

Transcript Details

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Managing IBD Care for Diverse Patient Populations: Part 2

Announcer:

You're listening to *Crohn's and Colitis Foundation Perspectives* on ReachMD. This activity is supported by an independent educational grant from Bristol Myers Squibb. Before beginning, please be sure to review the disclosure statements as well as the learning objectives.

And now, here's Dr. Freddy Caldera.

Dr. Caldera:

Hello, my name is Dr. Freddy Caldera. And I'd like to welcome you to our discussion on Managing IBD Care for Diverse Patient Populations, A Multidisciplinary Panel Discussion. I'm an Associate Professor of Medicine at University of Wisconsin Madison in the Department of Medicine and Division of Gastroenterology and Hepatology. I'm an IBD-ologist. And I have the pleasure of being joined by three great faculty.

Dr. Stacy Ogbeide, she's a Board-Certified Clinical Health Psychologist and a Board-Certified Specialist in Obesity and Weight Management. She is currently the Director of Behavioral Health Education and Family Medicine Residency, the Primary Track Coordinator for the Clinical Psychology Internship, and Associate Professor and Clinical in the Department of Family Med and Community Medicine. She also has a joint appointment in the Department of Psychiatry and Behavioral Sciences, and most recently was an Assistant Dean for the faculty in the Office of Faculty with the Long School of Medicine at UT Health San Antonio.

We are also joined by Dr. Bhat, a Clinical Pharmacy Specialist in Gastroenterology at Cleveland Clinic, where she oversees the medication experience including education, safety monitoring, and adverse effect management of patients with inflammatory bowel disease. In addition to her clinical practice, Dr. Bhat also does clinical research and participation education.

And finally, we're joined by Dr. Lisa Malter. She's a gastroenterologist at The New York City area with a focus on inflammatory bowel disease. She oversees the advanced fellowship in inflammatory bowel disease offered by NYU's Langone Division of Gastroenterology and Hepatology, but she also leads the center's educational efforts, which include free health seminars for patients and the public.

So today, we'll be discussing some of the underlying themes from the last webinar, Through the Looking Glass: Managing IBD Care for Diverse Patient Populations, which Dr. Malter did a great job of discussing the changing landscape of IBD care. And she also spoke with two patients from Black and African American and Hispanic background about their journey and some of the experiences they went along the way, which included having a delay in diagnosis because underlying bias - bias, having issues with access to care and how that impacted their patients journey, some challenges they face to health literacy, and talking about shared decision and talking about shared decision-making, and how it's important what to consider the patient's cultural imbalance.

So to discuss this issue, we're going to cover some learning objectives and speak to our experiences from the lens of each of our disciplines. We're going to discuss cultural and cognitive biases that may contribute to health disparities in IBD for different IBD patient populations, including Black and African American, Hispanic or Latino, and Asian. We're going to identify differences in disease perception and self-management within IBD patient populations. And we're going to describe shared decision-making models or methods that may work to facilitate open communication between the ca - patient and the clinician, so we can provide the best care for our patients.

And before we begin, we can – we'll discuss what the medical background and what we all do. So Dr. Ogbeide, I will start with you. What experience do you have in dealing with the IBD population? And what has been your experience as far as some of the health disparities these patients may – may experience or have experienced?

Dr. Ogbeide:

Absolutely. So in one of my roles I work as a behavioral health consultant in the primary care setting. Uh, so my specialty is clinical health psychology. What that means is, I work with all types of patients with all presenting ages on different health conditions and helping them adjust to having that chronic health condition like IBD, and really helping them make health behavior changes that can improve their management of IBD over the long run.

Dr. Caldera:

Thank you. That's a great answer. Dr. Bhat, tell us about some of the - some of the things you have experienced. And I'm especially interested in your prior professional experience. You were working in the Boston area, and I know you worked at an underserved, worked with a high underserved population.

Dr. Bhat:

Yeah, thank you, Dr. Caldara. So I've been practicing in inflammatory bowel disease for about 3 years now. And, as a pharmacist, my role really consists of anything related to medication management. And I'm really focusing on education, including monitoring of medications, the management of side effects, and health maintenance needs. In my role, so I typically interact with patients, primarily one on one. And I work alongside with the gastroenterologist to optimize patient care and outcomes. So at my prior position, I worked in the New England area. And the patient demographic of the patients that we've seen in this institution consisted primarily of 75% coming from an underserved population and even furthermore, about 23 - or at least 27% did not speak English as their primary language. So I've worked with a very diverse patient population. And also I'm part of the South Asian IBD Alliance, which is a organization that convened earlier last year. And it was designed to help minimize disparity dispel some stigma, and promote early diagnosis and improve access to treatment particularly if they're of South Asian origin.

Very excited to be here today, so thank you for having me.

Dr. Caldera:

No, thank you for joining us. And Dr. Malter, tell us about your experience. And obviously, in your last webinar, you taught us a lot. So tell us about your experience.

Dr. Malter:

Thank you, Dr. Caldera. And thank you for having me tonight. So I'm an IBD clinician based out of NYU where I spend a fair amount of my time involved in direct patient care. And in that role, I exclusively work out of our city hospital and have taken care of the underserved with inflammatory bowel diseases dating back to 2011. And in this work every day I see patients that encounter numerous challenges based on their race, ethnicity socioeconomic circumstances –and social determinants of health that impact their ability to thrive and live with their chronic illness.

And in addition to my clinical work, I also work actively to try and help some of the educational gaps that occur in training in gastroenterology which can sometimes lead to the delays in care that our patients see and probably many of you have experienced when you see patients as a second or third referral after they've been seen and not truly diagnosed with their condition.

Dr. Caldera:

Well, thank you. And Dr. Malter, I think we could probably both agree as to both gastroenterologists, I mean, diagnosing a patient with IBD from the patient's perspective, even without any disparities, and without - with great health literacy - medical literacy, it's a challenging diagnosis and journey to go through. So I imagine a lot of your patients - I'm in Madison, Wisconsin, and while we don't have the diversity of New York it's a tough diagnosis to initially get and to learn where to go and who to call and when you should call your gastroenterologist, that I imagine some of your patients from different backgrounds or like Dr. Bhat said, who may not speak the

language, all those become more bigger barriers for them to feel better.

Dr. Malter:

Definitely true. Yeah, I think we see a very diverse patient population with prisoners and patients who have just moved to the United States from, from outside of the country from all parts of the world where I do practice, which is very unique and presents a great challenge, like I said, every day.

We I think, you know, many patients as we've heard two sample stories in our last webinar, experience a bias is where they're told that they can't have inflammatory bowel disease. And as clinicians, we know that there is no one gold standard test that says you have ulcerative colitis or you have Crohn's disease. And therefore, getting to the diagnosis in and of itself can really require a heavy lift for patients and for clinicians in terms of ordering the right tests in a timely fashion and walking away from the compilation of results that you get to land on the diagnosis of inflammatory bowel disease. And even starting to explain that to patients can be quite challenging, especially with language barriers and cultural barriers, especially those that can coexist with gastrointestinal illnesses. Because GI illnesses can be very embarrassing for patients to deal with and very frightening for them to be faced with, especially if within their own communities they're not getting the support that they may need.

It's really important I've noted, to try and meet my patients where they're at by developing a rapport with them and getting them to hopefully feel comfortable with me so that they're willing to share their own personal experience, so that I can understand how I can best help them.

Dr. Caldera:

And that's great. And thank you for all you do. I'm sure your patients love you.

And - and on that note, I think we probably should talk about how once we diagnose this patient, how we deal with cultural or socioeconomic situations in the practice setting. And I think I'll start with you Dr. Bhat, as a clinical pharmacist, I mean, once we diagnose someone, then we start talking about treatment, I'd be interested in how you look at socioeconomic barriers, because some of our treatment options can be very expensive. And I'd be interested to see how you deal with those barriers. And also, as you are part of this South Asian IBD Alliance, and if there are any cultural difference from that same point that you have dealt with?

Dr. Bhat:

Yeah, so that's a great question. And I'm definitely mindful of cultural and socioeconomic factors. Because as you mentioned, Dr. Caldera, they definitely influence medication management. So I'd like to kind of break it up.

In regards to cultural considerations when I'm meeting with patients, I always prefer to check what their preferred languages are. I like to utilize interpreters appropriately to ensure that we're really having an open communication, and that they're receiving the proper information that they need, and that the proper management strategies are being conveyed. I'm also mindful about treatment hesitation particularly in regard to biologics. I think that we'll see a lot of this across patient populations. And so, in this context, I definitely try to dive in a little bit more to see if there are potentially cultural factors that may be a potential barrier, and adjust these accordingly, if I can. I also ask about complementary and alternative medication use, because this is often emphasized in certain cultures, and so I like to always assess and make sure that that's not necessarily going to be a barrier or a hindrance to escalation in therapy needed.

And then from a socioeconomic standpoint, I'm always thinking about insurance coverage, as you probably can imagine. And I'm really looking to address any potential barriers to medication affordability and access. And so, for example, if we're going to be recommending an infusion, I always ask about if they have the necessary transportation accommodations, or do they even have the work flexibility, and can they essentially address all these components that are needed for them to be on treatment consistently.

So in general, I'm looking to see a big picture, but I'm also trying to make sure that all these puzzle pieces that affect that individual patient basically lines up. Because at the end of the day, we can make all these medication recommendations but if a patient can't commit or they can't access the treatment, then our recommendations are essentially useless.

The South Asian Alliance IBD group has done a great job in terms of addressing a lot of cultural factors. And in the South Asian population particularly, there's the stigma about IBD not necessarily being a real disease. So that organization is doing a great job in trying to dispel some of the stigma and some of the perceptions, if you will. Even from a socioeconomic factor, one thing that's kind of I find interesting is the fact that there's actually different types of gaps when it comes to medication access and costs, both within the

United States and internationally. So I really think we're doing a really fantastic job in trying to kind of bridge these gaps together, bring clinicians in both the U.S. and international together to potentially collaborate and see how, globally, we can improve patient care for patients with IBD.

Dr. Caldera:

Okay, well, that sounds great. And thank you for all the work you are doing.

Dr. Malter, it sounds like you were telling us that this is probably something you experience every day when you're doing IBD clinic to some degree, whether it might be cultural or socioeconomic situations. Can you give us how you deal with these situations?

Dr. Malter:

Yeah, so to be honest, it's rare that a patient doesn't have a challenge that they're facing. I think even in the best of circumstances when there are not socioeconomic factors or racial factors, I think every patient can struggle with chronic illness, but some of those can be more significant depending on psychosocial factors economic status, and race, especially with the bias that some patients have faced.

I really try - you know, we take care of as clinicians of two diseases and from the outside that can sound maybe - maybe boring to other clinicians who might take care of a wider array of conditions. But I think in IBD, we know that it's two diseases that can play out in so many different ways. And so different for each patient, even when two people in the same family have the condition. And I find that that's the case with kind of all of these different factors, and really trying to understand the patient taking a very personalized approach to their care, which includes thinking about their disease and what types of medications would be best suited to treat the medical aspect of their disease, but also taking into account who they are, can they get to your appointments, do they have family support, do they have transportation, did they have the resources to get their medication what psychosocial aspects of their disease or their life are at play? And understanding these factors up front is really going to help set up success for the patient or help you get to a place of success, which success for one patient may look very, very different than success for another patient. So in that personalized approach, kind of trying to understand what the goals are for that particular patient and eliciting them from the patient themselves. Because we as clinicians may put out a strategy that we think is very manageable, and we can see to the other side of it where the patient will be well and back on track. But if the patient's expectations are very different from that of a clinician, that mismatch can be really hard and can create a negative dynamic between the clinician and the patient which is obviously not what we're trying to do. We're all here to try and get our patients better and be able to live their lives. So really trying to understand and align.

And depending on the resources that the patients need, sometimes those resources can be obtained locally within my own practice setting sometimes going beyond my practice setting to my institution on a larger level, and then also being aware of resources that are available to patients, including many that the foundation provides in order to optimize the patient's outcomes.

Dr. Caldera:

No, that's great. And I agree with you on so many levels. In my practice, I typically ask questions - a couple of questions that are not medically related, where I'd love to know what people do. I'd love to know what their family life is like and what they love to do. Because I'm sure you've experienced this, Dr. Malter, where someone with inflammatory bowel disease, their life becomes different and they get used to a new normal, and sometimes, at least knowing what they'd love to do, what they can't do, can help you appreciate when you're going to get them better, and depending on their social life, you know, it can depend on if you're asking them to do too much and you're kind of setting them up to fail.

So Dr. Ogbeide, as a clinical health psychologist I want to make sure with your expertise, you're telling us, and any providers and the providers listening, of how we should be dealing with these situations.

Dr. Ogbeide:

Absolutely, and I just want to definitely recognize that Drs. Bhat and Malter, I think the approaches that they shared and they use are absolutely fantastic really taking a personalized approach to the patient's needs that sitting right in front of them. So I definitely echo what they shared.

An additional approach that I like to use, and I encourage other clinicians to consider or think about using is something called cultural humility. And there's lots of different definitions that are out there on cultural humility. But one of the ones that I really like is from the

National Institutes of Health, and they define cultural humility as really this lifelong process of self-reflection on the part of the clinician, so on us as well as self-critique, where we are not only learning about our patient's culture the person who's sitting in front of us, but also examining our own beliefs, our own cultural identities, our own values, and how that might impact our care with the person sitting in front of us. I think sometimes it's really easy to maybe think or assume we're doing the best for our patients or the families that we're serving, because well, this is what I would do, if this was the situation I was in. But sometimes that might not be the best approach for the patient or the family. Because we're not necessarily taking the lens of their experience, we're putting our own experience into the situation.

So I really appreciate cultural humility, just because it helps us take a step back, and helps us slow down in the process, especially in a very busy clinical setting to say, 'Okay, what am I bringing to the table? What might I be introducing into the conversation with the patient or family that might be ignoring their point of view?' So I definitely would encourage clinicians to think about cultural humility as an approach to use with their patients and families.

Dr. Caldera:

That is great. Would you mind just sharing for our providers who might not be familiar with this, what are some open-ended questions where, you know, I like to start an appointment of like, 'How can I help you today? Or what can I do?' What would be good ways to make sure that we're meeting patient's needs from that standpoint?

Dr. Ogbeide:

I think something that you mentioned a moment ago about how you start conversations with your patients, I really liked. You talked about getting a sense of what do you do for work? What's a typical day look like for you? I think that can really open up the conversation to navigating into really getting a sense of what their values are. What is it that's important to them? Whether you're talking about it in the context of their care, or just in general because whether or not the patient or family realizes it, when they're speaking in general terms, you can still connect that back to their IBD care. So if someone talks about, I really love spending time with my grandchildren. It's the highlight of my week is spending time with them.' But maybe they're having some trouble with adherence. Maybe they're having some trouble taking their medications consistently, or changing their diet, you can really link that back to, you know, 'I really want to do, you know, make a plan that works best for you. I know that you've told me you've had some trouble with sticking to some of the dietary changes needed to manage your IBD and you also mentioned to me that love being a grandparent. And so I want to make sure we have a plan that keeps you here long enough to do these things that you enjoy doing with your grandchild. So I wonder if it's okay if we talk about additional ways to help you with your diet?'

So you're really linking their values, their expressed values with what their IBD goals of care are. So that's one maybe concrete example that clinicians can think about incorporating into their conversations with patients and families

Dr. Caldera:

Well great. That's a great example because honestly, what we want to do is we want to acknowledge those issues and help providers know what to do. So thank you.

And I think on that note, we've talked about some of the challenges already in this space. But I think overcoming these challenges is a big topic. So Dr. Malter, why don't we start with you? I mean, you already told us a lot of these challenges, but what do you do, who do you reach out to, do you have a great nurse that helps you with all these resources? Or what do you do?

Dr. Malter:

So kind of in line with working at a city hospital we tend to be under-resourced. And so I can't say I have a great go-to for a majority of these issues. I've gotten creative, I would say, over my time working there. And so, I would say some of the things that have really helped me are strong relationships with clinicians in different divisions and departments. So when our patients have needs that go beyond the gastrointestinal tract, which as we know, inflammatory bowel disease doesn't just limit itself to the gastrointestinal tract. I kind of have my go-to clinicians that work in my practice site, but sort of can understand the the urgency with which some of our patients need to be seen; not all the time. But, you know, having those people to reach out to so that sometimes it can take 90 days to get an appointment in a particular clinic, and an IBD patient who's on immunosuppressive medication, can't afford to wait 90 days. And so you know, getting help booked into those more urgent slots having those clinician connections I think is helpful.

Being an underserved hospital, we do have resources in our pharmacy to help with patient assistance programs. And I do rely on that quite heavily. Many of our medications are extremely costly, as you're all aware, and getting the medication is one thing, but then there can be limitations on administering medications, especially medications that are parenteral in nature. And so, working with our team member who oversees all of the patient assistance programs at our hospital has been really instrumental.

But then also trying to work closely with either our nursing services or nursing services that are provided through some of the pharmaceutical companies that help support patients in accessing their medications, delivering their medications and having resources during ongoing therapy have been really helpful to keeping my patients on track.

And then we do have some, we keep kind of a list of clinicians that are able to see patients at a reduced fee for things like nutrition services psychosocial needs, things like that. And so I'm truly grateful for all of those clinicians who sort of appreciate the needs and the vast needs of the IBD patient. And just keep clear communication lines open between those clinicians as well as to the patients to make sure they understand why they need the support of these different people or members of their care team in order to get them to a place of wellness.

Dr. Caldera:

Well, thank you. Thank you. Thank you for all those answers.

And Dr. Ogbeide, you gave us some great insight of, you know, how we should approach this, but when the patient opens up and talks about those challenges, what would you recommend of how to deal with that?

Dr. Ogbeide:

Yeah, absolutely. You know, cultural humility sounds great in practice. But the work involved can be difficult. It can be challenging, just because it's asking a lot of the clinician to do a lot of introspection a lot of self-reflection, especially when you have patients who have different experiences than you. Even if you are from a similar cultural background from the person sitting across from you you still have very different life experiences. And so that can be challenging to take a step back and dig into some of the potential biases that could be there that could be impacting the care that you're providing to the patient, or the care that the team is providing. And so, I think that can be a challenge just because self-reflection can be uncomfortable. It's not necessarily an easy thing to do, especially if you've not done that before. And so, I think that is a potential challenge but also has some great solutions to it in terms of digging into some of the literature out there on cultural humility. There's lots of good podcasts. There's lots of good articles out there that don't take that long to dig into and to begin to learn how to do this.

So if you're a clinician out there thinking about wanting to try this with the patient, but you might be nervous about doing this I would encourage you to give it a try anyway. Look into the resources to help support the work that you're doing in the space because I guarantee your patients will appreciate this approach that you take with them.

Dr. Caldera:

Thank you. Well, sounds like I've got to download some new podcasts when I'm out exercising. So thank you for that.

And lastly, Dr. Bhat, I imagine you may be pulled in some of these scenarios many times as a clinical pharmacist, just dealing with, you know, how expensive our medicines are, and if there's any way you can support these patients with patient assistance. But I'd be interested in your take on this topic.

Dr. Bhat:

So in the context of medication management being mindful of additional considerations and aware of available resources is really essential. And so I've worked with patients that have been told that, for example, biologic therapy is poison and that they're sick because they haven't utilized complementary treatment. So in this kind of situation or context I think really providing disease education and providing support can really go a long way.

And what that support might look like is actually linking these patients to other patients that have actually walked in their shoes. So having that peer network support can really be a strong, valuable resource.

I've also worked with patients who have been not able to have permanent housing. And they've been at risk for actually having their

medications stolen, or they don't necessarily have reliable transportation. And so, I'm showing that not only are you connecting these patients to available resources where you can find them, but actually having a way to reach these patients and providing regular check-ins or in touch can really be impactful.

So again, I think that's kind of echoing what everyone had already mentioned, and what appears to be a common key theme, is really that being aware of the patient as a whole and then knowing the resources that are available to help them navigate the potential challenges it's really a key approach to help them overcome these barriers.

Dr. Caldera:

Okay, well, thank you. And also, I think, moving on when we're talking about cultural biases, Dr. Ogbeide, I think I would really like your experience of how we can deal with these disparities in diagnosis and care of patients of diverse backgrounds. And while you don't see patients with inflammatory bowel disease all the time, but maybe we can start with you, and you can help teach us how we should be dealing with these things.

Dr. Ogbeide:

Absolutely. You know, I think many of our health systems our clinics we all make certain assumptions about our patient population, whether it's well-meaning or not well-meaning, whatever the may be, and we may not realize how much that impacts the patient's perceptions of the care that they're receiving from your health system or your clinic as a whole.

So I give one example that I'm sure many clinicians experience are patients missing your appointments. Why would someone miss an appointment? And many times we may put that on the patient, of 'they're not invested in their healthcare. I can't believe they missed an appointment. They're incredibly, you know, medically ill. You know, they still haven't gotten this lab work, they keep missing the appointments to go get this done.'

So many times we often forget weaving the healthcare system as a whole, forget that patients who fall into the complex category are patients who are marginalized or could be classified as historically excluded. All of the patient populations that were described on this webinar today would fall into this category. And so I think if, as healthcare systems, if we can take a step back to understand that, the way we might design the healthcare systems in terms of how to access care that the way they're designed could actually be set up as a barrier to some of our patient populations. It's not easy to call to make an appointment to clinics. If you've never done that, or it's been a while since you've called a clinic in your own health system, if you're a clinician I would encourage you to call the call center and try and get an appointment to see how long you're on hold, or how long until you're disconnected or you're scheduled for an appointment, but it's scheduled with the wrong provider who happens to be out of town so that appointment's cancelled and not scheduled again. So sometimes the systemic barriers and organizational issues can actually be barriers to our patients accessing care.

And so, I would say that taking that step back to see what biases are we bringing in on the table as healthcare organizations that could be impacting how patients receive care, get access to care, or just try their best to get access to care, but they keep hitting roadblock after roadblock after roadblock. And so again, I would encourage us as healthcare providers end these systems to really encourage us to go back to our systems and see what can we do to decrease some of those barriers so people can access care a lot easier.

Dr. Caldera:

And those are so many great points on so many ways. I can tell you, as someone who has tried to get appointments for some of my family, those are great points, that they're not easy. And I think for any of the providers on the call who teach residents, fellow medical students, APP, and nurse practitioners, I think it's our responsibility that before we see one of these patients and they get kind of labeled noncompliant, or they're not interested in treatment, I think you brought great points. Dr. Ogbeide, we need to know where their journey and why they're facing barriers rather than saying they don't want to be treated. So thank you for that.

Dr. Bhat, could you share your experience about this?

Dr. Bhat:

Yeah, so I actually would say that Dr. Ogbeide did a great job in kind of explaining I think the common scenarios that we typically tend to see. From a medication perspective, I commonly hear lots of common terms. I commonly hear terms like nonadherence, frequent flyer, poor compliance. And so even in this context, it's kind of again, putting into perspective, what are these factors that are leading us to

potentially medicate a patient this way.

I think the other thing also that's uh, interesting to potentially note is that sometimes we consider patients to not be a good historian. And so, I think kind of going back to Dr. Ogbeide's point, that there is something called implicit bias. And I think that this is something that as clinicians, we can work on that rather than jumping to the assumption that, 'oh, kind of, again, they missed their appointment just because they don't prioritize their medical health, they they're not taking their medications because they don't prioritize the effect that the medication is going to have.' And I think just putting it into context, and really taking a step back, looking at the patient, as a whole, but also looking at the individual pieces, and really showing that you understand what's happening in the patient's shoes before you're making any assumptions.

And I think that's really going to go a long way. Because once you put in the time and the effort to really understand the patient's life, their story it makes it a lot more - a little bit easier, if you will, to kind of see what you can do to help them and make sure that you meet them halfway in getting them to feeling better.

Dr. Caldera:

Thank you. Thank you.

And Dr. Malter, I'd be interested in your experience, because it sounds like your = your clinic is almost like a small UN at times, and must be a very interesting place to work at where you see people from all over the world.

Dr. Malter:

Yeah, it definitely does feel like that. You know, the one patient comes in and they're struggling with maintaining their shelter bed because they're using the bathroom so much. And the next patient comes in and doesn't, you know - doesn't speak English as a first language and has just moved to the country and is struggling to find work and is sick and manage their children. And you know, the next patient can be somebody who was recently incarcerated and struggling to find their way and understand living in the world with a chronic illness with their newfound freedom.

So I definitely - it's each patient, again, is unique in that personalized approach, but I think that there's oftentimes just concern or a bias that the patients come with having seen oftentimes other clinicians whether it's in the gastroenterology field or not that have kind of minimized - I mean, I think that they're, you know, again, since we have no gold standard test and IBD can look like a lot of different things oftentimes, there can just be a lot of lack of commitment to the diagnosis before they get to an IBD clinician. And I think we're all aware of the changing demographic that we mentioned in that first webinar, and that this really is a disease that can affect everybody. And while historically, we haven't had data to determine the best way to treat everybody, we need to have a much more open approach because anybody can have this condition. Um, and many, many manuscripts about IBD, talk about the affluent patient population from more temperate climates. And when you take a deep dive into our studies to look at who's represented, when we assess treatments, that is a patient population that we're mostly working off of. And so there are just a lot of gaps currently. And thinking about those gaps, having an awareness of those gaps and understanding or working towards narrowing those gaps, so that we can have a more comprehensive model for managing our patient population, which looks very diverse and has very disparate needs, depending on the practice environment and the demographics of the patient population that is in your clinic.

Dr. Caldera:

No, and thank you for that answer. And I think all those are great points. Because what it really comes down to is making sure that we're finding the barriers so that we can successfully treat our patients, which I find that can be one of the big things that I talk with the fellows were, you know, anyone can come up with a great plan, but we really need to make sure the patient's okay with that plan. And I'd be interested in how you approach shared decision-making, Dr. Malter, to make sure that the plan that you recommend you get buy-in from your patients, because some of our medicines can sound very scary. And I've had some patients say, 'why can't I just say on prednisone? You know, it makes me feel real good'

Dr. Malter:

Yeah, so I love to practice shared decision-making. I attempt to do it with all of my patients. I definitely try and assess where they're coming from and how comfortable they are weighing in on the decisions, understanding that I don't intend to kind of give them a plan and say that you must stick with this, but rather, trying to educate them and try and get their buy-in. I really like the ask-tell-ask method of

communication, to kind of figure out where they're at, provide them some information, and get a sense on how much they can kind of almost regurgitate back to me to understand what their knowledge base is, as well as understand the level of engagement that they have. And sometimes you may mistake their level of engagement. So you may think that they're not engaged, but it's because there's underlying psychosocial issues at play, or the visit is taking a long time, because as we all know, the conversations about IBD management are really at times unwieldy especially with all of these additional factors at play beyond just disease management. And so, trying to get a sense of where they're at.

And I think time is probably the biggest limitation which nobody has mentioned yet tonight. But I think it is important to kind of identify that elephant in the room and address the fact that sometimes it takes a number of visits to really spend the time to get at what is impacting the patient's participation in their care and understand what their goals are. And we as clinicians don't always have that luxury because of the way medicine is structured right now.

And so, taking time to assess where they're at and knowing that sometimes you don't have to make the decision on that first visit or a second visit. And so sometimes more visits in order to get to that shared decision-making and making sure your patient is truly on board and having the opportunity to voice any concerns or questions that they may have in a non-pressured way.

Dr. Caldera:

And that's great. And it sounds like we practice in similar manners. That's funny, I usually tell the fellows when someone comes in and is acutely diagnosed, and there say, and I tell them, 'you got to show him you care.' So regretfully, I end up overbooking my clinic a lot because it can be a lot that first visit. So I usually say, 'well, why don't we have you just come back, and let's talk some more,' and that helps. Dr. Bhat, tell us how you deal with shared decision-making?

Dr. Bhat:

Yeah, so I'll say that one of the advantages that I typically have when I see patients is that the plan has usually been outlined by a gastroenterologist prior to them coming to see me. So they know that a medication is likely in their future. And if they have the luxury of deciding which treatment to be on, then I'm happy to have that discussion about the potential options. Otherwise, I get to provide targeted education.

And so, because my discipline is a little bit much more structured, I'm focused primarily on medication, I actually will start my visit off with what questions or concerns do you have that you want to make sure we definitely address today. And then I will basically outline my approach for the visit. So that basically will include a med reconciliation, followed by a review of some health maintenance, followed by review of symptoms disease assessment, and then I actually will tackle the medication component. And it's really important to me to include the logistics of what that looks like and how it's going to impact their day-to-day living, and what exactly does that mean on their end when time to go forward and in terms of integrating this medication into their life.

So I have the ability to really make sure that I'm outlining what the future is going to look like for a patient going forward. And in the process, make sure that I get to know the patient and understand what their typical life is going to look like, and what concerns or hesitations they might have. But having the opportunity to ask that up front really goes a long way. Because if there's anything really bothering them or if there's anything that's a major concern, I will hopefully hear about it right off the bat. And I think engaging them, having a conversation, not just being a didactic lecture about the medication, but kind of assessing what's your work schedule like any hesitations about potentially storing this medicine? So kind of just uh, asking questions relating to how the medication component ties in with their lifestyle, and then hopefully finding out more as we converse through the visit that will allow me to effectively deliver care in a patient-centered manner that's going to be most effective and useful for them.

Dr. Caldera:

And thank you. And thank you for that.

And, Dr. Ogbeide, can you tell us is there anything else as gastroenterology providers that we should be doing to make sure that we're getting a patient's input so we are doing this shared approach?

Dr. Ogbeide:

Absolutely, I think what doctors Bhat and Malter shared, are spot on with the main components of shared decision-making which it

comes down to making sure the patient's an active participant in the discussion in their health care exploring their options, getting their preferences and values. So everything that was shared I would really encourage clinicians to use that same approach. No matter what shared decision-making approach you use, they all really have those core components of the patient and family being an active participant, exploring options that are consistent with the patient's culture and values and their preferences.

So I think the take-home message is no matter what model of shared decision-making that you use please use shared decision-making so you can really get your patients voice in the design of their care plan.

Dr. Caldera:

Thank you. Thank you. And that's going to kind of wrap us up for today. But I can't begin to thank you, Dr. Ogbeide, Dr. Bhat, and Dr. Malter, for joining us today on this webinar to discuss how we can manage patients with IBD from diverse patient populations who, you know, we need to know that these barriers exist. But you've given us some great tips of how we can overcome these challenges, how we can help patients because that's what we're here for, and making sure the future of the field knows and moves this topic forward. So you provided some great insight, and I would encourage everyone to listen to Dr. Malter's previous webinar, titled Through the Looking Glass: Managing IBD Care for Diverse Patient Populations. You can find the link in the description area of this webinar. And thank you all for your time. And thank you all for being here today.

Announcer:

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