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		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.
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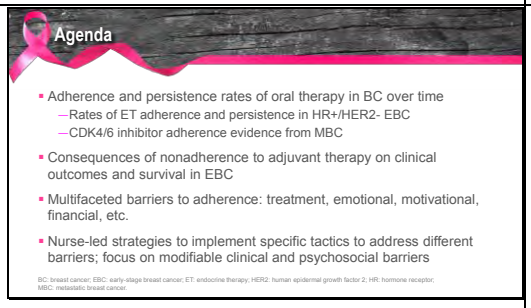
3		Today, we'll discuss adherence and persistence rates of oral therapy in breast cancer over time: rates of endocrine therapy adherence and persistence and CDK4/6 inhibitor adherence evidence from previous metastatic breast cancer trials. We'll discuss the consequences of nonadherence to adjuvant therapy on clinical outcomes and survival in early-stage breast cancer. We'll discuss multifaceted barriers to adherence, such as treatment, emotional, motivational, and financial aspects. And we'll discuss nurse-led strategies to implement specific tactics to address different barriers, focusing on modifiable clinical and psychosocial barriers.

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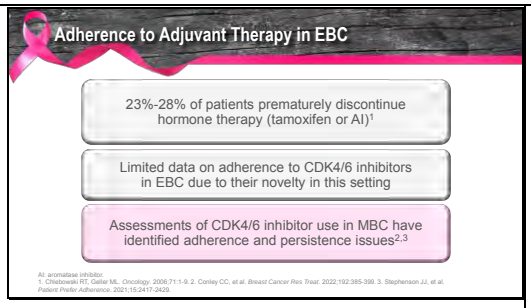
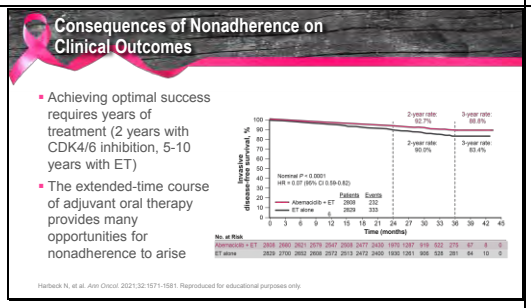
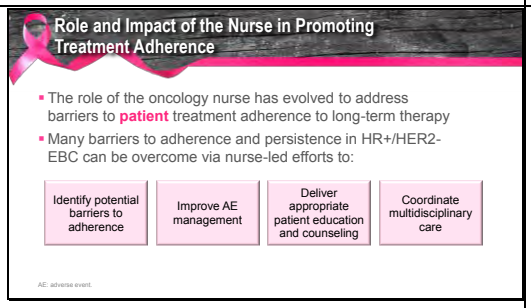
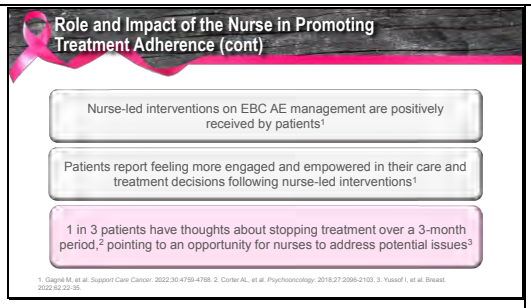
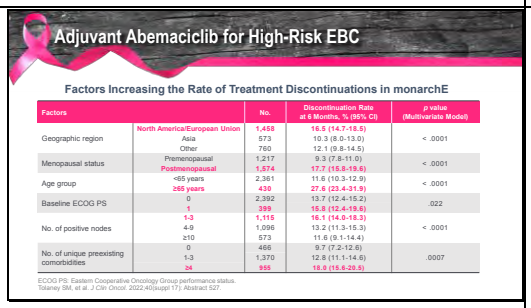
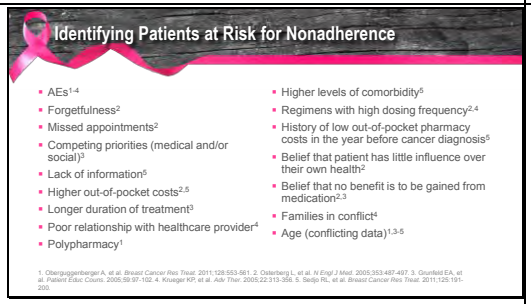
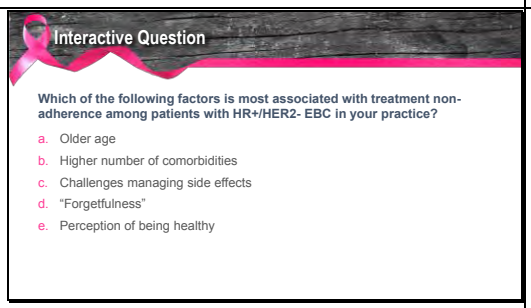
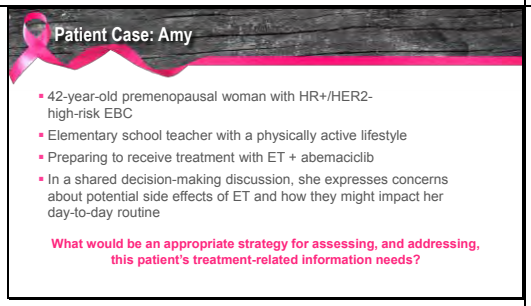
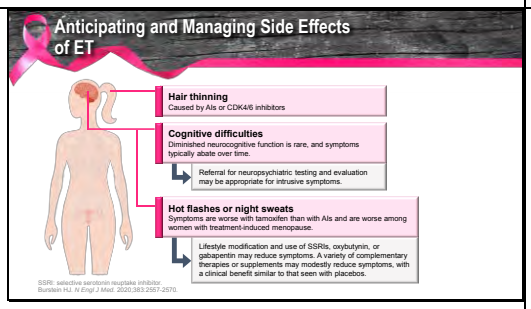
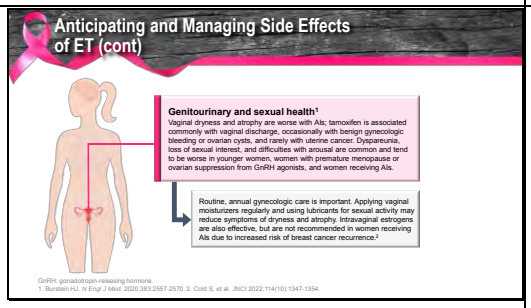
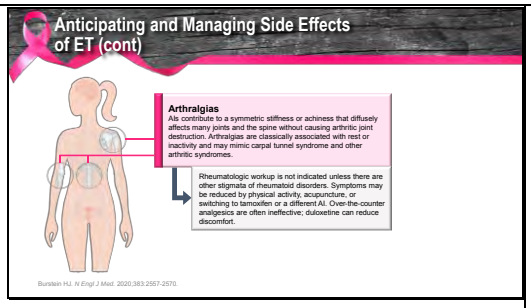
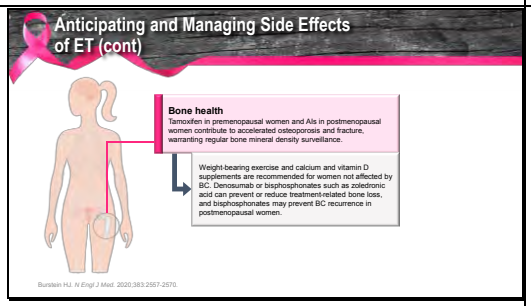
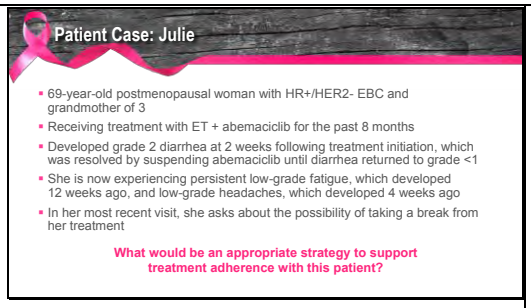
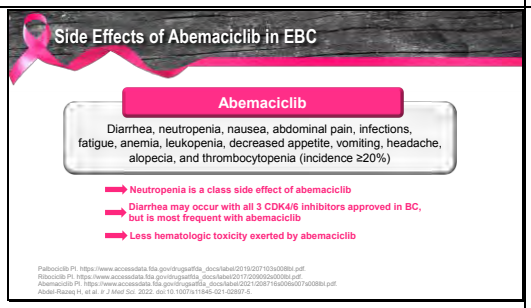
4		Adherence to adjuvant therapy in early-stage breast cancer: We know that 23% to 28% of patients prematurely discontinue hormone therapy, whether it be tamoxifen or an aromatase inhibitor. It's quite a lot. There are limited data on adherence for the CDK4/6 inhibitors in early-stage breast cancer because it is new. However, we do have some evidence from the metastatic breast cancer setting that we will discuss.
5		What are the consequences of nonadherence on clinical outcomes? 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. 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. So it is important, really important to address nonadherence and to help patients stay on therapy.
6		What is the role of the oncology nurse? 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: 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.

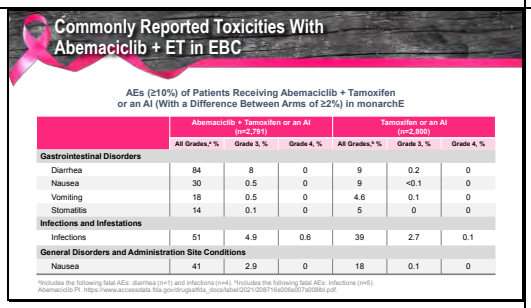
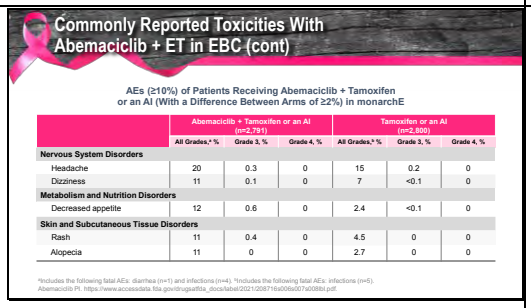
7		So nurse-led interventions on early-stage breast cancer adverse event management are positively received by patients. They like it. They feel more engaged and empowered in their care and their treatment decisions. And 1 in 3 patients have thought about stopping treatment over a 3-month period, pointing to an opportunity for nurses to address potential issues.
8		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. 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.
9		Here is a long list of why a patient may not be adhering to their medication. 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. Patients that don't understand why they're taking the medication or aren't

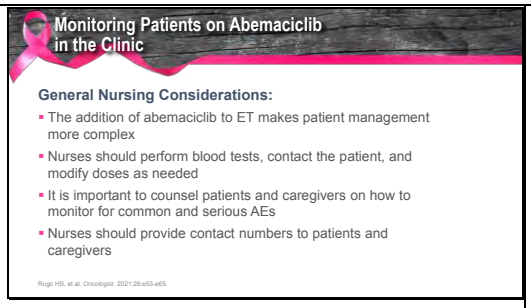
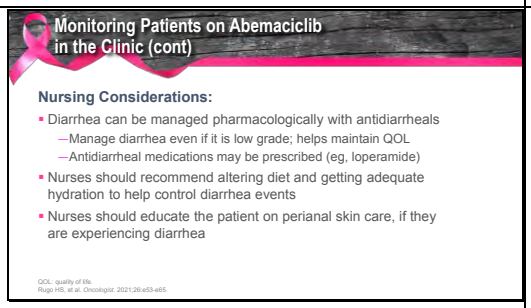
		fully on board with the idea that they have this risk that they could be reducing with taking the medication, which is a major issue, and I do a lot of education in the clinic to explain to them why we recommended the medication to them. Patients taking a lot of medications may be more likely to not take it. 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.
10		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? a) Older age b) Higher number of comorbidities c) Challenges managing side effects d) "Forgetfulness" e) Perception of being healthy
11		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. 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. So just talking about endocrine therapy to begin, what would be the appropriate

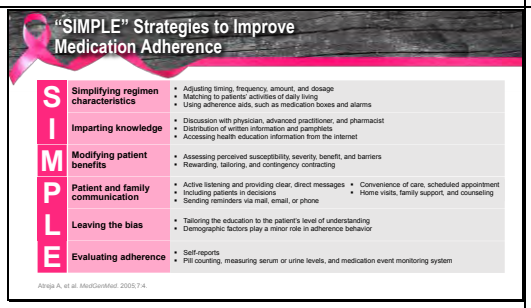
		strategy for assessing and addressing this patient's treatment-related information needs?
12		First, to discuss the side effects with her, we let her know that there can be some hair thinning because of the abemaciclib and the aromatase inhibitor that you're about to put her on. There could be some decreased 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. 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.
13		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. 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.

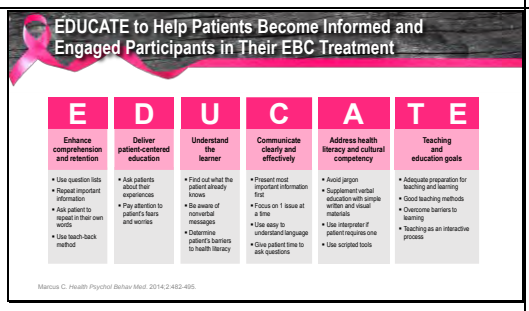
14		Joint aches and stiffness are super common with the aromatase inhibitors. So I do discuss having them exercise 30 minutes a day, 5 days a week, doing something with weight resistance. If they are having a lot of joint aches and stiffness and it just seems to be out of proportion to what you would 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. 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. Again, there's a medication, an SNRI, that you can give to patients called desvenlafaxine, which could help reduce joint aches and stiffness. So you let them know that you have solutions for them.
15		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.

16		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. 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. She's now experiencing persistent low-grade fatigue. It developed about 12 weeks ago. Some low-grade headaches, which developed about 4 weeks ago. And at her most recent visit, she asked about the possibility of taking a break from her treatment. What would be the appropriate strategy to support treatment adherence with this patient?
17		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. 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. 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.

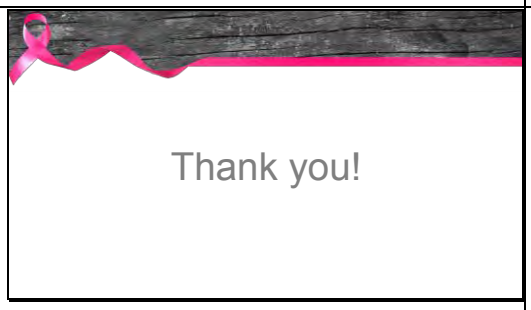
		Diarrhea is also expected. It is most common with the abemaciclib as compared with the other CDK4/6 inhibitors. But like I said, there's decrease in white blood cells with abemaciclib.
18		Here are the toxicities that were seen in the trials. If you compare the patients getting abemaciclib with those who were not: Diarrhea, like I said, very common, 80%; a lot of patients experiencing that. Nausea, 30%. And about 20% experiencing vomiting with that. Stomatitis was seen, mouth sores, in patients, about 15%. I have patients use a steroid mouth rinse or a topical steroid. That heals that up very quickly; very effective. There was a higher rate of infections, although I'm not having patients being hospitalized with these infections. They're usually mild.
19		Headaches were seen at a higher rate in patients taking the abemaciclib versus not. But not at a huge increased rate. A slight increased rate of dizziness. More decreased appetite. Slightly higher rates of rash and hair thinning.

20		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. 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. 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.
21		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. 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. 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

		them every time we talk to them is really important.
22		Here is a nice way to remember a strategy that you can use with patients to improve their adherence—SIMPLE: 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. 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. 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, patient and family communication: Making sure you're providing clear, direct messages to the patients, including family

		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. 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. 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.
23		To help patients become informed and engaged participants in their treatment, there's another easy way to remember some steps that would help—EDUCATE. 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

		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. 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. 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. 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

		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. 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. 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.
24		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. Thank you.