with PSA have a higher level of psychosocial burden and can often suffer from anxiety, depression, and some of them may have suicidal ideations. In addition to that, patients with PSA also have increased risk for cardiovascular diseases, both the cardiovascular risk factors, such as hyperlipidemia, hypertension, insulin resistance, diabetes, and obesity, and also major adverse cardiovascular outcomes such as MI, stroke, or cardiovascular death. Now, when we think about these various comorbidities, it's really important to start to think about how we can really have a plan for co-management of all these different factors that may affect our patients with PSA. So not only just think in terms of the skin and the joint, which we talked about earlier and the comorbidities that I just talked about, it's also important to address lifestyle factors.

Now these can be time-consuming and difficult to address oftentimes in the single clinical session, but maybe connecting these patients with other clinicians who specialize in this area can be very helpful. Identifying triggering factors in our patients can also be helpful in terms of reducing just the overall disease burden. In some patients, it may be helpful to know the genetic response factors that could be playing into a role in terms of their disease progression. And then finally, individual patients may have different individual responses to the treatment.

April Armstrong:

So understanding what are the predictors of response within the different individuals and have more research in that area will really help us guide our decision-making process in the future. Now, the reason that we want to take this holistic approach, comprehensive approach to addressing these various factors that can be impacting our patient's disease process is because we want to assemble for some of our patients will suffer from these multiple comorbidities a multi-disciplinary team.

And this team is very important because we all have our own sort of little area of specialty that we know well. And the whole goal of this team is to make sure that the patients are connected with the best clinician that can address that particular comorbidity. So in addition to a rheumatologist and a dermatologist, it's very important that they are connected with a primary care physician. And I oftentimes want to make sure that they have that because that is oftentimes a springboard for referral to other specialists such as cardiology or endocrinology or psychiatry, other specialties that may be relevant to these patients' comorbidities. Now with that, I also oftentimes think the role of the pharmacist is really critical. So I thought maybe Allan, you can talk a little bit about that aspect.

Allan Gibofsky:

Sure. I think you have the pharmacist on your last slide, but I think what I've observed is that the pharmacist plays an important role in the multi-disciplinary team in so many levels. They're an important resource that can provide counseling to us and to our patients on things like dosing, route of administration, storage and disposal, even treatment expectations. They're very good in giving patients tips on adherence and reminding patients about adverse events. One of the things that's the bane of a physician's existence is this concept of prior authorization. I don't know why the term prior is there. Reminds me of the word laptop. Either you have a lap or you don't. But prior authorization is something that takes a lot of time and pharmacists have been shown to be particularly useful in reducing prior authorization burden.

There are several studies showing that when the physician's office encounters insurance denials, 70% of them or more that were challenged with the involvement of the pharmacists were overturned by the managed care organization. Pharmacists are at the forefront of offering preventive services. Vaccinations, monitoring, medication management, and reconciliation are a part of their toolbox and shouldn't be overlooked. And finally, pharmacists, as the final point, can also provide our patients with important resources and education to strengthen their health literacy and also participation in their care.

April Armstrong:

Great. Thank you, Allan, for that. Now, what can you recommend in terms of some of the best practices that you subscribe to related to co-management and the coordination of care in patients with psoriatic arthritis?

Allan Gibofsky:

Well, if the patient is referred to me by the dermatologist, then the first thing I want to assess with the dermatologist is what is the more important domain: the skin or the joints? Because if it's the skin, then really it's my colleague in dermatology who will be monitoring the patient more regularly. If it's the joints, it's likely to be me. The other thing I want to establish is whether the dermatologist is available to prescribe and monitor biologic agents that require a parental route because if they have an infusion unit that's more convenient than mine, then it may be that if we agree on a biologic of the kind we've discussed, the patient may better receive it from that facility than for me.

Allan Gibofsky:

So I think there are a number of best practices that involve co-management with a dermatologist as well as other members of the healthcare team, but the key word that I would use for all of them is interactive and regular communication. April, what about you? What are some of the best practices that you've identified?

April Armstrong:

Yes. So we sometimes get referral from rheumatologists to ask us to identify rash that may be able to help them in terms of diagnosis for PSA. I would say in those cases, all you have to do is let us know what your suspicion of the rash may be, why you're referring this patient to dermatology. That way we can make sure that in addition to our kind of full skin check, that we pay a special attention to the skin exam that can give us clue to see if a patient has psoriasis or some kind of other dermatological condition. I think that in terms of the management of patients with psoriasis and psoriatic arthritis, I think just to amplify the point that you talked about earlier, Allan, is that it's very important to have a clear agreement between the rheumatologist and the dermatologist who is taking the primary responsibility of the... for example, the prescription of a systemic medication.

And this is very important for a number of reasons. For monitoring, for also just ensure continuity of care and the continuity of the medication being provided to the patient. But I also, in those circumstances, want to make sure, as you said, the clear communication. If a rheumatologist is the person, for example, prescribing, a biologic, but then as a dermatologist, I see their skin not quite improving, having that more ready access to the rheumatologists and vice versa to ensure that if there are any revisions that need to be made based on the skin or the joint exam, whoever is primarily responsible for that systemic medication can take that into consideration and make any changes as necessary.

Allan Gibofsky:

Now, April, as a result of the unusual circumstances that we've all been going through in all of the specialties all around the world and for all of our patients... and by that I referred to the COVID pandemic... dermatologists have really been at the forefront of telehealth. What have you learned about health both before and ever since the pandemic started?

April Armstrong:

Dermatologists have used telehealth for a while because skin is almost this perfect organ where we can really transmit the images and really help do the diagnosis and the recommendation, as long as the images are comprehensive and clear. And we've done telehealth in terms of both live, interactive video-based interaction as well as what's called [inaudible 00:30:19] forward, where the images are taken ahead of time and then sent to the dermatologists, and the dermatologists evaluate those images asynchronously. While it was initially developed to serve patients in a rural or underserved areas as well as the US Army, these days, due to the pandemic, it has been extended to serving patients from essentially any setting who don't want to really access a healthcare facility. And what we have learned is that first of all, the telemedicine can be used effectively to help care for patients with chronic inflammatory skin diseases, especially when we are thinking about patients who are more comfortable with the technology.

April Armstrong:

Our group a few years back published a paper that compared the outcomes of patients with psoriasis, whether they are cared for online or in person, and actually found that there were no differences between those who were cared for online or in person in terms of their psoriasis disease severity or their quality of life. There are several telehealth tips I can talk about. It's very important to actually develop a very strong relationship between the healthcare provider and the patient. This is important because for some patients, and some clinicians to that extent, perhaps something could be lost in this technology world. So we have to start with a place where even greater trust is necessary. If you find that the telehealth is not the perfect modality for your patient, I will say still have the patient come to the office. It's fine. Or maybe for their initial visit so that you can establish that face-to-face care. You can establish that face-to-face interaction.

And if you feel that the relationship is there and then the patient is comfortable with using technology, then you can transition to maybe have some of the visits being done through telehealth. I think the visits that are perfect for tele-health are regular visits where the patient perhaps is not experiencing a flare, may need a medication refill that needs to be associated with the visit. But overall, I would say it's really important to work with our patients and to ensure that their tele-health experience, be it through video or through this asynchronous modality, that we offer them a good experience. And most of that good experience comes from our ability to really address their concerns and their questions.

Allan Gibofsky:

Well, thank you very much, April. That brings us to our SMART goals. And as we've been discussing in this podcast, it's important to engage patients as partners in their care and in treatment decisions. But it's also important to recognize that holistic care for patients with psoriatic arthritis requires a multidisciplinary approach, including a pharmacist, for the optimal management of psoriasis and psoriatic arthritis. Perhaps the most important thing to emphasize is that there needs to be open lines of communication across and between the specialties, many of which will be involved in the care of patients with psoriatic arthritis. And finally, that patient satisfaction is an important indicator and also a predictor of adherence, treatment optimization, and outcomes. So April, let me thank you for participating in our [inaudible 00:33:57] evening. Let's recognize that we've given a lot of information in a short period of time, and we've only given part of the information because this is an episode of a three-part series.

And we sincerely hope that our viewers will take advantage of all of the episodes in the series. These activities and a wide variety of activities on inflammatory disorders for both healthcare providers and patients are available on the CME Outfitters psoriatic arthritis education hub. As I mentioned earlier, credit is available for this activity. And to receive CME or CE credit, please click on the link to complete the post-test and evaluation online and be sure to fill in your ABIM ID number and date of birth on the evaluation so CMEO can submit your credit to the ABIM for Maintenance of Certification credit. Participants can print their certificate or statement of credit immediately. Thank you for joining us today. Whether you're a rheumatologist, dermatologist, primary care provider, or other healthcare practitioner, I hope we've given you some ideas and strategies to better engage your patients with psoriatic arthritis in their treatment decisions and ultimately in their care.