

Editorial

Back to Basics: Prioritizing Communication as a Key Instrument in Managing Rheumatoid Arthritis



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Patients with rheumatoid arthritis (RA) have come to experience a tremendous increase in therapeutic options with disease-modifying antirheumatic drugs (DMARDs).¹ After decades of dissatisfying drug therapy results with conventional synthetic DMARDs (csDMARDs) only, the introduction of the first tumor necrosis factor inhibitors in the late 1990s has revolutionized RA treatment.² Over the last 3 decades, different biologic DMARDs (bDMARDs) and targeted synthetic DMARDs (tsDMARDs) have been administered, targeting different disease mechanisms and showing efficacy after failure of csDMARDs. These manifold opportunities were then required to be framed in a structured management plan such as the treat-to-target (T2T) recommendations in 2010.³ Treatment of RA was established, with suggestions of adequate holistic measurement of disease activity.^{4,5} The inclusion of the patient perspective was integrated by using patient-reported outcome measures (PROMs) as part of the assessments.^{6,7,8} With improved therapeutic options, treatment goals have changed. The patient–healthcare professional (HCP) team strives for achieving and maintaining clinical remission, which has become a realistic goal for many patients with RA.^{9,10} However, pharmacological treatment alone will not be sufficient to address all the layers affected by RA and to improve disease activity and RA-related health issues. Even in recent randomized controlled phase III trials of novel tsDMARDs, Boolean or Simplified Disease Activity Index

remission rates are approximately 20% after 6 months.^{11,12,13} The majority of these trial patients can be classified as being in a state of low disease activity (LDA), demonstrating the efficacy of therapy but underlining the theory that we need to go beyond DMARD therapy when treating patients with RA. For example, lifestyle interventions such as weight loss or exercise can reduce disease activity.^{14,15} Apart from clinical trial data, an increase in remission rates and fewer episodes of flares over the past 20 years may also be observed in clinical practice.¹⁶ All this highlights the need for more effective ways to achieve clinical remission, as the current armamentarium of DMARD treatment options is not sufficient.

Shared decision making is one of the overarching principles in both T2T and management recommendations.^{3,9} Building a trusting relationship that puts the patient in the driver's seat along with their HCP as they steer toward their set goals with full confidence would be the ideal situation. Enabling this optimal environment is unquestionably harder than simply assessing joint counts and writing prescriptions. Therefore, an Outcomes Measures in Rheumatology (OMERACT) subgroup outlined a core domain set that aims to better explain and define the process of shared decision making and facilitates the process of implementing it in daily routine.^{17,18} To enable shared decision making, patients need to be educated and informed about their disease and the possible treatment options, including potential side effects. This enhances confidence in the choice of management strategies and promotes adherence to therapy, thereby facilitating better outcomes and attaining remission instead of LDA. Patient beliefs about health, disease, and therapy influence behavior, confidence, adherence, and in the end, outcomes.^{19,20,21,22}

Aware of this complex situation, Kahler et al, in this issue of *The Journal of Rheumatology*, reported on the development of a goal elicitation tool to foster communication between HCPs and patients and to help to overcome discrepancies in attitudes and priorities within the patient–HCP team.²³ This project produced an applicable communication tool within realistic scenarios that included different stakeholders involved in the care of patients with RA.²⁴ In particular, the stakeholders are of

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utmost importance to withstand any implementation problems and to gain high acceptance within the whole healthcare team. Besides patient factors, time constraints in clinical practice also limit the implementation of the perfect shared decision-making scenario. Many easy-to-follow steps could improve satisfaction, confidence, education, and adherence to a set treatment plan, but this is often hindered by ineffective communication between patients and HCPs. The derived tool of Kahler et al should come into effect precisely at this point to facilitate communication and expression of goals in order to accomplish the best possible experience for patients and HCPs. The output of this iteratively and dynamically derived communication tool is a set of relatively simple, self-explanatory questions or points for reflection presented on a single page that patients complete before meeting with their rheumatologist. Out of 7 themes (pain, work, daily activities, side effects, sleep, tiredness, and mood) and a free-text section, patients may choose the top 3 priorities they deem to be relevant for the particular visit. The placement of the goals in a circular design is complemented by open questions that should help patients reflect and start the conversation with the clinician. It is an aid to facilitate the patient in being an active participant in the consultation, rather than passively answering the physician's questions. This one-pager is still in need of testing in different clinical practice settings and may also be potentially worth implementing online. An online tool with the option for completing the questions using voice recognition for patients with disabilities who are limited by the paper-and-pencil format would be beneficial. Further, an online version would enable patients to navigate back in their history to see how well they managed previously reported priorities in the time between the clinical meetings. This tool by Kahler et al might indeed enhance better communication and improve shared decision making in a clinical practice setting. The goal elicitation tool will not replace the assessment of the components of disease activity and impact, including those domains covered in PROMs that are important for the majority of patients.²⁵ Conversely, using a variety of PROMs alone will not replace the conversation between 2 equal partners (patient–physician), but should instead complement clinical evaluations, and instrument-based assessments after they have completed their PROM questionnaires. Scores derived from PROMs should inform the clinician and stimulate discussion, particularly in areas that are contradictory to the clinical assessment. This type of communication would help in building trust to enable collaboration in managing a chronic condition.^{26,27}

In our daily routines, we as HCPs must be mindful of the different perspectives, abilities, and cultural and socioeconomic backgrounds of our patients, in order to form a strong partnership from the time of diagnosis onward.²⁸ Even though it would seem obvious to do so, it is the duty of HCPs to invite patients to be an active partner and to facilitate self-management of RA. The European Alliance of Associations for Rheumatology (EULAR) recommendations for the implementation of self-management strategies provide an overview of what HCPs, together with patients, could address beyond pharmacological therapy.²⁹ A considerable proportion of patients with RA would benefit

from escalating DMARD therapy as they remain in moderate disease activity, despite the availability of treatment alternatives.³⁰ A common reason for this is patient preference: most patients would of course rather have their RA disease activity better controlled but do have concerns in changing the strategy. Intensified communication and consequent shared decision making would help to overcome these problems most of the time.³¹

Around 3 decades past the introduction of bDMARDs, the rheumatologic community has proposed concepts of patient empowerment and self-management alongside or integrated in patient-centered care.^{16,28,32,33} Active and effective implementation of these concepts in daily routine care is already overdue and remains one of the greatest challenges. The goal elicitation tool by Kahler et al²³ is a step toward better patient–HCP communication, which is at the epicenter of shared decision making and, therefore, of the effective management of patients with RA.

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