
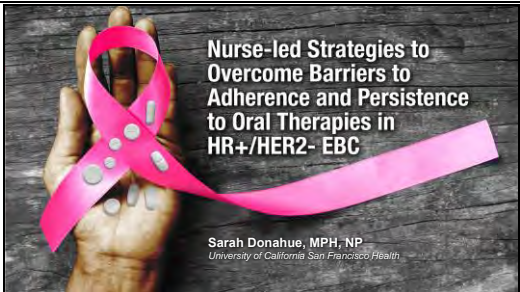
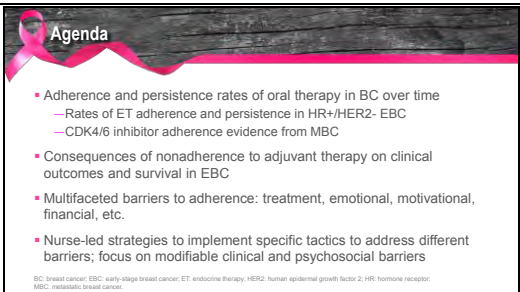


Optimizing Oral Therapy in HR+/HER2- Early Breast Cancer: Nurse-led Strategies to Improve Adherence and Persistence

Nurse-led Strategies to Overcome Barriers to Adherence and Persistence to Oral Therapies in HR+/HER2- EBC

1	 <p>Optimizing Oral Therapy in HR+/HER2- Early Breast Cancer: Nurse-led Strategies to Improve Adherence and Persistence</p>	<p>Hi, I'm Sarah Donahue. I'm a nurse practitioner at the University of California-San Francisco, in San Francisco. Today I'm going to be talking to you about nurse-led strategies to overcome barriers to adherence and persistence to oral therapies in hormone-positive/HER2-negative early-stage breast cancer.</p>
2	 <p>Nurse-led Strategies to Overcome Barriers to Adherence and Persistence to Oral Therapies in HR+/HER2- EBC</p> <p>Sarah Donahue, MPH, NP University of California San Francisco Health</p>	
3	 <p>Agenda</p> <ul style="list-style-type: none"> Adherence and persistence rates of oral therapy in BC over time <ul style="list-style-type: none"> Rates of ET adherence and persistence in HR+/HER2- EBC CDK4/6 inhibitor adherence evidence from MBC Consequences of nonadherence to adjuvant therapy on clinical outcomes and survival in EBC Multifaceted barriers to adherence: treatment, emotional, motivational, financial, etc. Nurse-led strategies to implement specific tactics to address different barriers; focus on modifiable clinical and psychosocial barriers <p><small>BC: breast cancer; EBC: early-stage breast cancer; ET: endocrine therapy; HER2: human epidermal growth factor 2; HR: hormone receptor; MBC: metastatic breast cancer.</small></p>	<p>Today, we'll discuss adherence and persistence rates of oral therapy in breast cancer over time: rates of endocrine therapy adherence and persistence and CDK4/6 inhibitor adherence evidence from previous metastatic breast cancer trials.</p> <p>We'll discuss the consequences of nonadherence to adjuvant therapy on clinical outcomes and survival in early-stage breast cancer.</p> <p>We'll discuss multifaceted barriers to adherence, such as treatment, emotional, motivational, and financial aspects.</p> <p>And we'll discuss nurse-led strategies to implement specific tactics to address different barriers, focusing on modifiable clinical and psychosocial barriers.</p>

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<p>4</p>	<p>Adherence to Adjuvant Therapy in EBC</p> <ul style="list-style-type: none"> 23%-28% of patients prematurely discontinue hormone therapy (tamoxifen or AI)¹ Limited data on adherence to CDK4/6 inhibitors in EBC due to their novelty in this setting Assessments of CDK4/6 inhibitor use in MBC have identified adherence and persistence issues^{2,3} <p><small>AI: aromatase inhibitor; 1. Chibrovski ET, Cellular M., Oncology. 2008;71:1-6. 2. Conley CC, et al. Breast Cancer Res Treat. 2022;192:385-390. 3. Stephenson JJ, et al. Patient Prefer Adherence. 2021;15:e2017-2020.</small></p>	<p>Adherence to adjuvant therapy in early-stage breast cancer: We know that 23% to 28% of patients prematurely discontinue hormone therapy, whether it be tamoxifen or an aromatase inhibitor. It's quite a lot.</p> <p>There are limited data on adherence for the CDK4/6 inhibitors in early-stage breast cancer because it is new. However, we do have some evidence from the metastatic breast cancer setting that we will discuss.</p>
<p>5</p>	<p>Consequences of Nonadherence on Clinical Outcomes</p> <ul style="list-style-type: none"> Achieving optimal success requires years of treatment (2 years with CDK4/6 inhibition, 5-10 years with ET) The extended-time course of adjuvant oral therapy provides many opportunities for nonadherence to arise <p><small>Harbeck N, et al. Ann Oncol. 2021;32:1571-1581. Reproduced for educational purposes only.</small></p>	<p>What are the consequences of nonadherence on clinical outcomes?</p> <p>We know that with endocrine therapy, it reduces the risk of recurrence by 40% to 60%. So if patients aren't taking that medication, that reduction in risk is lost.</p> <p>With the CDK4/6 inhibitors, we know that if patients don't take it for the 2 years that were found to be beneficial in the trials, they don't get that benefit.</p> <p>So it is important, really important to address nonadherence and to help patients stay on therapy.</p>
<p>6</p>	<p>Role and Impact of the Nurse in Promoting Treatment Adherence</p> <ul style="list-style-type: none"> The role of the oncology nurse has evolved to address barriers to patient treatment adherence to long-term therapy Many barriers to adherence and persistence in HR+/HER2-EBC can be overcome via nurse-led efforts to: <ul style="list-style-type: none"> Identify potential barriers to adherence Improve AE management Deliver appropriate patient education and counseling Coordinate multidisciplinary care <p><small>AE: adverse event.</small></p>	<p>What is the role of the oncology nurse?</p> <p>It has evolved to address barriers to patient treatment and adherence to long-term therapy. Many barriers to adherence and persistence in hormone-positive/HER2-negative breast cancer can be overcome by our strategies:</p> <p>We can identify potential barriers to adherence. We can improve adverse event management. We can deliver appropriate patient education and counseling. And we can coordinate multidisciplinary care.</p>

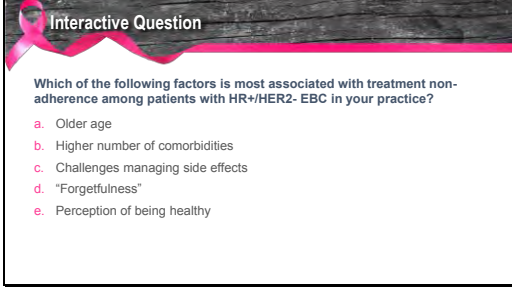
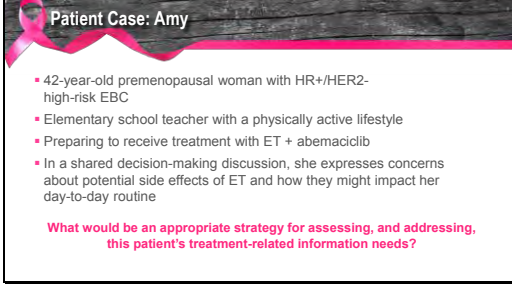
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<p>7</p>		<p>So nurse-led interventions on early-stage breast cancer adverse event management are positively received by patients. They like it. They feel more engaged and empowered in their care and their treatment decisions.</p> <p>And 1 in 3 patients have thought about stopping treatment over a 3-month period, pointing to an opportunity for nurses to address potential issues.</p>																																																											
<p>8</p>	<table border="1"> <thead> <tr> <th>Factors</th> <th>North America/European Union</th> <th>No.</th> <th>Discontinuation Rate at 6 Months, % (95% CI)</th> <th>p-value (Multivariable Model)</th> </tr> </thead> <tbody> <tr> <td rowspan="3">Geographic region</td> <td>Asia</td> <td>1,458</td> <td>16.6 (14.7-18.5)</td> <td rowspan="3">< .0001</td> </tr> <tr> <td>Other</td> <td>573</td> <td>10.3 (8.0-13.0)</td> </tr> <tr> <td>Other</td> <td>760</td> <td>12.1 (9.8-14.5)</td> </tr> <tr> <td rowspan="2">Menopausal status</td> <td>Premenopausal</td> <td>1,217</td> <td>9.3 (7.6-11.0)</td> <td rowspan="2">< .0001</td> </tr> <tr> <td>Postmenopausal</td> <td>3,874</td> <td>17.2 (15.8-18.6)</td> </tr> <tr> <td rowspan="2">Age group</td> <td><65 years</td> <td>2,361</td> <td>11.6 (10.3-12.9)</td> <td rowspan="2">< .0001</td> </tr> <tr> <td>≥65 years</td> <td>438</td> <td>27.6 (23.4-31.9)</td> </tr> <tr> <td>Baseline ECOG PS</td> <td>0</td> <td>2,392</td> <td>13.7 (12.4-15.2)</td> <td>.022</td> </tr> <tr> <td rowspan="3">No. of positive nodes</td> <td>1</td> <td>399</td> <td>16.8 (12.4-19.8)</td> <td rowspan="3">< .0001</td> </tr> <tr> <td>2-3</td> <td>1,115</td> <td>16.1 (14.0-18.3)</td> </tr> <tr> <td>4-9</td> <td>1,096</td> <td>13.2 (11.3-15.3)</td> </tr> <tr> <td rowspan="3">No. of unique preexisting comorbidities</td> <td>0</td> <td>466</td> <td>9.7 (7.2-12.6)</td> <td rowspan="3">.0007</td> </tr> <tr> <td>1-3</td> <td>1,370</td> <td>12.8 (11.1-14.8)</td> </tr> <tr> <td>≥4</td> <td>588</td> <td>18.8 (15.8-22.5)</td> </tr> </tbody> </table>	Factors	North America/European Union	No.	Discontinuation Rate at 6 Months, % (95% CI)	p-value (Multivariable Model)	Geographic region	Asia	1,458	16.6 (14.7-18.5)	< .0001	Other	573	10.3 (8.0-13.0)	Other	760	12.1 (9.8-14.5)	Menopausal status	Premenopausal	1,217	9.3 (7.6-11.0)	< .0001	Postmenopausal	3,874	17.2 (15.8-18.6)	Age group	<65 years	2,361	11.6 (10.3-12.9)	< .0001	≥65 years	438	27.6 (23.4-31.9)	Baseline ECOG PS	0	2,392	13.7 (12.4-15.2)	.022	No. of positive nodes	1	399	16.8 (12.4-19.8)	< .0001	2-3	1,115	16.1 (14.0-18.3)	4-9	1,096	13.2 (11.3-15.3)	No. of unique preexisting comorbidities	0	466	9.7 (7.2-12.6)	.0007	1-3	1,370	12.8 (11.1-14.8)	≥4	588	18.8 (15.8-22.5)	<p>So we know from the MONARCH-E trial, this early-stage breast cancer trial, that there were some factors associated with early discontinuation of the abemaciclib. I'm not sure how reliable this information is, but it did show that patients in certain regions were more likely to discontinue; that postmenopausal women were more likely to discontinue—which I'm not sure why that would be—older patients, along with that postmenopausal group would be more likely to discontinue; patients with fewer positive nodes would be more likely to discontinue; and patients with more comorbidities.</p> <p>It is something to consider, but it may not be something that is applicable or useful in the clinical setting with your individual patients. I think just addressing exactly what they are worried about and what they're experiencing is most important.</p>
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<p>9</p>		<p>Here is a long list of why a patient may not be adhering to their medication.</p> <p>I've had patients with memory issues or forgetfulness. Abemaciclib in particular is taken twice a day, and they also have to take this hormone therapy once a day, so it's easy to forget.</p> <p>Patients that don't understand why they're taking the medication or aren't</p>																																																											

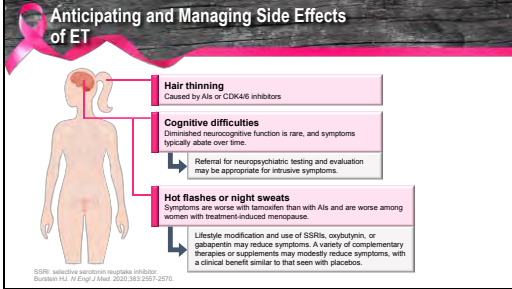
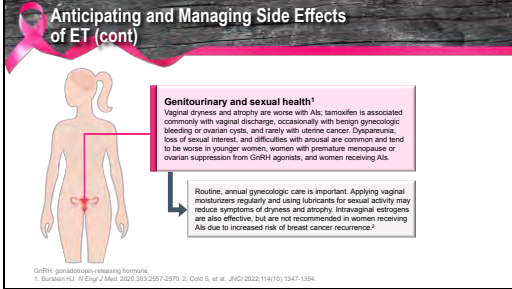
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		<p>fully on board with the idea that they have this risk that they could be reducing with taking the medication, which is a major issue, and I do a lot of education in the clinic to explain to them why we recommended the medication to them.</p> <p>Patients taking a lot of medications may be more likely to not take it.</p> <p>I'm not going to go through each one of these, but there's definitely a lot of reasons for each individual patient where they may find it difficult to take their medication every day. And really helping them to overcome those obstacles is really important.</p>
10	 <p>Interactive Question</p> <p>Which of the following factors is most associated with treatment non-adherence among patients with HR+/HER2- EBC in your practice?</p> <ul style="list-style-type: none"> a. Older age b. Higher number of comorbidities c. Challenges managing side effects d. "Forgetfulness" e. Perception of being healthy 	<p>Which of the following factors is most associated with treatment nonadherence among patients with hormone receptor-positive/HER2-negative early-stage breast cancer in your practice?</p> <ul style="list-style-type: none"> a) Older age b) Higher number of comorbidities c) Challenges managing side effects d) "Forgetfulness" e) Perception of being healthy
11	 <p>Patient Case: Amy</p> <ul style="list-style-type: none"> ▪ 42-year-old premenopausal woman with HR+/HER2-high-risk EBC ▪ Elementary school teacher with a physically active lifestyle ▪ Preparing to receive treatment with ET + abemaciclib ▪ In a shared decision-making discussion, she expresses concerns about potential side effects of ET and how they might impact her day-to-day routine <p>What would be an appropriate strategy for assessing, and addressing, this patient's treatment-related information needs?</p>	<p>So I'm going to discuss a case. Amy is a 42-year-old premenopausal woman with hormone-positive/HER2-negative high-risk early-stage breast cancer.</p> <p>She's an elementary school teacher and she has a very physically active lifestyle. She's preparing to receive treatment with endocrine therapy and abemaciclib. And in shared decision-making discussions, she expresses concerns about potential side effects of endocrine therapy and how that might impact her day-to-day routine.</p> <p>So just talking about endocrine therapy to begin, what would be the appropriate</p>

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		<p>strategy for assessing and addressing this patient's treatment-related information needs?</p>
<p>12</p>	 <p>Anticipating and Managing Side Effects of ET</p> <p>Hair thinning Caused by AIs or CDK4/6 inhibitors</p> <p>Cognitive difficulties Diminished neurocognitive function is rare, and symptoms typically abate over time. Referral for neuropsychiatric testing and evaluation may be appropriate for intrusive symptoms.</p> <p>Hot flashes or night sweats Symptoms are worse with tamoxifen than with AIs and are worse among women with treatment-induced menopause. Lifestyle modification and use of SSRIs, oxybutynin, or gabapentin may reduce symptoms. A variety of complementary therapies or supplements may modestly reduce symptoms, with a clinical benefit similar to that seen with placebos.</p> <p><small>SSRI: selective serotonin reuptake inhibitor Bosman M, et al. <i>Engl J Med</i>. 2020;383:2507-2516</small></p>	<p>First, to discuss the side effects with her, we let her know that there can be some hair thinning because of the abemaciclib and the aromatase inhibitor that you're about to put her on.</p> <p>There could be some decreased memory, word-finding issues. You can refer her to neuropsychiatric testing. I do find that they have to have quite a bit of dysfunction to get positive testing. So I'd wait. I don't have that be a first step; only if they're having a lot of dysfunction will that testing be helpful.</p> <p>Hot flashes and night sweats can occur, for sure, with these medications—mostly with the endocrine therapy. So I talk to them about cooler rooms, lighter layers at night, using a fan. There are medications out there, like SSNIs and SSRIs, gabapentin, and oxybutynin that could help. So we discuss those. And I tell the patient, if these happen, I will have solutions for you.</p>
<p>13</p>	 <p>Anticipating and Managing Side Effects of ET (cont)</p> <p>Genitourinary and sexual health¹ Vaginal dryness and atrophy are worse with AIs; tamoxifen is associated commonly with vaginal discharge, occasionally with benign gynecologic bleeding or ovarian cysts, and rarely with uterine cancer. Dyspareunia, loss of sexual interest, and difficulties with arousal are common and tend to be worse in younger women, women with premature menopause or ovarian suppression from GnRH agonists, and women receiving AIs. Routine, annual gynecologic care is important. Applying vaginal moisturizers regularly and using lubricants for sexual activity may reduce symptoms of dryness and atrophy. Intravaginal estrogens are also effective, but are not recommended in women receiving AIs due to increased risk of breast cancer recurrence.²</p> <p><small>GnRH: gonadotropin-releasing hormone. 1. Bosman M, et al. <i>Engl J Med</i>. 2020;383:2507-2516. 2. Cull S, et al. <i>JNCI</i>. 2022;114(10):1547-1554.</small></p>	<p>We do find with the aromatase inhibitors that patients can have vaginal dryness, so I tell patients it's great to prevent it by using something every night, like coconut oil or vitamin E. I let them know that they could, over time, develop vaginal dryness and that could cause some pain with intercourse. So we discuss ways of preventing it, like with daily moisturizer.</p> <p>I always make sure that these patients, when I'm starting endocrine therapy, have a gynecologist because I find partnering with them can be really helpful in treating vaginal dryness or symptoms associated with intercourse.</p>

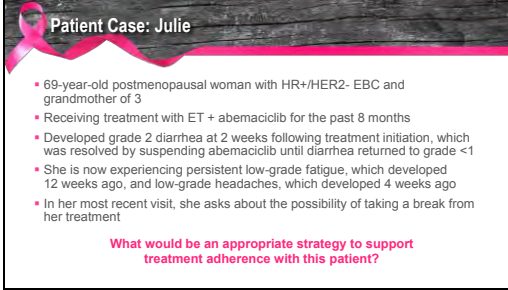
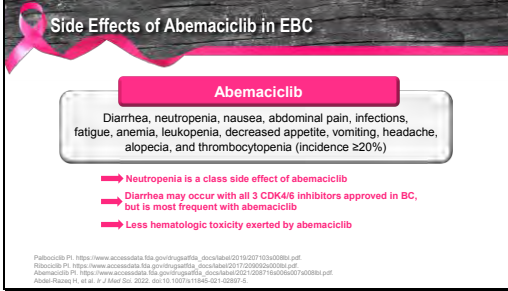
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<p>14</p>		<p>Joint aches and stiffness are super common with the aromatase inhibitors. So I do discuss having them exercise 30 minutes a day, 5 days a week, doing something with weight resistance. If they are having a lot of joint aches and stiffness and it just seems to be out of proportion to what you would expect, you could consider sending them to rheumatology for a workup. But often those patients already had joint aches and stiffness prior, so it's not a new thing that develops with the aromatase inhibitor.</p> <p>If they're having a stuck thumb, or if they have one joint that was problematic before and is really bothering them still, I can send them to ortho; they can get the joint injected. That can often alleviate the symptom permanently so that they can tolerate their aromatase inhibitors.</p> <p>Again, there's a medication, an SNRI, that you can give to patients called desvenlafaxine, which could help reduce joint aches and stiffness.</p> <p>So you let them know that you have solutions for them.</p>
<p>15</p>		<p>Bone health: Decreased bone density can occur on the hormone therapy that we give. We monitor bone density tests. We give them calcium/vitamin D. We check their vitamin D levels. Even if it's low enough, we tell them we can give them a medication like zoledronic acid; that's actually been shown to reduce the risk of breast cancer going to bones, so it's not the end of the world if they have some decreased bone density. You tell them you're going to be helping them prevent bone loss and fracture, and that it's very manageable.</p>

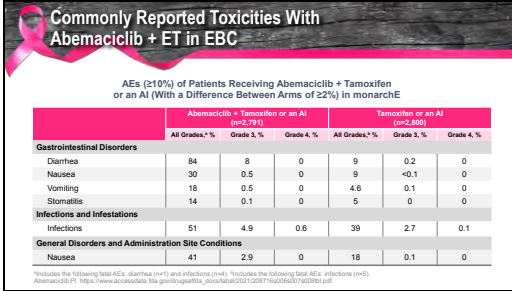
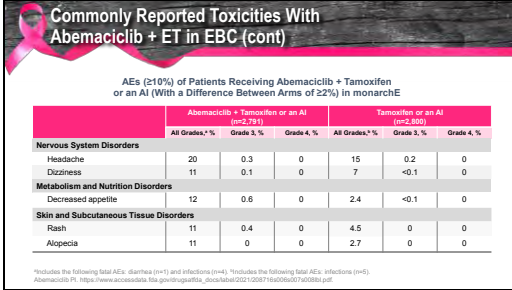
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<p>16</p>	 <p>Patient Case: Julie</p> <ul style="list-style-type: none"> 69-year-old postmenopausal woman with HR+/HER2- EBC and grandmother of 3 Receiving treatment with ET + abemaciclib for the past 8 months Developed grade 2 diarrhea at 2 weeks following treatment initiation, which was resolved by suspending abemaciclib until diarrhea returned to grade <1 She is now experiencing persistent low-grade fatigue, which developed 12 weeks ago, and low-grade headaches, which developed 4 weeks ago In her most recent visit, she asks about the possibility of taking a break from her treatment <p>What would be an appropriate strategy to support treatment adherence with this patient?</p>	<p>So we have Julie, another patient. She's a 69-year-old postmenopausal woman with hormone-positive/HER2-negative early-stage breast cancer. And she's a grandmother of 3. She's receiving treatment with endocrine therapy and abemaciclib. She's been on these therapies for 8 months so far.</p> <p>She has grade 2 diarrhea that started 2 weeks after she started. And that resolved by suspending the abemaciclib until her diarrhea returned to less than grade 1, or less than 4 stools in a day.</p> <p>She's now experiencing persistent low-grade fatigue. It developed about 12 weeks ago. Some low-grade headaches, which developed about 4 weeks ago.</p> <p>And at her most recent visit, she asked about the possibility of taking a break from her treatment.</p> <p>What would be the appropriate strategy to support treatment adherence with this patient?</p>
<p>17</p>	 <p>Side Effects of Abemaciclib in EBC</p> <p>Abemaciclib</p> <p>Diarrhea, neutropenia, nausea, abdominal pain, infections, fatigue, anemia, leukopenia, decreased appetite, vomiting, headache, alopecia, and thrombocytopenia (incidence ≥20%)</p> <ul style="list-style-type: none"> Neutropenia is a class side effect of abemaciclib Diarrhea may occur with all 3 CDK4/6 inhibitors approved in BC, but is most frequent with abemaciclib Less hematologic toxicity exerted by abemaciclib <p><small>Patb000001.P1: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/02071034/00001.pdf R0b000001.P1: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/20090200001.pdf Abemaciclib.P1: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/20090200001.pdf A0001: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/20090200001.pdf A0001: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/20090200001.pdf</small></p>	<p>The side effects of abemaciclib, we've gone over these. They're diarrhea, nausea, abdominal pain, and neutropenia. Infections can occur. Fatigue. Low red blood cells and white blood cells can occur. Headache, hair thinning. These are the more common side effects.</p> <p>I'm seeing in my patients mostly diarrhea, neutropenia, and fatigue. Just so you're aware. This is a long list and that's what I'm usually seeing.</p> <p>Neutropenia is expected with abemaciclib. We often have patients with a mild neutropenia. It's not quite like the other CDK4/6 inhibitors. But it is expected with this medication.</p>

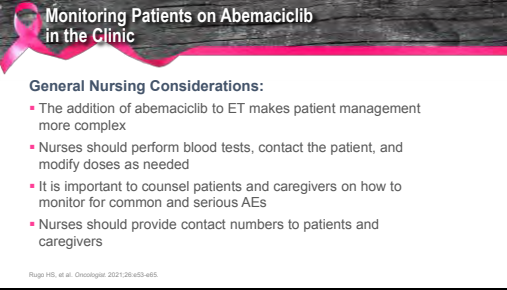
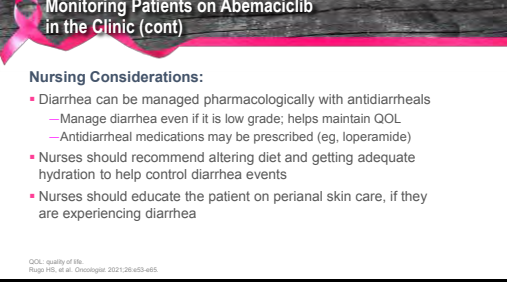
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		<p>Diarrhea is also expected. It is most common with the abemaciclib as compared with the other CDK4/6 inhibitors.</p> <p>But like I said, there's decrease in white blood cells with abemaciclib.</p>																																																																												
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<p>20</p>	 <p>Monitoring Patients on Abemaciclib in the Clinic</p> <p>General Nursing Considerations:</p> <ul style="list-style-type: none"> ▪ The addition of abemaciclib to ET makes patient management more complex ▪ Nurses should perform blood tests, contact the patient, and modify doses as needed ▪ It is important to counsel patients and caregivers on how to monitor for common and serious AEs ▪ Nurses should provide contact numbers to patients and caregivers <p><small>Rupp HS, et al. Oncologist. 2021;26:e653-e655.</small></p>	<p>The addition of abemaciclib to endocrine therapy makes the patient management more complex. We know that. So the nurses need to perform or order blood tests, interpret those blood tests, contact the patient, and modify doses as needed.</p> <p>And it's important for the nurse to counsel patients and caregivers on how to monitor for these common and serious adverse events that can occur with abemaciclib.</p> <p>And it's really important that the nurses are providing contact numbers to the patients and caregivers so if something like a serious event were to occur—a patient's having shortness of breath or a cough, or a patient's having leg swelling, a patient is having an infection—they need to be able to contact us right away. So we give them a phone number. We have them contact us through the electronic medical record as well. And just always have a way and a route to reach us quickly.</p>
<p>21</p>	 <p>Monitoring Patients on Abemaciclib in the Clinic (cont)</p> <p>Nursing Considerations:</p> <ul style="list-style-type: none"> ▪ Diarrhea can be managed pharmacologically with antidiarrheals <ul style="list-style-type: none"> – Manage diarrhea even if it is low grade; helps maintain QOL – Antidiarrheal medications may be prescribed (eg, loperamide) ▪ Nurses should recommend altering diet and getting adequate hydration to help control diarrhea events ▪ Nurses should educate the patient on perianal skin care, if they are experiencing diarrhea <p><small>QOL, quality of life. Rupp HS, et al. Oncologist. 2021;26:e653-e655.</small></p>	<p>Diarrhea can be managed with medications. Loperamide is often the first medication that we go to. Starting the medication as soon as they experience their first episode of diarrhea really helps to maintain the patient's quality of life.</p> <p>We also recommend that patients have a blander diet, avoid raw vegetables, avoid spicy foods, and increase their hydration to manage the diarrhea and reduce the side effects of it.</p> <p>We also need to talk to patients about perianal care. If patients are having a lot of diarrhea, they could develop fissures. They could have an exacerbation of a hemorrhoid. So we really need to be asking about that. Patients often won't just offer up that information. So asking</p>

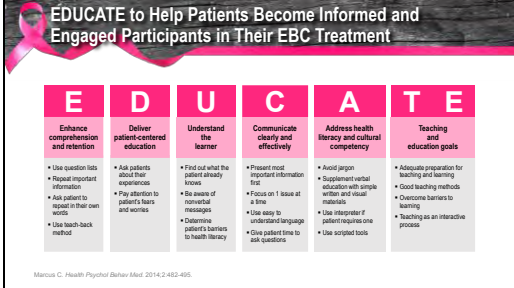
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		<p>them every time we talk to them is really important.</p>
<p>22</p>	 <p>“SIMPLE” Strategies to Improve Medication Adherence</p> <ul style="list-style-type: none"> S Simplifying regimen characteristics <ul style="list-style-type: none"> Adjusting timing, frequency, amount, and dosage Matching to patients' activities of daily living Using adherence aids, such as medication boxes and alarms I Imparting knowledge <ul style="list-style-type: none"> Discussion with physician, advanced practitioner, and pharmacist Distribution of written information and pamphlets Accessing health education information from the Internet M Modifying patient benefits <ul style="list-style-type: none"> Assessing perceived susceptibility, severity, benefit, and barriers Rewarding, tailoring, and contingency contracting P Patient and family communication <ul style="list-style-type: none"> Active listening and providing clear, direct messages Including patients in decisions Spending reminders via mail, email, or phone Convenience of care, scheduled appointment Home visits, family support, and counseling L Leaving the bias <ul style="list-style-type: none"> Tailoring the education to the patient's level of understanding Demographic factors play a minor role in adherence behavior E Evaluating adherence <ul style="list-style-type: none"> Self-reports Pill counting, measuring serum or urine levels, and medication event monitoring system <p><small>Heath A, et al. MedClinRes. 2009;7:4</small></p>	<p>Here is a nice way to remember a strategy that you can use with patients to improve their adherence—SIMPLE:</p> <p>S stands for simplifying regimen characteristics: Making sure they take their medications at easy times of the day, maybe with breakfast and dinner for the abemaciclib; using their phone or an alarm to remind them it's time to take your medication always helps; pill boxes help.</p> <p>I, imparting knowledge: Discuss with them why they're taking the medication and why it could help them to reduce their risk of recurrence, and what it would mean if they did have a recurrence and they didn't take the medication. Metastatic disease is not curable, and so it's really important to try our best to prevent that from occurring.</p> <p>M, modifying patient benefits: It's important to assess the patient's perceived susceptibility to having adverse events. What are they worried about? Do they think they're going to have horrible diarrhea and are they just not going to want to take it, even if you tell them it won't be that bad? And what do they think the benefit will be? And what do they think the barriers to treatment could be? And making sure that you reward them and you tailor the treatment to them and talk to them about what would happen if they were to experience a bad outcome or a bad side effect. And just really going over that with them and figuring out where they are before you start them on the medication.</p> <p>P, patient and family communication: Making sure you're providing clear, direct messages to the patients, including family</p>

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		<p>members, if you can. Sending reminders by email or phone. Make sure you're having them come in when they can come in and making thing as convenient as possible. We do things where we alternate video visits with in-person visits. That really can help with patients. And then, if it's somebody that needs a lot of support with taking medication, like our patients that maybe have memory issues or that are disabled, just making sure that we can provide them with the support that they need at home.</p> <p>L, leaving the bias: We make sure to tailor the education to the patient's level of understanding. We consider demographic factors that play a role to their adherence.</p> <p>E, evaluating adherence: We ask them to tell us what they're taking. Are you getting in the 2 doses of abemaciclib in a day? Asking them in a way that they are willing to tell you if they're actually taking it. There are other, even more aggressive ways of evaluating adherence, like pill counting and measuring serum levels of the medication. We don't use those, but they could be used in certain situations. But definitely just encouraging your patients to be honest and open about what they're taking. I think it matters on how you ask.</p>																					
23	 <p>EDUCATE to Help Patients Become Informed and Engaged Participants in Their EBC Treatment</p> <table border="1"> <thead> <tr> <th>E</th> <th>D</th> <th>U</th> <th>C</th> <th>A</th> <th>T</th> <th>E</th> </tr> </thead> <tbody> <tr> <td>Enhance comprehension and retention</td> <td>Deliver patient-centered education</td> <td>Understand the learner</td> <td>Communicate clearly and effectively</td> <td>Address health literacy and cultural competency</td> <td colspan="2">Teaching and education goals</td> </tr> <tr> <td> <ul style="list-style-type: none"> Use question lists Repeat important information Ask patient to repeat their own words Use teach-back method </td> <td> <ul style="list-style-type: none"> Ask patients about their experiences Pay attention to patient's fears and worries </td> <td> <ul style="list-style-type: none"> Find out what the patient already knows Be aware of non-verbal messages Determine patient's barriers to health literacy </td> <td> <ul style="list-style-type: none"> Present most important information first Focus on 1 issue at a time Use easy-to-understand language Give patient time to ask questions </td> <td> <ul style="list-style-type: none"> Avoid jargon Supplement verbal education with simple written and visual materials Use interpreter if patient speaks another language Use scripted tools </td> <td colspan="2"> <ul style="list-style-type: none"> Adequate preparation for teaching and learning Good teaching methods Overcome barriers to learning Teaching as an interactive process </td> </tr> </tbody> </table> <p><small>Marcus C. Health Psychol Behav Med. 2014;2:482-495.</small></p>	E	D	U	C	A	T	E	Enhance comprehension and retention	Deliver patient-centered education	Understand the learner	Communicate clearly and effectively	Address health literacy and cultural competency	Teaching and education goals		<ul style="list-style-type: none"> Use question lists Repeat important information Ask patient to repeat their own words Use teach-back method 	<ul style="list-style-type: none"> Ask patients about their experiences Pay attention to patient's fears and worries 	<ul style="list-style-type: none"> Find out what the patient already knows Be aware of non-verbal messages Determine patient's barriers to health literacy 	<ul style="list-style-type: none"> Present most important information first Focus on 1 issue at a time Use easy-to-understand language Give patient time to ask questions 	<ul style="list-style-type: none"> Avoid jargon Supplement verbal education with simple written and visual materials Use interpreter if patient speaks another language Use scripted tools 	<ul style="list-style-type: none"> Adequate preparation for teaching and learning Good teaching methods Overcome barriers to learning Teaching as an interactive process 		<p>To help patients become informed and engaged participants in their treatment, there's another easy way to remember some steps that would help—EDUCATE.</p> <p>E, enhance comprehension and retention: We use question lists. We repeat important information. In my clinic, I will tell the patient when they're starting the medication about the side effects or what to do. Then they talk to one of my triage nurses who tells them the same thing. And</p>
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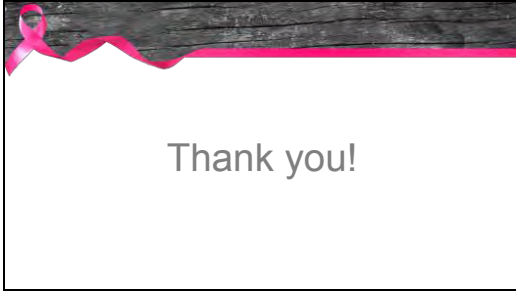
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	<p>then they talk to the pharmacist who tells them the same thing. So making sure that they get that information many times. We ask the patient to repeat back in their own words what we've told them. What are you going to do when you experience diarrhea? What are you going to take? What did I tell you to do? So that teach-back method is very helpful. I ask them what they would say to me if I was starting the medication.</p> <p>D, deliver patient-centered education: We ask patients about their experience and pay attention to their fears and worries, and really address those when we're talking to them about the medication.</p> <p>U, understand the learner: Find out what the patient already knows. Be aware of nonverbal messages. Maybe they're telling you that they really, really are worried about taking the medication, and then by the end of the visit telling you, "Okay, I'll take the medication", but they're not really that enthusiastic about it. I wouldn't be surprised if that patient came back in 2 weeks and hadn't been taking it. So really listening to them and meeting them where they're at. And then, determining patients' barriers to health literacy. Some patients just don't understand what you're saying to them. So it's important to tell them about their treatment in a way that they can understand. And that will help them get on board.</p> <p>C, communicate clearly and effectively: Present the most important information first. Focus on 1 issue at a time. Some patients I found when I'm in a visit and I'm telling them about something will start going off about all different things. And I tell them, "Okay, stop. I am a very simple person and I need to go 1 at a time, and we'll get through this." We just have to</p>
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		<p>slow it down. Make sure to use easy language that they can understand. And give them time to ask questions. I know that we're busy in our clinics and we're going from one room to another, but it's really, really important to give them that time that they need so they feel heard.</p> <p>A, address health literacy and cultural competency: Avoid jargon, avoid medical terms that they may not understand. Supplement verbal education with written and visual materials. A lot of patients like to read what you've told them afterwards. Use an interpreter, of course, if needed. And scripted tools.</p> <p>T and E, teaching and education goals: Adequate preparation for teaching and learning. Use good teaching methods. Overcome barriers to learning. And teach as an interactive process.</p>
24		<p>Those were a few tools that I hope you can use with your patients to encourage them to adhere to their medication. It is really on us oncology nurses to help our patients to adhere to their treatments.</p> <p>Thank you.</p>