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Making a Difference: Patient-Centered Ulcerative Colitis Care in the Era of JAK Inhibitors and S1P Modulators

Announcer Introduction:

Welcome to CME on ReachMD. This activity is presented by Dr. Alan Moss and is brought to you by Boston University Chobanian & Avedisian School of Medicine, Center for Continuing Education in joint collaboration with ReachMD, and is supported by an educational grant from the Bristol Myers Squibb Company. Before starting this activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives. And now, here's Dr. Moss.

Dr. Moss:

Did you know that upwards of 2.5 million people in the United States have inflammatory bowel disease? Given the unpredictable nature of these painful and debilitating intestinal diseases, there's a significant burden on individuals in the community. So, with that in mind, what strategies can we use to address those challenges?

This is CME on ReachMD and I'm Dr. Alan Moss, Director of the Crohn's and Colitis Program at Boston Medical Center and Professor of Medicine at the Boston University Chobanian and Avedisian School of Medicine. And I'm really delighted to welcome Dr. Sophie Balzora to the program. She is going to join me to discuss the specific targeted agents for ulcerative colitis and share her insights on individualized management strategies. Dr. Balzora is a Clinical Professor of Medicine in the Division of Gastroenterology and Hepatology at the NYU Grossman School of Medicine and is a practicing Gastroenterologist with a clinical expertise in inflammatory bowel disease.

Dr. Balzora, so great to have you join me today.

Dr. Balzora:

Thank you so much Alan for that introduction.

Dr. Moss:

You're more than welcome. So, question 1 and part 1 of this podcast will be discussing some of the background of ulcerative colitis, or UC for short, and some of the conventional and newer therapies that we have to treat it. So, with that in mind, let's start with some background, Sophie. What are some of the basics regarding the pathogenesis and burden of illness of ulcerative colitis?

Dr. Balzora:

Well, Alan, as you mentioned earlier, an estimated 2.4 million people in the US have IBD. I think that's a much higher number than people tend to realize. And actually, a good chunk, about 40%, of patients with UC suffer from chronic continuous or intermittent symptoms that are considered quite severe, and about 50% of those do not achieve sustained clinical remission. Importantly then, colectomy is necessary in about 20-30% of patients with UC and is usually one of patient's biggest fears. The reason for colectomy usually falls into 2 big buckets, I find.

One is a disease that doesn't respond to medical therapy, or what we call medically refractory disease. Or due to precancerous mucosal changes, or just frank malignancy. As you can imagine, the pathogenesis of IBD can be quite complicated, right, and multifactorial. You see, the gene variance, immune dysregulation, abnormal gut microbiota, and environmental triggers each play an important role, and to varying degrees from individual to individual with IBD.

Dr. Moss:

So, that's a great background and context for this discussion. Thank you. So, when people talk about the targets of therapy, what does that mean to you? What do we mean and what are we trying to achieve when we talk about pharmacotherapy to treat ulcerative colitis?

Dr. Balzora:

So you mentioned previously the idea of clinical remission, right? So, it's important to establish targets or goals of therapy in IBD and their implications. And the more precise our goal, the more likely a given patient will do well long-term on that given therapy. So, with clinical remission we see things like symptom improvement, right? People say they have fewer bowel movements, they have less blood, their bowel movements are formed, and – which in the most immediate terms is great for the patient and very satisfying to us as physicians, but we of course now know that we need to be more targeted to obtain the best outcome. So, we get more and more targeted with improvement in biomarkers, like fecal calprotectin and C-reactive protein, and then even more targeted still with endoscopic healing. And then the golden goose, of course, which can be quite difficult to achieve I find in some patients, is histologic healing.

So, it's critical to explain these concepts to patients because the conversation does go hand in hand, I find, when working through different therapeutic options, right? If they don't understand your rationale regarding switching to different therapy agents, and why we assume some potential risk of medications for big benefits, I find it becomes really hard to truly engage with shared decision-making with your patient.

So, we know the end-goal is to treat to target to achieve sustained remission. I feel like getting people into remission, or inducing remission, is generally a lot easier, right, in terms of goals than keeping them there. So, now we have to think about our considerations for drug choice. So, this decision-making falls into a few main categories. The right patient for the right drug at the right time is how I like to think about it, and of course, with the right outcome. So, what are the considerations when we think about these concepts? I think one, we have to think about patients that are low risk, right? Patients who are considered to be low risk are those that we find have you know, very mild disease on colonoscopy, right? Their biomarkers aren't, you know, fluoridly abnormal.

And so we're not really at the point at which we can say this is the right drug for you at the right time based on this type of personalized medicine approach that we're trying to take. But we will eventually get there. What we do have available is really the ability to assess factors that would make a patient more or less likely to adhere to medications, practice things called therapeutic drug monitoring to dose adjust accordingly. And of course there's debate about whether we want to do that proactively or reactively, which is a whole other conversation, right? But when we think about the patient in front of us, we think about their clinical circumstances, we think about the drug class that we might expose them to. Then, you finally think about the right outcome, and that goes about thinking about what our target is, right? Is our target endoscopic healing? Is it histologic remission? And how will you tailor your treatment options accordingly while also keeping things in mind, like symptom improvement, which is, of course, what the patient definitely cares about.

Dr. Moss:

So, that was a great focus on targets for treatment and you did mention there drug choice. So, if we think really about our approaches to therapy, how has that changed over the last decade with ulcerative colitis with regard to what's the first therapy, and when do we pick the next therapy?

Dr. Balzora:

So, that's a great question, because I know in my introduction you mentioned how I have a clinical interest in IBD and I feel like one of the most fascinating things about the treatment of patients with IBD, and how we think about the disease, is how dynamic the medical management approach has been over the past decade or so. We've gone from this, kind of, quote-on-quote step-upward approach, where the rationale was that we offer more aggressive therapy in quote-on-quote for patients who sort of have to prove their disease severity to us over time with these need-to-fail therapies as we use to say in the language we used to use. But, when we talk about failed therapies like mesalamine or thiopurines to a quote-on-quote bigger and badder agent, right? but of course, now we take a different approach, which we call the top-down approach that really appreciates that severe disease really warrants therapies that can appropriately treat the type of disease a patient has, and early on in the disease, which is key. So, we don't want to offer these types of therapies after patients have cycled through mesalamine, have cycled through steroids for long periods of time, right? Endured the side

effects of steroids and so on. Instead, we like to say that appropriate early therapy for severe disease really benefits patients both in the short and long term. So, when you think about that how do we really convey to patients, hey, you're someone who is considered to have moderate or severe UC. How do you express that to the patient in front of you?

I think when we think about things like the UC Care Pathway, we first make the diagnosis, right? We consider the whole patient we – beyond their IBD, right? Not just at their disease that's in their colon, but also their comorbidities, their age, potential risks of a given pharmacotherapy, and then we stratify them based on their colectomy risk. So, we think about low-risk patients, right, with limited disease extent, right? It only involves a small part of their colon and there's mild disease on colonoscopy. Versus patients who are high risk for colectomy. And those are patients with extensive disease, patients who have those deep ulcerations on colonoscopy, people who have a young age of symptom onset, which can oftentimes mean much earlier than the time their IBD is actually diagnosed. Those who have required steroids during their disease course, have a history of infections like c. difficile, or CMV, and those with elevated biomarkers, like fecal calprotectin and – and c-reactive protein.

So, depending on the clinical scenario you know, induction of remission can happen at an inpatient or outpatient setting given how sick the patient might be, and a different set of options for maintenance therapies exist compared with that low-risk patient that I described earlier.

Dr. Moss:

So, Dr. Balzora, you mentioned in terms of treatment there are many agents available. We've got the TNF blockers, agents that block integrins, IL-12, 23 and so forth. So, I wanted to focus for this podcast on JAK inhibition and S1P modulation, which are kind of the newer kids on the block so-to-speak. So, let's start with the JAK inhibitors. What do you, when you think about JAK inhibitors, what do you think about in terms of how they differ from other agents, and what are the implications for their use in ulcerative colitis?

Dr. Balzora:

That's a good question. I mean, I think, again, this is really a remarkable time and as burdensome as the disease can be, it's really great to be able to offer so many options to patients that weren't available to us before. So JAK inhibitors, or Janus kinase inhibitors, are the first small molecules used in the treatment of UC and are orally administered meds. So, within JAK inhibition itself, certain molecules, like tofacitinib, offer more broad inhibition as a JAK-1 and 3 inhibitor. Filgotinib and upadacitinib inhibit JAK-1, right?

So, JAK are a family of enzymes that activate proteins that carry signals from one part of the immune system to another. So, blocking the actions of these enzymes helps suppress certain immune responses that lead to the inflammation we see in IBD, particularly ulcerative colitis.

So, despite it being a small molecule, and being an oral agent, it's really attractive to patients. But these inhibitors can knock out many targets, rendering it a pretty robust immunosuppressive agent, even though it's just given by mouth.

Dr. Moss:

And so, thankfully for ulcerative colitis, we currently have 2 JAK inhibitors that are FDA approved for ulcerative colitis. So when you think of them, what are the pros and cons of this class and how might they compare?

Dr. Balzora:

The 2 approved therapies for UC are tofacitinib and upadacitinib, the latter being more recently approved. Tofa is a more broadly acting JAK inhibitor than Upa. When thinking about the class of JAK inhibitors, a big draw is that this class of meds are oral agents approved for the use in moderate and severe UC, and that they work quickly in achieving remission. And then there are some important downsides to consider. So, as previously mentioned, it really casts a wide net from a blockade standpoint, so it is a potent immunosuppressant. Herpes zoster, for instance, is seen in 3% of patients and routine blood work is required while on drug as it can affect cholesterol levels, blood counts, liver enzymes, and can increase one's risk of thromboembolic disease. And so, I think this is an important time to stress you know, the the critical need to have healthcare maintenance stressed during every visit regardless of what meds patients are on, but particularly when they're on these potent immunosuppressants, it's so important to to stress the need for vaccinations at the right time and get lab work on a regular basis as necessary depending on what drug a patient is on.

Dr. Moss:

That's a great overview of the JAK inhibitors. We know from the induction data they're about similar in terms of percentage of patients who achieve remission during the induction phase.

So, let's move on to the S1P modulators, or what are essentially S1P functional antagonists. This is a new area of interest in the IBD

field. So what is S1P and how might it be important in treating ulcerative colitis?

Dr. Balzora:

So, S1P modulators, or sphingosine-1 phosphate receptor modulators, are attractive therapeutic targets because they regulate lymphocyte trafficking and vascular permeability. Also, an oral agent, the therapies within the class vary slightly as to how vast their targets are. Both are used to treat moderate and severe ulcerative colitis.

Dr. Moss:

So, similar to the JAK inhibitors, there are 2 S1P modulators available in the United States for ulcerative colitis, and others in late-stage clinical trials. So, could you maybe give us an overview of the pros and cons of this class and how you think about them when you present them to patients?

Dr. Balzora:

Sure. So ozanimod and etrasimod are the 2 S1P modulators available in the US for UC. Patients on both meds fare considerably better in terms of clinical remission than those on placebo during the induction phase. The pros of S1P modulators, as mentioned previously, is that they are oral agents with limited immune effects. The disadvantage is that there are multiple safety considerations with these meds. Those with a history of heart attacks, certain conduction abnormalities or arrhythmias, or even sleep apnea are not candidates for the drug. Additionally, prescreening blood work with a complete blood count, or CBC, liver function tests, and EKG are needed given the potential non-GI effects of this class of drug.

Dr. Moss:

So, that's a great way to round out our discussion on Chapter 1. I want to thank you, Dr. Balzora, for helping us better understand the role of some of these newer agents in clinical practice and I encourage everyone to stay tuned for Chapter 2, which will focus on a patient case and ulcerative colitis care. Thank you.

Dr. Moss:

So, let's continue with part 2 of this program. In our last chapter, we discussed some of the background to ulcerative colitis and some of the newer therapies available, such as JAK inhibitors and S1P modulators. I wanted to start this chapter with a simple case study. So, let's say you have a patient with moderately active ulcerative colitis. She's 38-years-old, she's failed a mesalamine product. So, Dr. Balzora, what are your initial steps in evaluation before you're thinking about the next steps for this patient?

Dr. Balzora:

So, before changing treatment in any patient, it's important to gather some objective data. We need to confirm not only the presence of inflammation but assess disease activity before moving ahead with a change in medication. Biomarkers can be a great help, particularly the fecal calprotectin. I like to obtain one at baseline and throughout time points in a patient's disease. I find it's an excellent noninvasive means of critical information gathering. It can be a predictive marker of relapse or flare, and we usually look for a level above 150 to make that determination.

Dr. Moss:

So, once you confirm her disease is active, based on an elevated calprotectin, you've ruled out infections. You're now moving beyond a 5-ASA agent, so how do you decide what's next? Are there data on comparative studies of efficacy and risks in different agents versus others?

Dr. Balzora:

So, the question after we move on from mesalamine derivatives is what drives the next choice. So, if you recall in Chapter 1, we talked about the right drug for the right patient and the right target. A 2021 study in *Gut* compared various biologic and small molecule agents for UC and found that induction upadacitinib for clinical remission in all patients, meaning those who were both anti-TNF naïve, or anti-tumor necrosis factor naïve, and exposed had the greatest efficacy. And that was followed by low and high dose infliximab. High-dose infliximab ranked first for endoscopic remission.

So, when I think about the patient in front of me, keeping in mind their disease severity and activity, comorbidities, preferences, and values, we make a shared decision on which medication is most appropriate keeping in mind the benefits and the risks of each class of agents, and then ultimate therapy that is the right choice for her.

Dr. Moss:

So let's say based on pair or regulator preference, this patient has to be started on anti-TNF next. At what point are you deciding yes, this is a responder or non-responder, and if it's a non-responder, what are you thinking after anti-TNFs?

Dr. Balzora:

So, I want us to think back to that bullseye we have in head, right, with the series of targets. So, it's important to continually assess and reassess in varying ways if our target is begin achieved. So, not only do we regularly evaluate symptoms, like stool frequency and urgency, presence of blood in the stool, but we also consider therapeutic drug monitoring, usually around week 14 for anti-TNFs, to ensure levels are where we want them to be. Biomarkers can also be quite helpful, as we talked about earlier, especially when compared to where they fell at disease onset and at the time of flare. And then finally, nothing really replaces endoscopic evaluation, right? So, about 6 to 12 months after starting medication, we take a look inside and that can really offer a wealth of objective information.

Dr. Moss:

And so, if this 38-year-old woman has failed mesalamine and failed her anti-TNF, what class are you thinking about next? Or do you have a go-to next in your sequencing?

Dr. Balzora:

That's a great question. I mean, we have to think about the whole patient. Not only the disease activity when you're seeing them, but also how old are they, what other medical conditions they have. But for this patient in particular, you know we can definitely consider small molecule medications. I think the one important thing for women, particularly of childbearing age, is is it safe in pregnancy? And I'll say that generally speaking you know, a lot of the medications we have in our armamentarium are, which is fantastic. But particularly with the small molecules like JAK inhibitors, that does, you know, give me pause in terms of which medication to start. So, I would be more apt to think of something like vedolizumab, though it does take a little bit of time to work compared to some other agents. Something like ustekinumab perhaps might be a nice choice for her. but I think that that's when you have to really think about those other factors that go into the right medication for the right patient at the right time.

Dr. Moss:

So, for those just joining us, this is CME on ReachMD. I'm Dr. Alan Moss and joining me to talk about the management of ulcerative colitis is Dr. Sophie Balzora.

Dr. Moss:

You know, as you mentioned both the small molecules, the JAK inhibitors, and the S1P agents we're trying to avoid in pregnancy, but the monoclonal antibodies we have a good safety record for the most part, so that's very helpful.

So, with this in mind let's think about the multidisciplinary care for ulcerative colitis, because it's not just about patient symptoms, it's also about the whole patient. So, other than gastroenterologists, what are the roles that are important to help manage a patient with ulcerative colitis?

Dr. Balzora:

That's a great question because IBD is an incredibly complex disease, right? And there are so many critical team members that contribute to a patient's success. In addition to GIs like ourselves are colorectal surgeon, rheumatology, ophthalmology and dermatology, psychiatry and psychology colleagues are really critical. APPs like nurse practitioners and physician assistants, PharmDs, nursing clinicians, and dieticians also play a crucial role. Social workers, medical secretaries, I think are oftentimes overlooked, but contribute significantly to the overall care of our patients, and really, you know, when you think about it, that's just to name a few, right?

Dr. Moss:

Exactly. And so, you've got a lot of team members there and so, how do you justify this? How do you explain the benefits of this for patients in terms of patient satisfaction and outcomes?

Dr. Balzora:

So, I really do think that team work truly makes the dream work here. I think treating the patient wholly is something that we're really trying to grab onto incredibly tightly. And you'll find that when you actually talk to patients and take the time to do so that patient-centered perspective, especially for those with moderate or severe disease, especially those are historically underrepresented, is such an important and robust and impactful approach when we're thinking about multidisciplinary care. Other key features as I mentioned earlier are to practice that shared decision-making, right? Working towards patient activation where they really feel engaged and

knowledgeable about their disease you know, can be incredibly empowering. And acknowledging the social barriers that may hinder favorable disease outcomes. And then of course which is so important, the mental health burden the disease may carry for many.

So I think that some features of an IBD team includes one that improves access to care, definitely, facilitates communication between a multidisciplinary team, provides culturally sensitive and culturally tailored patient education, promotes and emphasizes health maintenance practices, is sensitive to mental health and acknowledges what I think were talking about more and more often, thankfully, is the social determinants of health that hinder recovery and remission.

Dr. Moss:

I'm glad you brought those up because they are really important to recognize for all IBD teams. So, as we end this chapter and think about our patient advocate for the next part, you're a very experienced IBD doctor, what are the kind of key take-homes in managing ulcerative colitis that you've picked up over the years?

Dr. Balzora:

So, I think first and foremost, and we've kind of strung this along throughout our discussion here, Alan, is to treat the whole patient, right? Treat the entire patient, not just their colon. Severe disease warrants appropriate therapy. Don't delay in prescribing the right medication for the right patient early on in their disease. Biologic therapy is becoming the mainstay of moderate to severe ulcerative colitis and Crohn's disease. You know, there are all these complex immune pathways in IBD that provide a lot of targets with a variety of strengths and weaknesses that are important to discuss with the patient in plain language. I'll say, like I mentioned before, thankfully we're at a place where currently available biologic therapies are many, right, compared to years ago, and include a mix of small molecules and monoclonal antibodies. And then I think that this treatment personalization in IBD is dependent on a couple things. One, patient characteristics, right? Genotype, comorbidities, prior medication exposures that may render future ones less efficacious, and personal desires and preferences, and of course, characteristics of the drug, like pharmacokinetics, efficacy, and their safety profiles. And then, finally, what is the future of IBD, right? The future of IBD is one of precision medicine with a focus on interpretation of data to predict flares and modify the disease.

Dr. Moss:

So, thanks again, Sophie. That's a really helpful and inspiring overview. We're indeed in a time of precision medicine and we need to address this approach to make it appropriate to not that one-size-fits-all, that we make it beneficial to the patients. So, thank you so much Dr. Balzora for being with us today. Thank you to our audience for joining us and please stay tuned for our third and final chapter, for our Patient Advocate. Thank you.

Dr. Moss:

For the last chapter of our podcast, I'd like to welcome Ms. Latonia Ward, who's been an IBD patient for 30 years, having received her diagnosis at the age of 17. She is also currently the Director of Community and Culture for the Color of Crohn's and Chronic Illness. Ms. Ward, thank you for being here today.

Ms. Ward:

Thank you so much for having me. It's my pleasure.

Dr. Moss:

So, I wanted to start by asking you about your experience receiving ulcerative colitis care because you've been a patient for a long time. What's your experience with the treatment you've received and how – are there any differences in access to care and treatment options that you've come across, either personally or with your organization?

Ms. Ward:

Well, yes. I was a very young girl at the time I was diagnosed, and I was on Medicaid at the time. At my diagnosis my mother and I were clueless about this disease, but when I started getting treatment, everyone seemed to be so interested in my case. And when I would go to appointments, I had several student doctors always at my appointments. I was treated mostly on steroids and inflammatory medication at the time, and I was on that medication for 6 years. After that, I was offered surgery which I ended up getting a Brooke ileostomy. It was stated that I was not maintained well on the medication therapy that I was on, so that's when they offered me the surgery.

As far as access to care, I believe I had timely access to care. I was diagnosed within a month of going to the doctor with my symptoms, and so I felt that was pretty good timing. But I was limited with my insurance. Everyone who I needed to see, all of the doctors, all of the

specialists, you know, all of them didn't accept my insurance of state Medicaid. And then of course, I'm sure that Medicaid didn't cover a lot of the things that I might have needed at the time which could very well be the reason why I went straight to surgery instead of being offered other medication. I will never know.

Also, early in my journey I did have to travel to New Orleans, which is about 2 hours away from where I live, for treatment, so that put a strain on us because, you know, the distance and I wasn't working, or I was in high school, so that was a little difficult at the time.

Dr. Moss:

So, you mentioned there about, you know, the timing of your access to care and the timing of your diagnosis. What do you think would help patients realize now is the time to bring this up to my doctor, now is the time to – to get a referral to gastroenterologist so they do get timely access both the diagnosis and – and also to the right treatment?

Ms. Ward:

I would say if you start having symptoms pain, constipation, diarrhea especially blood in the stool, and – and this is more than once, this is an ongoing thing. Please, please go to the doctor and see what's going on. A lot of times we kind of wright off those GI issues as something I ate, or anything other than I have something going on. But if it's happening more times than not, it's very important to go and get a test.

A lot of times we don't know to go and ask for a test, so I would like to publicly say today, it's okay to go and ask for a test, say something is not right with me. You are the expert for your body, and you know if something is not right. Time and time again people have waited years to finally get a diagnosis and it's because we were blaming it on because we like fried foods, or something. So, I think if you have any of the symptoms on a regular basis, please go to the doctor.

Dr. Moss:

Yeah. I love that perspective, you are the expert on your body, because I think that's absolutely true. Okay, let's move on to the next question.

Dr. Moss:

What are your main priorities when you're discussing new treatment, or in general, you know, with your organization, what are your constituents telling you about their priorities? Is it mostly safety they're interested in, is it mostly efficacy, the type of medication? What are the main priorities people are concerned about or interested in learning more about?

Ms. Ward:

When it comes down to medication, a lot of times we have to remember that when people are sick and they're at a point where they need medication, they're just really desperate to find something that works. And of course, after that they're more concerned with if my insurance is going to cover it, because the medication is so expensive, it's not going to do any good to have a medication that you can't get because it's too expensive.

Dr. Moss:

So, you mentioned 2 important points, right? One is just does this drug work, or will it work for me,which relates back to Chapter 2, and also, will it be covered? So, will my payer cover it? And so, do you think, are there differences in those priorities to say someone who has maybe better access or better insurance in terms of how they get served?

Ms. Ward:

Of course. I believe that people in well-served communities would have an idea from their office of the success rates. A lot of times the people that I come in contact with, if they have had access difficulties they don't have those relationships with their providers to often talk about those success rates, and if the medication works how long it takes. So that's when a lot of times community becomes important for that patient. But also, I think that if they are in those well-served communities more times than not they have a reason to believe that their insurance would cover the medication especially if the patient has developed a relationship with their doctor and they trust their doctor since their diagnosis. So, I really think that they would have a better understanding in that situation. Me personally, as a 17-year-old diagnosed, I was just in a space of being grateful that someone quote-on-quote took my case to treat me, versus trying to figure out if this doctor was trustworthy, or if my insurance company was going to be able to cover the medication that I needed, so forth and so on.

Dr. Moss:

Yeah. So, you mentioned building trust and, on an individual level, are there things that patients want their doctors to think more about, or ask them about, or are there things that they leave unsatisfied because they weren't given opportunity to discuss during the visit?

Ms. Ward:

Yes. I hear a lot of patients just say that they want to be talked to as a human being. They want to feel like the physician cares about their well-being and that they want what's best for them. That's including having the patient involved in their decision process. Even if the patient doesn't have any idea whatsoever what's going on, just take a moment to try to educate the patient on their condition.

You know, patients I've seen over the past few years have been finding their voice and learning that it's okay if you're not satisfied with your physician and you can have that conversation with your physician, but I know a lot of times with the community that I'm in, and the community that I serve, historically, you really don't ask your physician anything. I tend to say we have those three P's the parent, the pastor, and the physician, where we're kind of like, whatever they say is law, right? So, but we're learning that you can ask the questions, and it's important that our providers take a moment to just educate us, talk to us, let us know, because we're going straight to Google and Google is sometimes not the best place we need to end up at.

Dr. Moss:

Yeah. I totally agree. And one other part of that process is follow-up, right? Many patients are lost to follow-up. They miss their appointments, they miss their infusions or injections, they don't refill the medicine. How can we do a better job in getting patients more involved in that and encouraging them to try and not miss those appointments or treatments?

Ms. Ward:

It's very important for patients to participate actively in their care plan. And now, a lot of doctors' offices have the portals that we can go to, which is very awesome. The patients can go and see their information, message their doctors, have questions and concerns, all of that. I think what could be helpful for the clinicians, or the offices is if they have someone who can answer those questions in a timely manner. Also if there's room in their office or databases where they can send email type of reminders about appointments or medication refills. I think most patients understand that they're not the only patient that their doctor has, right? But it's the gentle gestures that go a long way in helping a patient stay on track. Now remember, like I said earlier, it's about the relationship and it doesn't seem one-sided if you're getting little reminders here and there, or if you hear from your clinic more than just on the day that you're supposed to show up for your appointment.

Dr. Moss:

I like that concept of gentle gestures, because, you know, they cost nothing, right? So before we close, I want to end on this and bring us back to this shared decision making. From your perspective as a patient, what does that mean to you and how can we encourage this at the highest level for patient engagement?

Ms. Ward:

Shared decision making to me is discussing the pros and cons of your condition and treatment plan, and seeing how you're going to go forward. Educating each other, and finding the best and right now solution for you as a patient. This is important because now, I'm okay, I trust you with my life, because that's in general, it's really what it is. I'm trusting you with my life. And if we are able to discuss my next steps I feel like I have an option. And sometimes so many patients are left where they don't have any options. Even if my options come down to, I don't have an option but this next one step, at least we discussed it. At least I got that first information about my healthcare from my doctor's office versus me going to search the internet or the social media to try and get answers. So many patients never feel the feeling of having options. They feel forced into a situation when they're already in a vulnerable state, so I think just promoting shared decision-making is very, very important.

Dr. Moss:

Yeah. So, I totally agree, and I'm glad that you raised that point for us. So, on that note, let's close out our discussion of ulcerative colitis and some of the disparities in care that we know are present. I'd like to thank my guest, Ms. Latonia Ward, for giving us a better perspective and understanding on the unmet needs from a patient, as well as the importance of using shared decision-making in practice. Ms. Ward, it was a pleasure speaking with you today. Thank you.

Ms. Ward:

Thank you. It was a pleasure speaking with you as well.

Announcer Close:

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