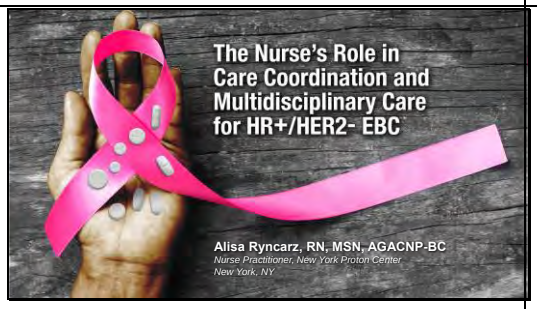
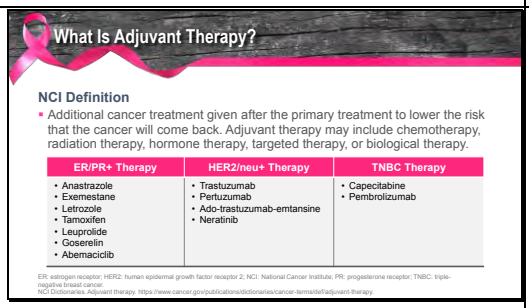
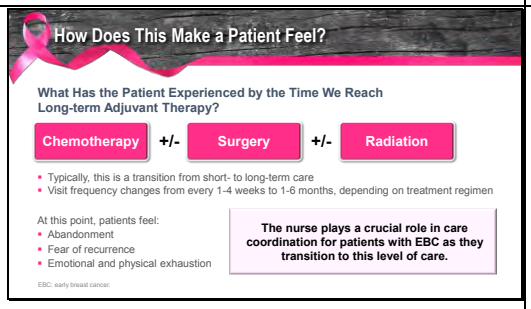
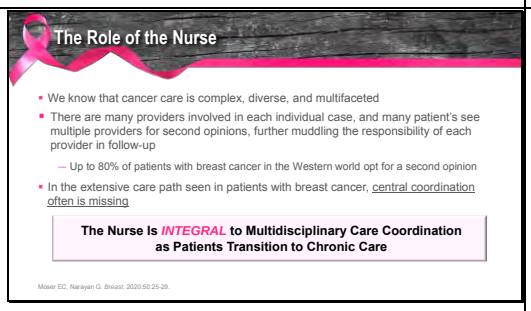
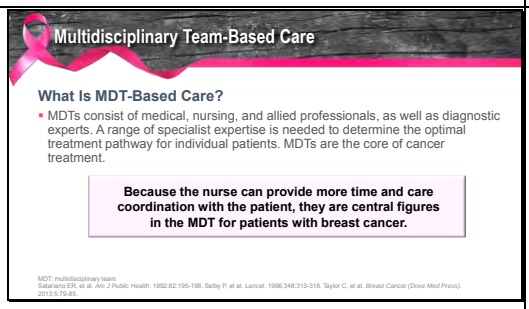
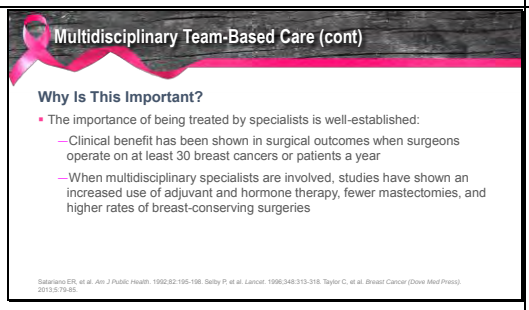
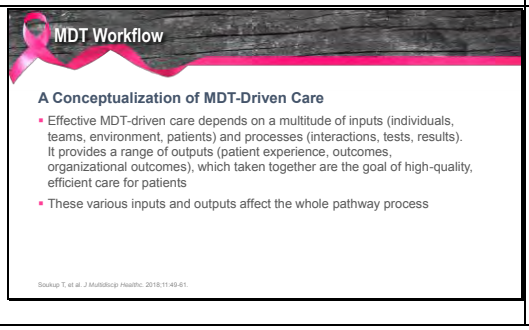
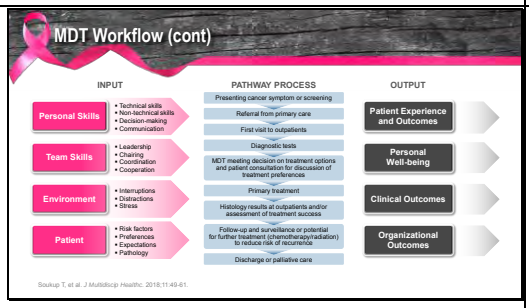
Optimizing Oral Therapy in HR+/HER2- Early Breast Cancer: Nurse-led Strategies to Improve Adherence and Persistence

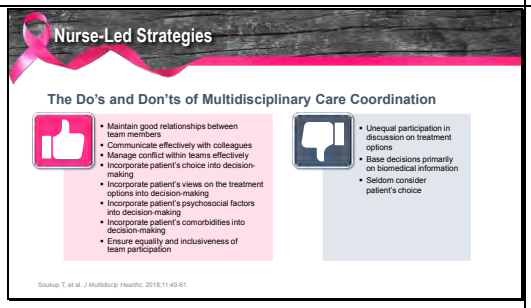
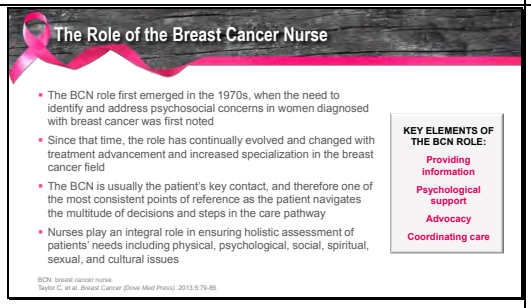
The Nurses Role in Care Coordination and Multidisciplinary Care for HR+/HER2- EBC

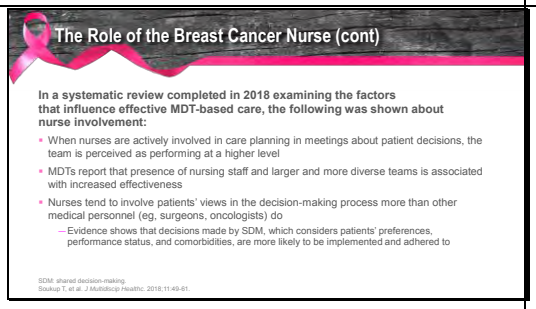
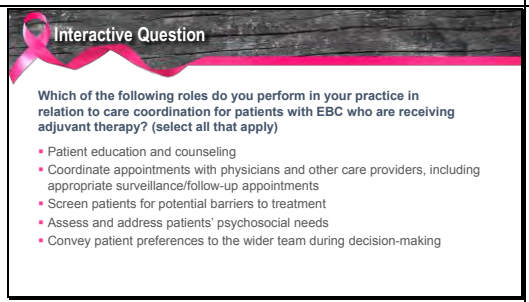
1		Hello, my name is Alisa Ryncarz. I'm an oncology nurse practitioner in New York. And this is Activity Five. We're going to be discussing the nurse's role in care coordination and multidisciplinary care for hormone receptor-positive/HER2-negative early breast cancer.
2		
3		When we get to this discussion of care coordination, we're really talking about adjuvant therapy. The NCI definition of adjuvant therapy is "additional cancer treatment given after the primary treatment to lower the risk that the cancer will come back." Adjuvant therapy may include chemotherapy, radiation therapy, hormone therapy, targeted therapy, or biologic therapy. We know that in breast cancer, the type of subset of breast cancer you have dictates the actual treatment that you receive. So here are just some examples for hormone receptor-positive cancer: We always use aromatase inhibitors, such as anastrozole, exemestane, letrozole, or tamoxifen. Or sometimes ovarian suppression with leuprolide or goserelin. And sometimes an adjuvant CDK4/6 inhibitor called abemaciclib. For HER2-positive therapy, we use trastuzumab, pertuzumab, ado-trastuzumab-emtansine, or neratinib. And for triple-negative therapy, when we're discussing adjuvant therapy, it's

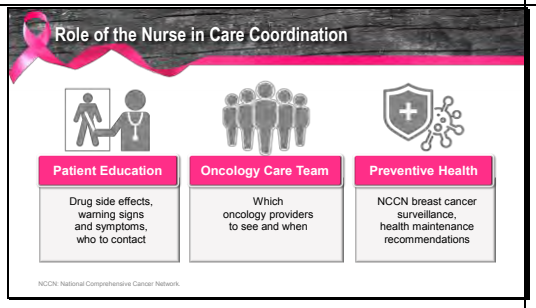
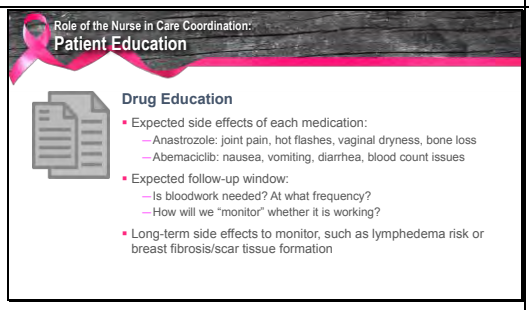
		typically either capecitabine or pembrolizumab.
4		When we get to the adjuvant therapy stage, the patient has experienced a lot in their cancer journey. Sometimes they have experienced chemotherapy, neoadjuvant chemotherapy or adjuvant. They've had surgery and sometimes they may even have received part, if not all, of their radiation while having this discussion. When we get to this point, typically we're moving from frequent follow-up and very high level monitoring to more spread-out and loose follow-up. Visit frequency usually changes from every 1 to 4 weeks to every 1 to 6 months, depending on their regimen. This is really a transition from acute to chronic care. At this point, patients feel abandonment, emotional and physical exhaustion, and sometimes fear of recurrence that starts to pop up when they're not being actively monitored so closely. So the nurse plays a crucial role in this care coordination for patients with early breast cancer as they transition from acute to chronic care.
5		The role of the nurse is very important in this specific phase because cancer care is so complex, diverse, and multifaceted. There are many providers involved in each individual case, and many patients see multiple providers for second opinions, further muddling the responsibility of each provider in follow-up. In a study conducted in 2020, it was actually shown that up to 80% of patients with breast cancer in the Western world opt for a second opinion.

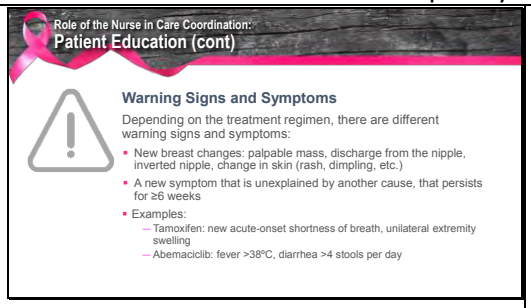
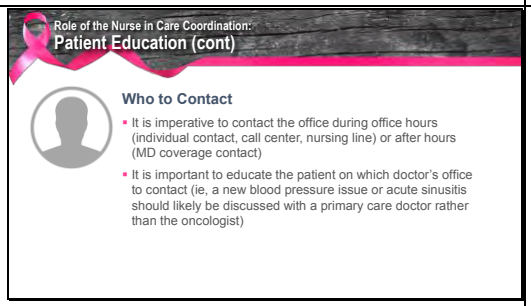
		In this extensive care path, we know that central coordination is often missing. So the nurse is very integral to the multidisciplinary care coordination as patients transition to more chronic care.
6		When we talk about multidisciplinary team-based care, or MDT-based care, this is really a group of medical, nursing, and allied professionals, including diagnostic experts. We know that a range of specialist expertise is needed to determine the optimal treatment pathway for individual patients. MDTs are the core of cancer treatment. Because the nurse can provide more time and care coordination with the patient, they are central figures in this MDT-based approach for patients with breast cancer.
7		Why is this important? We know that being treated by specialists, the benefit of them has been very well-established. There's a study that has shown a long time ago in 1992 that there was a significant clinical benefit in surgical outcomes when surgeons operate on at least 30 breast cancer patients a year—so if there's more specialized breast surgery. We also know that when multidisciplinary specialists are involved, studies have shown an increased use of adjuvant and hormone therapy, fewer mastectomies, and higher rates of breast-conserving surgeries.
8		When we talk about MDT, it is a very complicated workload because there's a lot of people involved. We'll talk through the variety of inputs, the processes that happen, and the range of outputs and outcomes that we're looking for. Our goal

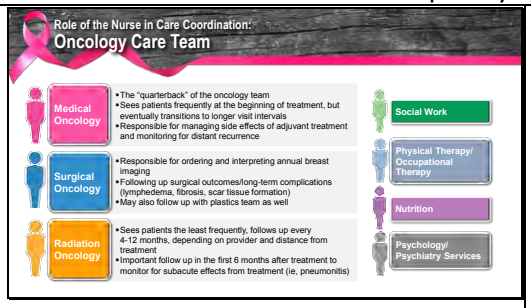
		through this entire process is high-quality, efficient care for patients.
9		The first aspect of this is the input. So this is going to have to do with the people who are on the multidisciplinary team and how they work together. So it'll be their personal skills, their team skills, the environment they're operating in, the healthcare context—if they have stress interactions, distractions, time. And the patient themselves—how the patient is feeling, how they're presenting. All of those things enter into this workflow. Then there's actually the process that the patient goes through that the multidisciplinary team is working through. That's presenting signs and symptoms, referrals, diagnostic tests, finding pathologies, meeting for treatment plans, discussing subsequent updated surgical pathology, talking about adjuvant treatment, follow-up and surveillance, different ways to act on different new complications, and ultimately surveillance discharge from the practice. This whole cancer journey, this whole pathway process that patients go through—the multidisciplinary team is involved the entire time in all of these decisions. When we're looking at outputs from this process, we want to look at a couple of different things. We want to make sure that the patient is having a good experience and great outcomes, the best that we can provide with the best decisions we're making. Making sure that the patient and the providers have good well-being. That the clinical outcomes are, again, as good as we want, as we can get. And that the organization is providing supportive care in a way that patients are

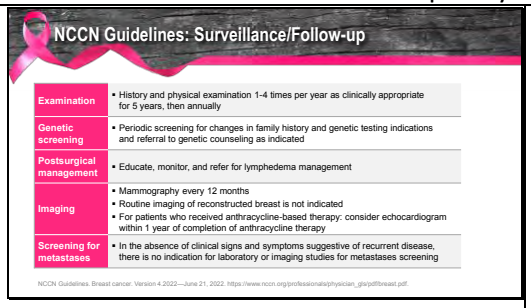
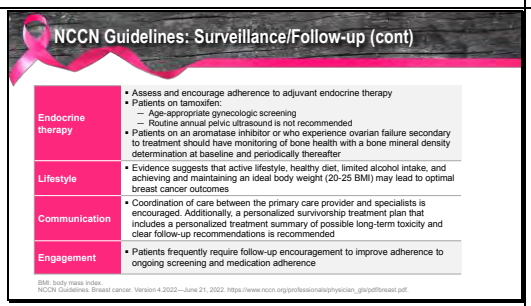
		happy to be with the organizations they are with.
10		The dos and don'ts of multidisciplinary care coordination. We want to make sure that you're maintaining good relationships between team members; communicating effectively with colleagues; managing conflict within teams effectively; and incorporating the patient's choice, patient's views, patient's psychosocial factors, and the patient's comorbidities into the decision-making. And ensuring equality and inclusiveness of team participation. Some don'ts to be aware of in the multidisciplinary care coordination are, we don't want to have unequal participation in discussion on treatment options. We want to make sure we're not basing decisions primarily on biomedical information and not looking at the patient as a whole. And we want to make sure that we are taking the patient's choice into consideration and we're not just breezing by that in our decision-making process.
11		The role of the breast cancer nurse. The breast cancer nurse role first emerged in the 1970s when the need to identify and address psychosocial concerns in women diagnosed with breast cancer was first noted. Since that time, the role has continually evolved and changed with treatment advancement and increased specialization in the breast cancer field. The breast cancer nurse is usually the patient's key contact and therefore one of the most consistent points of reference as the patient navigates the multitude of decisions and steps within the care pathway.

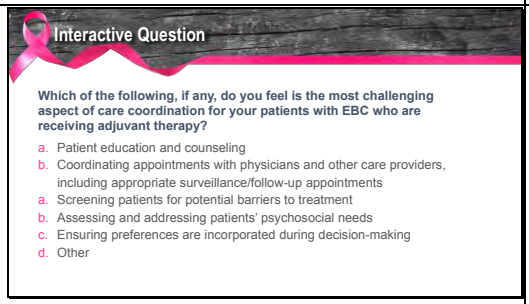
		Nurses play an integral role in ensuring holistic assessment of patients' needs, including physical, psychological, social, spiritual, sexual, and cultural issues. It's very, very important that they are involved heavily with the patient in providing information, psychological support, advocacy, and again, coordinating care.
12		In a systematic review completed in 2018 examining the factors that influence multidisciplinary team-based care, the following was shown about nurse involvement: When nurses are actively involved in care planning in meetings about patient decisions, the team is perceived as performing at a higher level. MDTs report that the presence of nursing staff in larger and more diverse teams is associated with increased effectiveness. Nurses tend to involve patients' views in the decision-making process more than other medical personnel, such as the surgeons or oncologists do. And we know with evidence about shared decision-making, when the patients' preferences are involved in the decision-making, they're more likely to be implemented and adhered to.
13		Which of the following roles do you perform in your practice in relation to care coordination for patients with early breast cancer who are receiving adjuvant therapy? Patient education and counseling. Coordinate appointments with physicians and other care providers, including

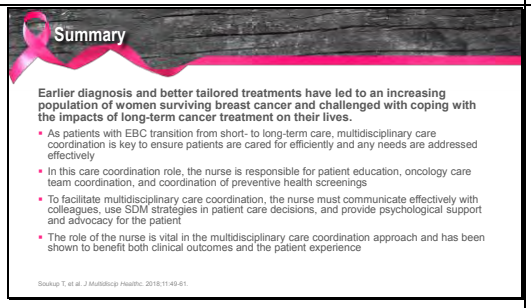
		appropriate surveillance/follow-up appointments. Screen patients for potential barriers to treatment. Assess and address patients' psychosocial needs. Convey patient preferences to the wider team during decision-making.
14		We talk about the role of the nurse in care coordination. There are 3 main areas that we're going to discuss: Number 1 is patient education. That is assessing drug side effects, warning signs and symptoms, and who to contact in certain cases of adverse effects. Number 2 is coordinating within the oncology care team. So, which oncology providers to see and when. And number 3 is discussing preventive health. We want to make sure we're always reviewing NCCN guidelines for breast cancer surveillance and health maintenance recommendations.
15		First off is patient education. We want to make sure we're giving very, very thorough drug education. We want to discuss expected side effects of each medication, the expected follow-up for each medication, as well as long-term side effects to monitor for, such as lymphedema risk or breast fibrosis or scar tissue formation.

16		When we talk about warning signs and symptoms, depending on the different treatment regimens, there are different warning signs and symptoms you want to make sure you're educating about. But for all breast cancer patients, we want to educate them on being alert for new breast changes, such as palpable mass, discharge from the nipple, inverted nipple or a change in the skin, such as rash or dimpling. We want to make sure they are aware that if there is a new symptom that is unexplained by another cause, that persists for more than 6 weeks, they should be notifying their provider. And other drug-specific signs and symptoms we want to talk about are, for something like tamoxifen, new-onset shortness of breath or unilateral extremity swelling because we know of the slightly increased risk of DVT and PE. And then for a medication such as abemaciclib, we want to make sure we discuss the warning thresholds of a fever higher than 38 °C, or diarrhea, more than 4 stools per day.
17		When those things happen, you want to make sure you're educating the patient on who to contact both during office hours and afterhours if there's a covering fellow or doctor. It's also important to educate the patient on which issues actually require medical oncology follow-up versus something like a new blood pressure issue or a runny nose that should be discussed with a primary care doctor rather than the oncology team.

18		When we talk about care coordination and the team, there are 3 main facets to the oncology care team: Number 1 is medical oncology. We see them as the quarterback. They're usually the ones who are seeing the patient most often at the beginning and following them more consistently than the rest of the team typically when they're on adjuvant treatment. So we really center oncology-focused care around the medical oncology team. The surgical oncology team is typically responsible for ordering and interpreting annual breast imaging, following up surgical outcomes and long-term complications. And sometimes the patients themselves follow up with the plastic surgery team as well. And radiation oncology may see patients typically less frequently, following up every 4 to 12 months, depending on the provider and where the treatment was. But it's important to follow up within the first 6 months after treatment to monitor for subacute side effects from that radiation treatment, such as pneumonitis. There are other important players in the oncology team. Nurses are really the best, if we use the word quarterback, at coordinating between all of these different groups. And that includes social work, physical therapy and occupational therapy, nutrition, and psychology and psychiatry services.

19		NCCN guidelines for surveillance and follow-up for breast cancer patients: This is something that we should be educating our patients on when we're seeing them in follow-up and that the nurse is really responsible for when we're doing general follow-up visits, especially if they're tolerating the medication well. We want to make sure we're focusing on health maintenance and surveillance. So we want to make sure that patients are getting physicals 1 to 4 times a year as clinically appropriate. We want to do periodic screening for changes in family history that would indicate a new genetic test needed. We want to educate, monitor, and refer for lymphedema management. We want to discuss breast imaging, such as mammography every 12 months or some echocardiograms required for patients who are on anthracycline therapy or previously received anthracycline therapy. And we want to discuss screening for metastases and how it's actually against the NCCN guidelines to be doing any screening lab work or imaging to monitor for recurring disease or for metastatic disease. It's shown that clinical signs and symptoms have been the best indicator for monitoring any new incidence of cancer.
20		Next, for patients on endocrine therapy, we always want to make sure in these follow-up visits that we are encouraging and monitoring for adherence to the medication itself. For patients on tamoxifen specifically, we want to make sure they're obtaining age-appropriate gynecologic screening. And it is actually recommended against annual pelvic ultrasound, per the NCCN guidelines.

		We also want to make sure that patients on an aromatase inhibitor or who experience ovarian failure secondary to treatment should be monitoring bone health with a bone mineral density determination at baseline and periodically thereafter. We want to make sure we're educating patients on lifestyle changes that can help promote optimal health, such as living actively, having a healthy diet, limiting alcohol intake and achieving and maintaining an ideal body weight. These have all been shown to influence breast cancer outcomes. We want to make sure that the nurse is really helping to coordinate between the primary care and all the different specialists. We know that there's importance in creating a survivorship treatment plan—a treatment summary of possible long-term toxicities to provide to the primary care doctors or to patients and their providers so that everyone's on the same page surrounding the patient's breast cancer treatment. And we want to make sure that patients are constantly engaging in follow-up visits and discussing and being open with what they're experiencing in order to improve adherence and ongoing screening.
21		Which of the following, if any, do you feel is the most challenging aspect of care coordination for your patients with early breast cancer who are receiving adjuvant therapy? a) Patient educate and counseling b) Coordinating appointments with physicians and other care providers,

		including appropriate surveillance and follow-up appointments c) Screening patients for potential barriers to treatment d) Assessing and addressing patients' psychosocial needs e) Ensuring preferences are incorporated during decision-making
22		In summary, earlier diagnosis and better tailored treatments have led to an increasing population of women surviving breast cancer and challenged with coping with the impacts of long-term cancer treatment on their lives. As patients with early breast cancer transition from short- to long-term care, multidisciplinary care coordination is key to ensure patients are cared for efficiently and any needs are addressed effectively. In this care coordination role, the nurse is responsible for patient education, oncology care team coordination and coordination of preventive health screenings. To facilitate multidisciplinary care coordination, the nurse must communicate effectively with colleagues, use shared decision-making strategies in patient care decisions, and provide psychological support and advocacy for the patient. The role of the nurse is vital in the multidisciplinary care coordination approach and has been shown to benefit both clinical outcomes and the patient experience overall.

23		Thank you so much.