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Counseling Strategies for Rheumatology Infusion Therapy

Announcer:

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This episode of Living Rheum, titled "Counseling Strategies for Rheumatology Infusion Therapy," is sponsored by Novartis US Clinical Development and Medical Affairs. The host and speakers have been compensated for their time. This program is intended for health care professionals.

Here's your host, Dr Jason Liebowitz.

Dr Liebowitz:

The process of providing infusion medication therapies to patients with rheumatologic disease can be complex and challenging. How should clinicians counsel patients to optimize care?

This is ReachMD, and I'm Dr Jason Liebowitz. Joining me to share counseling strategies to improve patient care are Dr Jonathan Greer and Mrs Karen McKerihan. Dr Greer is a rheumatologist with the Arthritis and Rheumatology Associates of Palm Beach. He's also an assistant clinical professor of medicine at both Nova Southeastern University and the University of Miami. Mrs Karen McKerihan is a family nurse practitioner in rheumatology and is also the infusion director with Articularis Healthcare in South Carolina. Dr Greer and Mrs McKerihan, thanks for being here today.

Dr Greer:

It's a pleasure to be with you.

Mrs McKerihan:

Thank you for having me.

Dr Liebowitz:

So, Dr Greer, to start us off, how should we approach counseling patients starting an infusion medication therapy?

Dr Greer:

This is probably the most important part of our discussion tonight. So, the discussion should start as soon as possible with the patient and their family, and that should be considered from the moment you think the patient may need to be on infusion medication or some other type of biologic treatment. If the patient needs an infusion or self-injectable therapy, think about it early on and then prepare the patients to expect they may need more aggressive treatment than simple medications we use every day. We will have to screen patients, for example, for tuberculosis and hepatitis B and C, to make sure they're appropriate candidates for the medication we may have in mind.

We also have to consider the logistics of therapy. That includes where the patient wishes to receive the medication. Do they want to inject it themselves? Do they want to receive an infusion in the office from us? Or do they want it from a separate center entirely? We have to consider the costs, both in terms of how much money it may cost the patient—or the practice, for that matter—and the time involved in getting the product to patient. And that time includes prior authorizations and dealing with insurance companies, which does take quite a bit of time in some cases. And then we should set expectations for the experience at the infusion center vs home infusion.

Oftentimes I will walk my patient down to the infusion center in our practice to show them what it's like to receive an infusion in the practice vs a self-injectable. And then, we want to set expectations regarding the outcomes of care and any follow-up issues that the patient may have.

Dr Liebowitz:

Wonderful. And Mrs McKerihan, who should be included in these discussions?

Mrs McKerihan:

Well certainly the patient and then the patient's family members, especially a spouse or a caregiver or a friend if they're going to be involved in getting the patient to infusion or helping with administration. So, it's definitely important to involve the patient and their circle that they choose to have around them. And then, of course, the physician, or the advanced practice provider, or the physician's assistant, or whoever else may be involved with the patient from the time they're discussing these options in the clinic to the time they get to infusion. Then, of course, the infusion nurse. You have to communicate with your nursing staff what is going to be prescribed, if there's any special considerations such as premedications.

And then it's also very advantageous to include the front office staff, or any medical assistants. Medical assistants often will field questions from the patients. And then the front office staff has to know what to expect and what the patient's going to expect. How often are the infusions, where might the patient have questions in terms of where to come, or how to get hold of the infusion staff if there were ever a time when they needed to postpone their infusion. So, it's important to involve all of the people who are from the beginning of the time the patient is seen in the exam room to the time the patient is infused.

Dr Liebowitz:

Excellent discussion. So, Dr Greer, when a patient is on infusion therapy, what are some challenges they may face and how should we approach addressing these challenges?

Dr Greer:

Well, as I mentioned previously, many patients are not able to envision this therapy in the first place and what an infusion would entail. So, I walk them down before they even receive an infusion to the infusion center, introduce them to my infusion nurses. And let's face it, the infusion nurses are going to answer the majority of the questions the patients may have once they're in that infusion chair. So, I ask the infusion nurses to describe a day in the life of a patient who is considering infusion therapy, and how they might receive that drug. So we prepare the patient on the need to reschedule as well. Sometimes there are circumstances where the patient cannot make it, or we have a problem on our end where we have to cancel patients or cancel days and have to reschedule.

We have to keep in mind that patients may have comorbidities, other disease states that could interact with the medicines we give, and patients need to be aware of that. Oftentimes, patients receive a premedication and my nursing staff, again, has to prepare the patient to realize they're going to get premedicine to prevent any adverse reactions during the infusion and to prepare the patient to know what they may experience if they have an infusion reaction.

Patients may not be aware that there are obstacles that could prevent timely delivery of infusion medications, such as the cost, or scheduling, or weather-related facility closures, staffing issues, infections, and allergic reactions, etc. Patients may also not be aware of common side effects and the need for follow-up care associated with infusion therapy, so they should be discussed in detail. And our patients are observed for a period of time after the infusion is completed to make sure they're not experiencing any delayed reaction, and also to answer any questions they may have. This is all communicated as a care plan by the infusion staff to the patient, and everyone has a checklist, so-called, to make sure we've gone through every part of this patient's infusion experience and do it the right way.

Dr Liebowitz:

Thank you, that's a very comprehensive summary. And Mrs McKerihan, what are some best practices that can be used to ensure optimal patient outcomes?

Mrs McKerihan:

Well, you definitely need to have clear protocols that spell out the various aspects of infusion care, and that includes routine assessment of the patient, vital signs, how often you assess the IV site, whether you're going to observe them after their administration. Also routinely assessing the competence of your clinical personnel, making sure that you are assessing them on a regular basis for the various skills that are needed in mixing and caring for these patients. Ensuring that laboratory results are up to date before any infusions

so that there's no delay when the patient comes in for infusion. Sometimes there's confusion about whether needed lab work is back in time for the patient to be safely infused, so it's best to determine that before the patient comes for their infusion.

Maintaining reasonable clinician-to-patient ratios, making sure that you're not overstaffing or understaffing your infusion area, that you're not running routinely behind, so adjusting the schedule for infusions sometimes is important, so that the patients do not have to wait too long to be seen. Monitoring vital signs, like I said earlier, before, during, and after infusion. And then, of course, informed consent is key, making sure that the patient understands what they're getting, that they have been given the opportunity to ask questions, and that you have this documented in the patient's chart that they have consented to the medication.

And then, having clear protocols in place, and materials that help the nurses deal with any infusion reactions. Do you have a protocol in place that allows the nurse to give any additional medications to address any side effects that the patient may be experiencing? I always, after we have a bad infusion reaction, we do debrief with my staff. I feel it's very important to talk about what happened, what did we do well, what could we have done better, and then adjusting any protocols or any communication issues that may have occurred during that episode. And then, communicating to the patients what they should expect, making sure that they know that the nurse is going to be there, that they will be getting vital signs. What should they be telling the infusion staff if they experience it?

I've had patients, at second infusion or third infusion, tell me that they've been having itching since the first infusion, but they just didn't know that they were supposed to say anything about it. And so, communicating to the patients what they should be reporting to the staff.

Dr Liebowitz:

Thank you very much. And to wrap up our discussion, Dr Greer, do you have any advice for clinicians on how to best counsel their patients?

Dr Greer:

Sure. We use several means of communication to engage our patients. It includes verbal, written, online, other printed areas, and video and audio media. I give the patients time to make the decision, so when I first see a patient and we decide on a parenteral therapy, including infusion therapy, we talk about the medications that I think are best for them. I give them printed information on that medication. We also give them a website to go on and give them time to work with their loved ones, their family members, their friends, talk it over with their other doctors, and then come back to discuss this.

We use a multidisciplinary approach with respect to communication, and I actually like to have the patient's family members—their spouse, for example—in the room, or if that's not possible, have them on the phone listening in. I don't have anything to hide, and I think we should be very clear about what the patient's expectations should be and what the family member's expectations should be. We also engage the other physicians who may be involved in patients' care: Their primary care doctors, any nurse practitioners, of course infusion nurses, and physician assistants.

The front office staff and the administrative staff is crucial, also, in helping us access medications, and we haven't really talked about that tonight, but getting good office staff to help you with the prior authorizations is crucial to streamlining the process where the patient can get their medication in a timely manner.

Having experienced infusion nurses goes without saying. It is crucial to have experienced infusion nurses who can mentor younger nurses. They are the lifeblood of the infusion center. They can put patients' minds at ease, and can handle emergencies, if necessary, with ease.

Therefore, hiring wisely for these thoughtful and attentive personnel is crucial. Also, if there are any failures of communication, with patients in particular, they should be reviewed with the staff as well as the providers, and see if there's any lessons we can learn to adjust our communication skills.

Dr Liebowitz:

Thank you for those final thoughts, and as we come to a close, I want to thank our guests for helping us better understand counseling strategies for patients receiving infusion medication with rheumatologic diseases. Dr Greer and Mrs McKerihan, it was a great pleasure speaking with you both today.

Dr Greer:

Thank you for having me on.

Mrs McKerihan:

Thank you for having me on as well.

Announcer:

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