Clinical Posters From JADPRO Live 2025

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JL1301C: A Case Study: Using Virtual Reality to Treat Anxiety and Claustrophobia During Radiation Therapy Simulation – Enhancing Emotional Well-Being and Preventing Unnecessary Interventions

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Background: Virtual Reality (VR) is a non-invasive, immersive tool that utilizes visual, auditory, and tactile stimuli to simulate an interactive three-dimensional environment. An APP/RN-led multidisciplinary team at a comprehensive cancer center implemented VR to reduce pain and anxiety in adult and pediatric oncology patients. Following an extensive literature review, the team secured stakeholder buy-in, conducted a cost analysis, and procured the necessary devices. Implementation included creating a nursing policy, infection control guidelines, patient and nursing education materials, exclusion criteria, and a sustainable workflow. VR was successfully integrated into the Adult Anesthesia Pain Service (APS) and Pediatric Ambulatory Care Center, with positive patient outcomes. A 43-year-old female with left breast ER+ HER2- invasive carcinoma and a history of generalized anxiety disorder, depression, claustrophobia, and panic attacks was referred to APS and Psychiatry after aborting a radiation therapy (RT) CT simulation due to a panic attack, despite receiving lorazepam (1mg IV). She had previously aborted an MRI Spine due to a panic attack, despite premedication with diazepam (10mg PO). If unable to tolerate CT simulation and RT, her oncologist noted she would require a mastectomy. **Methods:** The APP-led APS team developed a patient-centered plan of care that not only aligned with the patient's goals to avoid surgery, but also prevented the need for unnecessary sedation during RT and avoided a delay in oncologic treatment. The APP proposed the use of VR during CT simulation as a distraction modality to treat her anxiety and claustrophobia. The patient trialed the head-mounted VR device with handheld touch controllers and denied feelings of claustrophobia or anxiety during use. In collaboration with Radiation Oncology and Psychiatry, a multimodal plan was implemented: VR in combination with quetiapine (25mg the night prior, 50mg 1 hour prior), and lorazepam (2mg 15 minutes prior). The VR session included calming 360° nature videos with ambient music. **Results:** With the combination of VR and pharmacologic therapy, the patient completed RT CT simulation successfully. The patient anecdotally attributed the addition of VR to her successful treatment and expressed a willingness to use it again in the future, reporting "No benefit from medications," "Would not have been able to do simulation without VR," and "Would use again." **Conclusions:** The utilization of VR as a distraction measure + pharmacologic therapy treated this patient's claustrophobia and anxiety, allowing completion of CT simulation, ultimately helping to prevent any delay in care and avoid unnecessary surgical intervention or sedation during RT. Barriers to implementation include device limitations, such

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as a lack of "lay flat" functionality, which limited the view of certain applications. **Recommendations:** VR is recommended for adult and pediatric populations to treat pain, depression, fatigue, distress, and anxiety. VR has been found to be effective across various settings, including dental, burn, surgical, and oncologic care, port access, trauma, labor pain, lumbar puncture, episiotomy repair, dressing changes, spinal cord injury, and chronic pain. In addition to distraction, VR is utilized for skill-building, mindfulness, meditation, relaxation, breath training, guided imagery, exercise, rehabilitation, exposure therapy, and patient education.

JL1302C: A Compensation Model for Advanced Practice Providers in Oncology and Hematology

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Background: As the hematology and oncology field experiences ongoing challenges in the forms of increased patient populations, advances in available treatments, and workforce challenges, the Advanced Practice Provider (APP) has become an integral part of the specialized hematology and oncology care team. A large community oncology practice experienced rapid APP growth from 2017-2022 with more than doubling of their APP numbers. Compensation for APPs at that time was based on a basic local market analysis and the physician's preference on pay when hiring the APP. The lack of a formalized APP compensation model created issues within both the existing APP workforce, as they sought to understand how their compensation truly reflected their value and expertise, as well as the newly recruited APPs who had no clear understanding of career path and professional goals. **Methods:** An APP Performance Improvement Committee comprised of 6 APPs from various clinic sites and departments within the community practice was established with the charge to create a compensation model which was fair, transparent, and reflected the goals of the practice while acknowledging the APPs individual commitment and contribution. This committee worked together to gather current workforce data within the practice through an APP survey which queried APPs' years of experience, current clinical scope of practice, and professional development activities. An updated market analysis was also conducted in tandem with the Human Resources department. **Results:** The survey data was used to create current state baseline metrics for APPs and ultimately an APP compensation model that utilized clinical years of experience and overall scope of practice to determine a performance level which correlated to a base salary range, which is easily adjustable for every two-year market analysis updates. Survey results and the proposed compensation model were presented to the practice's executive leadership team and the board of directors, who elected to implement the model. **Conclusions:** With approval of the new APP compensation model, all currently employed APPs compensation underwent review to ensure that their current compensation fell within the appropriate range based on the new model, and if necessary, compensation was adjusted according to new model with physician approval. In addition, all new hire APPs initial compensation offers were created using the APP compensation model. Creating a formalized APP compensation structure allows for an equitable and transparent model of compensation where value is correlated to clinical expertise and experience, professional development, and alignment with practice wide goals. **Recommendations:** This model was primarily designed for the medical oncology specialty, which represented the majority of APPs within this large community practice. Further evaluation, potential updates, and expansion of this model would be beneficial to include other sub-specialized APPs within this community oncology practice including radiation oncology and surgical oncology.

JL1303C: A Large Network of Community Oncology Practices' Solution to Onboarding Novice Advanced Practice Providers into General Medical Oncology and Hematology

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Background: Amid current oncology workforce challenges and anticipated physician shortages, there has been a significant increase in the need for and utilization of Advanced Practice Providers (Nurse Practitioners and Physician Assistants) in the specialties of oncology and hematology. Most Advanced Practice Providers (APPs) are trained in the fields of adult, family, pediatric, gerontology, and acute care, which do not offer oncology and hematology specific education and training that is required to treat patients in this specialized field. **Methods:** A multi-practice APP committee was created across a collaborative community oncology network. This committee was comprised of 10 APPs from seven different community oncology practices across six states. The committee met monthly to create, organize, and implement a structured and comprehensive new hire onboarding and education program that pairs focused clinical experiences with topic specific didactic materials. Didactic materials included a disease specific virtual resource library, an accredited introductory continuing medical education course, and one on one case study and topic review with local APP practice leads and educators. Pre and post assessments were created for the new APPs to self-assess their oncology competency and confidence prior to program start and at the completion of the program. **Results:** After the first year of program implementation there were 62 APPs, across 15 individual practices, and 12 states who have enrolled and completed the program. Overall enrollment rate across the practice network was 33% of all newly hired novice APPs. Review of pre and post assessment data at the completion of the program revealed that there was a 76% improvement in APPs comfort and confidence in key clinical and administrative duties and an overall 68% improvement in extent of clinical content knowledge in the most common disease states represented in community oncology. Anecdotal results and feedback from practice leaders reported a rapid adoption of program template and resources due to ease of use and high clinical demand to educate these practitioners quickly and efficiently into direct patient care. APPs within the program reported the most valuable tools of the program were the virtual resource library and accredited continuing education course. **Conclusions:** Formal and comprehensive oncology and hematology specific education is a necessary part of novice APP training in the community oncology setting. With a structured onboarding and education program, which leverages technology to create increased access across multiple states and practice site locations, novice APPs were able to improve their comfort, confidence, and clinical knowledge in oncology and hematology.

JL1304C: A Match Made in Medicine: Advanced Practitioners and Industry – Partners in Cancer Care

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Background: Advanced Practitioners (APs) in oncology face the ongoing challenge of staying current with the rapidly evolving treatment landscape, including new drug approvals and updated clinical recommendations. One important, yet often debated, source of information is engagement with industry representatives across medical and commercial entities. While these interactions can support education around complex cancer therapies, APs hold varying perspectives on their value, ethical implications, and influence on clinical practice. This study aimed to explore APs' perceptions of the benefits, challenges, and educational impact of industry engagement, particularly in the context of a structured panel discussion. **Methods:** A mixed-methods survey was administered to oncology APs before and after a panel discussion. The panel included APs in clinical practice and industry representatives consisting of a Clinical Educator and a Medical Science Liaison. The discussion focused on the evolving role of industry representatives in clinical care. The survey assessed perceived benefits, ethical concerns, sources of medical information, and shifts in understanding regarding AP and industry relationships. **Results:** Primary perceived benefits of industry interaction included access to unbranded education, support for symptom management, and access to the latest information

on new treatments, technologies, and resources that impact patient care. The most commonly reported challenge for APs was insufficient time to engage in meaningful interactions with industry representatives. Concerns regarding ethics and undue influence on prescribing behavior decreased post-discussion, with "it is unethical to interact with industry" dropping to 0% from 3.9%, and "influence on prescribing decisions" decreasing by 4%. Notably, the belief that APs and industry can function as partners in care "to a great extent" increased by 16.2%, while those reporting "to a limited extent" decreased by 16.5%. Following the panel, 55% of respondents reported a change in their understanding of industry roles, and most participants indicated they felt more informed about the relationship's value and considerations. **Conclusions:** The panel discussion positively influenced APs' perceptions of industry engagement, reducing concerns around ethics and influence, and enhancing understanding of the collaborative potential between APs and industry. **Recommendations:** Ongoing dialogue and structured educational interventions may help advance ethical, informed partnerships between APs and industry. Programs should continue to clarify roles, address misconceptions, and emphasize patient-centered collaboration.

JL1305C: A New Era of Oncologic Rehabilitation: The Impact of Advanced Practice Providers Revolutionizing Rehabilitation Cancer Care

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Background: Hospitalized oncology patients often face complex discharge planning due to multifaceted medical needs and concurrent rehabilitation or skilled nursing requirements. Historically, oncology patients in rehabilitation settings have been at high risk for hospital readmission, which impacts patient safety and care quality. In October 2024, hospital-based oncology-experienced Advanced Practice Providers were integrated into the interdisciplinary consult team at a local rehabilitation center. The addition of these APPs aimed to enhance continuity of care, improve patient and staff satisfaction, and reduce hospital readmission rates. These APPs facilitate medication reconciliation, treatment plan alignment, care coordination, and goals-of-care discussions, working alongside hospitalists and rehabilitation staff to provide specialized oncology oversight. **Methods:** Prior to this intervention, oncology oversight at the rehabilitation facility lacked standardization, which increased the risk of complications and rehospitalizations. The consult team consisted of one APP and one hospitalist, conducting daily bedside and multidisciplinary rounds Monday through Friday. While primary medical management remained with rehabilitation physicians and nurses, the APPs offer oncology-specific oversight, supporting symptom management, medication safety, timely interventions, and patient-centered goals-of-care conversations. The APPs, selected for their extensive oncology expertise, rotated between the inpatient hospital and rehabilitation setting, fostering rapport with patients and staff across both care environments. This model allowed for seamless transitions for patients suitable for supportive care, including those not eligible for inpatient hospice or opting to pursue rehabilitation. Data collected included readmission rates before and after APP integration, with readmission defined as an inpatient stay exceeding 48 hours in the hospital. **Results:** Pre-intervention data from September 2023 to October 2024 indicated a hospital-to-rehab readmission rate of approximately 40%. Post-intervention data, collected from November 2024 to June 2025, demonstrated a reduction to 29%, representing a 11% decrease in readmissions. This decline reflects a measurable improvement in patient safety and care quality. Additional metrics under evaluation include medication reconciliation accuracy and adverse event rates. The APP-led model has facilitated the management of complex oncologic cases, such as bone marrow transplant and glioblastoma patients, enabling expansion of patient census while maintaining low readmission rates. **Conclusions:** The integration of oncology-experienced Advanced Practice Providers into the rehabilitation team has demonstrated a significant impact on reducing hospital readmissions and enhancing care quality. This innovative model underscores the value of specialized oncology expertise in multidisciplinary settings, promoting

evidence-based practices, leadership in care coordination, and professional growth for APPs. The positive outcomes highlight the critical role APPs can play in advancing patient-centered, high-quality oncology care within rehabilitation environments. **Recommendations:** Given the success of this model, further expansion and standardization of APP-led oncology oversight are recommended across rehabilitation and transitional care settings. Ongoing monitoring of clinical metrics such as medication safety and adverse events should continue to evaluate and refine the model. Additionally, fostering interprofessional collaboration and investing in oncology-focused APP training can sustain and enhance these positive outcomes. This approach offers a replicable framework for integrating advanced practice providers into multidisciplinary teams, ultimately improving patient safety, reducing readmissions, and elevating standards of oncologic rehabilitation care.

JL1306C: A Retrospective Feasibility Study of the Utilization of Artificial Intelligence in Dosing of High-Dose Methotrexate in Patients With CNS Lymphoma

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Background: Patients with central nervous system (CNS) lymphoma are treated with high-dose methotrexate (HDMTX), either alone or in combination with other agents, with doses commonly reaching 8 g/m^2. The primary toxicity of HDMTX is acute kidney injury (AKI), making careful dose calculation essential. This calculation typically incorporates patient-specific data, including creatinine clearance and cystatin C. At our institution, outpatient providers—often advanced practice providers (APPs)—are responsible for signing chemotherapy orders. Gathering the necessary data, performing manual calculations, and confirming doses with a pharmacist is time-consuming and can delay hospital admission, chemotherapy initiation, and workflow for the inpatient team. The objective of this project was to assess whether artificial intelligence (AI) could be used to efficiently calculate a safe HDMTX dose equivalent to what was actually prescribed. **Methods:** Data from 18 admissions for HDMTX administration were reviewed. For each case, patient-specific data were submitted to ChatGPT, with instructions to calculate an appropriate methotrexate dose. Data provided included: baseline planned dose (e.g., 8 g/m^2), sex, height, weight, baseline creatinine, peak creatinine from the prior cycle, 48-hour methotrexate level from the previous cycle, number of days required to clear MTX to < 0.1 µmol/L, current cystatin C, and previous cystatin C (if available). **Findings:** AI-generated methotrexate dose recommendations were within 10% of the actual administered dose in 44% of cases. In all discrepant cases, the AI recommended a higher dose than what had been prescribed by the provider. **Evaluation:** As healthcare increasingly integrates AI into clinical workflows, this question is highly relevant. Streamlining the HDMTX dosing process has the potential to improve efficiency in provider workflows, reduce inpatient treatment delays, and minimize patient wait times. Improved timeliness in chemotherapy initiation could also help prevent delays in hospital discharge, ultimately benefiting both patient care and operational throughput. **Recommendations:** Further investigation is needed to understand additional variables that may influence dosing decisions beyond those currently entered into AI tools. It is also important to explore whether nuanced clinical judgments—such as toxicity risk, performance status, or institutional patterns—are prompting providers to select lower doses. Future research should assess how underdosing or overdosing impacts clinical outcomes and evaluate how dosing evolves over successive HDMTX cycles. Additionally, comparing dosing recommendations from other AI platforms that incorporate clinical reasoning may yield different results and provide more robust tools for clinical decision support.

JL1307C: Administration of Intralesional Oncolytic Virus Injections by Advanced Practice Providers

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Background: Oncolytic viruses (OV) are an evolving cancer treatment designed to target cancer cells and activate the immune system.

Talimogene laherparepvec (T-VEC), a genetically modified herpes simplex virus type 1 (HSV-1), is the first FDA-approved OV for treatment of advanced melanoma. Additional OV therapies are under investigation, including vusolimogene oderparepvec (VO), also a genetically modified HSV-1 therapy, in combination with nivolumab, which has shown anti-tumor activity in patients with advanced melanoma who have progressed on prior anti-PD-1 therapy. OVs have historically been administered by oncologists, surgeons, and advanced practice providers (APPs) as intralesional injections into cutaneous, subcutaneous, and nodal metastases that are visible, palpable, or ultrasound-detectable. Encouraging treatment outcomes in melanoma have increased interest in injectable OVs, including investigational use in visceral metastases and other tumor types. While it is important that oncology centers are prepared to offer these therapies, administration of OVs requires increased provider time, clinic resources, and multidisciplinary collaboration. Many U.S. academic cancer centers currently utilize APPs for intralesional OV injections. Expanding the APP role to include intralesional injections could help meet rising demand for OVs. **Methods:** A survey of APPs practicing in cutaneous oncology across six U.S. cancer centers was completed to explore current practices of administering intralesional OV injections, including the role of APPs in OV administration, training requirements, and perceived barriers to OV administration. These results help identify current practice standards, determine feasibility of APP administration of Ovs, identify barriers to expanding OV therapies, and describe opportunities for improving OV workflows. **Results:** Responses were collected from 7 APPs (6 nurse practitioners, 1 physician assistant) all specializing in cutaneous oncology across 6 cancer centers, including 6 medical oncology APPs, and 1 surgical oncology APP. Three (42.86%) reported OV injections are performed solely by APPs, one (14.29%) by MDs only, and three (42.86%) by APPs and MDs. Most (71.43%) reported APPs perform 76–100% of OV injections at their sites. Four centers require no formal training; two require physician-led precepting; one requires internal credentialing. Two sites occasionally use ultrasound guidance; five do not. Three (42.8%) occasionally refer patients to interventional radiology (IR). 100% of respondents agree APPs are currently performing OV injections safely or are qualified to do so. Reported barriers include lack of training, APP schedule availability, and MD-only drug ordering policies. Institutional challenges include procedure time, limited APP staffing, space constraints, infection control, product thawing time, IR coordination, and cold storage. **Conclusions:** APPs effectively administer OV injections to superficial, clinically accessible malignant lesions in cutaneous oncology programs across multiple institutions. Institutions implementing OV therapies should utilize APPs and will need to focus efforts on overcoming barriers at the system level. Standardized training options would benefit APPs performing intralesional injections. **Recommendations:** Cancer centers should expand the role of APPs to include administration of intralesional injections, which may help increase patient access to effective therapies. Standardized training would support safe, effective implementation of OV therapies across cancer centers. An institutional champion for OVs can help facilitate OV implementation and help overcome institutional barriers.

JL1308C: Advanced Practice Provider-Led Care of Patients at End of Life (COPE) Pathway: Improving End-of-Life Transitions and Reducing In-Hospital Deaths in a Comprehensive Cancer Center Clinical Decision (Observation) Unit

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Background: The Care of Patients at End of Life (COPE) program is an Advanced Practice Provider (APP)-led initiative implemented in the Clinical Decision (Observation) Unit of a comprehensive cancer center. Developed to improve end-of-life (EOL) care and mitigate inpatient death rates, COPE offers a structured workflow for redirecting appropriate oncology patients to hospice services from an Observation setting, rather than inpatient admission. The program supports patient-centered goals while aligning with institutional quality metrics, including reducing in-hospital deaths that impact national

performance rankings. **Methods:** COPE was designed through interdisciplinary collaboration among APPs, hospital medicine, nursing, case management, social work, supportive care, and project management. Eligible patients include those who are imminently dying, enrolled in home hospice and experiencing acute symptoms, or seeking to initiate or transition hospice services. These patients are first identified in the Urgent Care Center and, if meeting COPE criteria, are transitioned to the Clinical Decision Unit under Observation status, where a dedicated team coordinates expedited hospice discharge. APPs serve as the clinical leads, initiating referrals and managing care plans. A provider survey was conducted to assess APP awareness, workflow comfort, and confidence in EOL discussions. Program performance was evaluated from February 2023 through January 2025 using internal dashboards and retrospective chart review. **Results:** Over the 24-month period, APPs consistently transitioned eligible patients to hospice directly from Observation, avoiding inpatient admission in the majority of COPE cases. Retrospective review identified numerous patients who were admitted to inpatient units and either died or transitioned to hospice within 3–7 days—indicating clear opportunities for earlier COPE intervention. Survey data showed strong APP awareness of the program, high perceived utility, and improved provider comfort with initiating goals-of-care conversations. Initial concerns regarding lack of palliative care training diminished with repeated use and supportive care backup. **Conclusions:** The COPE program demonstrates that APPs can lead EOL care transitions effectively in an acute oncology setting. Utilizing Observation status allows for timely, compassionate care without unnecessary hospitalization. This approach supports both patient-centered goals and institutional quality performance by reducing in-hospital deaths. **Recommendations:** Future efforts should focus on expanding eligibility criteria, embedding EMR prompts to identify potential COPE candidates earlier, and sustaining interdisciplinary collaboration. The COPE model may serve as a scalable blueprint for other oncology urgent care settings aiming to align compassionate EOL care with quality benchmarks.

JL1309C: Advanced Practice Provider-Led Model for Expedient Electrocardiogram Evaluation in Early-Phase Trials

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Background: A leading cause of non-approval and post-market withdrawals of oncologic drugs is cardiac sequelae. Thus, early-phase clinical trials require close cardiac monitoring to assess potential toxicities associated with investigational agents. Electrocardiograms (ECGs) are performed at multiple time points for patients on clinical trials, often with numerous ECGs performed on the same day. All ECGs must be evaluated for clinical significance by a provider listed as a protocol investigator. In a busy phase 1&2 oncology clinical trials practice, expedient review of ECGs is important to prevent dose delays, swiftly identify cardiac toxicities, implement appropriate medical interventions, and ensure protocol compliance. **Methods:** We implemented a team comprised of clinical trials advanced practice providers (CTAPP) with offsite clinical coverage dedicated to infusion suite management, including interpreting ECGs. ECGs that read as "Normal Sinus Rhythm" with QTc less than 450msec were automatically deemed clinically insignificant and did not require provider review prior to dosing. ECGs with other findings were deemed "abnormal" and sent electronically to the CTAPP team for review. We tracked time-to- response by a provider, written clearance of abnormal ECGs, and initiation of cardiac workup for the first twelve weeks of the pilot. **Results:** Over the twelve-week period, 111 abnormal ECGs were received. The average time to clearance was under 10 minutes. Of those, nine ECGs (8%) required further workup, and one ECG required consultation with on-call cardiologist (< 1%). No serious cardiac adverse events were identified during this time-period. **Conclusions:** Eliminating the need to review normal ECGs permitted a more focused and prompt response by reducing time between ECG completion and investigator clearance. This further led to timely patient dosing, swift identification of cardiac toxicities and subsequent workup, as well as compliance with protocol requirements. Designating a

CTAPP team to function as service coverage for all ECG clearances clarified contact ladders for infusion suite nurses, decreased duplicative work, and streamlined communication between clinic and infusion suites. **Recommendations:** Advanced Practice teams can streamline the ECG clearance process to decrease time to clearance by prioritizing abnormal ECGs for immediate review. Additionally creating a contact ladder was a critical element in the success of our pilot. As the role of the Clinical Trials APP is further delineated, infusion suite coverage for ECG clearance is a safe and practical role for CTAPP-led teams.

JL1310C: Advanced Practice Provider-Led Order Management Strategy During Electronic Health Record Implementation at a Leading Cancer Center: A Service-Based Approach to Ensure Go-Live Success

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Background: Transitions between electronic health record (EHR) systems are complex, high-stakes undertakings that require extensive planning and cross-disciplinary collaboration. At cancer centers, this process is further complicated by patient acuity, restricted medications, and specialty-specific workflows. Literature underscores the challenges of data migration during EHR transitions, including the risk of manual transcription errors and significant resource allocation (Penrod, 2017; Huang et al., 2020). At our institution, an EHR transition required a targeted, service-specific approach to safely and efficiently migrate inpatient orders, emphasizing the importance of assigning clinically experienced personnel to ensure data integrity and patient safety. Recognizing the limitations of nursing-only backloading models used in prior implementations, Advanced Practice Provider (APP) leadership proposed a novel strategy: embedding oncology-trained APPs directly into the order migration process. **Methods:** Nine months before go-live, a multidisciplinary working group was formed, including representatives from Nursing, Pharmacy, Admitting, APP leadership, and EHR vendor partners. Weekly meetings focused on mapping existing workflows and designing a migration strategy tailored to the inpatient oncology platform. APP leadership conducted census-based modeling to determine backloading needs and recruited 88 APPs across inpatient services—including solid and liquid tumor teams, surgical subspecialties, pediatrics, gastroenterology, anesthesia pain, and supportive care. APPs were co-located in a centralized workspace and organized by specialty, facilitating real-time collaboration, order verification, and peer consultation. APPs were tasked with transcribing service-specific orders, including complex medications, narcotics, and nutrition support, while nurses entered non-medication orders. **Results:** Using this APP-led, service-specific approach, a total of 575 patients were successfully backloaded into the new EHR—exceeding bed capacity and completed within a 15-hour window. By comparison, the EHR vendor noted that institutions relying solely on nursing for this process reported order entry taking between 24-48 hours. APP familiarity with service-specific regimens proved critical in mitigating transcription errors and accelerating chart readiness for go-live. **Conclusions:** Advanced Practice Providers play a pivotal role in EHR transitions, particularly in oncology environments where patient complexity demands service-specific expertise. Embedding APPs in the design and execution of the backloading process optimized workflow efficiency, upheld safety standards, and contributed to the seamless launch of a new enterprise EHR. Their deep clinical knowledge and familiarity with nuanced orders enabled rapid and accurate transcription, ensuring operational continuity. Cross-disciplinary collaboration with Nursing, Pharmacy, Admitting and the EHR vendor support was essential to the success of this initiative. **Recommendations:** Cancer centers preparing for EHR implementation should engage APPs early in the planning process and designate them as core contributors to service-level order migration. Leveraging APPs' clinical insight and familiarity with patient populations enhances safety, shortens transition timelines, and supports organizational readiness.

JL1311C: Advanced Practice Provider-Led Outpatient Lymphodepleting Chemotherapy Administration for Patients Receiving Tumor-Infiltrating Lymphocyte Therapy for the Treatment of Advanced Melanoma

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Background: In February 2024, lifileucel became the first FDA-approved adoptive cell therapy for the treatment of any solid tumor, and was specifically approved to treat advanced melanoma. This novel therapy, with its complex manufacturing and administration process, presented a steep learning curve for providers. The package insert specifies a lymphodepleting (LD) chemotherapy regimen of cyclophosphamide 60 mg/kg IV with mesna for 2 days, followed by fludarabine 25 mg/m^2 IV for 5 days before cell infusion. In clinical trials, preparative LD chemotherapy was given inpatient. Accordingly, many authorized treatment centers are administering LD chemotherapy in the inpatient setting. At our institution, we implemented an outpatient LD chemotherapy protocol led by advanced practice providers (APPs), including an expert cellular therapy APP on our cutaneous oncology team. Utilizing outpatient CAR-T protocols developed by our hematology colleagues, we implemented a 5-day "stacked" outpatient LD regimen prior to hospital admission for lifileucel cellular infusion. This project aims to document the APP role and the outcomes of this outpatient approach. Protocol Outpatient LD chemotherapy is administered for 5 days: cyclophosphamide and fludarabine on Monday and Tuesday, followed by fludarabine only Wednesday through Friday. APP-led visits occur daily for laboratory monitoring, toxicity assessment, intense supportive care, symptom management, education, appropriate antimicrobial prophylaxis, and treatment clearance. **Methods:** A retrospective chart review was performed to evaluate the outpatient LD chemotherapy process and the APP's role. De-identified data was collected on patients treated with commercial lifileucel between February 2024 and May 2025. Metrics included the percentage of outpatient LD visits completed by APPs, number of patients completing outpatient LD, early admissions, successful lifileucel infusions, hospital length of stay, and reasons for prolonged admissions or readmissions. **Results:** Thirteen patients received commercial lifileucel during the study period. APPs conducted 93% of outpatient LD visits, versus 7% by physicians. Two patients required early admission - one for fever and hypotension, and one for arrhythmia and hemorrhagic cystitis. Twelve patients completed lifileucel infusion on schedule; one experienced a delay. Two patients required prolonged admission– one for hyperbilirubinemia and weakness, the other for sepsis, seizures, and gastrointestinal bleed. Two patients were readmitted within 30 days, both due to infections. **Conclusions:** These findings reflect the complexity of tumor infiltrating lymphocyte (TIL) therapy and the high acuity of this patient population. Yet, 11 of 13 patients completed outpatient LD chemotherapy, preventing an estimated 77 inpatient hospital days collectively. Patients requiring hospital admission were identified and safely escalated to the inpatient setting. These results support the important role of APPs in outpatient LD chemotherapy. With expert APP oversight, outpatient LD administration can reduce hospital stays for TIL patients. **Recommendations:** Centers implementing cellular therapies such as lifileucel should consider outpatient LD protocols and utilize APPs trained in cellular therapies. It will be essential to better define the training for APPs in solid tumor cellular therapies. Continued exploration of APP-led outpatient models may reduce hospital stays, improve patient outcomes and satisfaction, and lower healthcare costs—benefiting not only melanoma patients but potentially those with other solid tumors in the future.

JL1312C: APPortunities: Advanced Practice Provider-Led Discussion Group to Promote Nurse Practitioner/Physician Assistant Workplace Well-Being

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Background: Burnout and compassion fatigue are problems frequently encountered by NPs/PAs in clinical practice. Current methods to improve burnout or compassion fatigue are focused on the individual. Limited opportunities exist to engage in self-care activities before or after work. In addition, increasing connection and communication among colleagues has been shown to improve employee morale and job satisfaction. **Methods:** With supervisor and division support, I created a lunch discussion group termed "APPortunities" for NPs/PAs working in outpatient and inpatient oncology at a large academic medical center. Lunch was complimentary

and provided by the oncology division. The idea was borne out of a previous discussion group at a JADPRO Braindate and a program available only to physicians at our center. To keep the group solution focused, a challenging work topic was chosen for discussion for each 45–60-minute guided lunch discussion. The meeting was not offered virtually or recorded to allow for candid discussion. Examples of guided discussion topics included imposter syndrome, managing difficult patients, and balancing APP autonomy. Groups met on average every 6-8 weeks. At the 12-month mark (after 9 sessions), the group was qualitatively surveyed anonymously via Microsoft teams survey regarding the impact of the group on measures such as burnout, connection, skills learned from colleagues and overall satisfaction with the programming. **Results:** 17 individuals responded to the survey with 82% [n=14] of participants having attended 1 or more sessions. Lack of time and competing meetings were identified as barriers to attendance. 100% [n=14] of participants indicated that APPortunities helped them feel more connected to their colleagues, answering strongly agree (78.5 %, [n=11] of participants) or agree (17% , [n=3] of participants). 100% [n=14] of participants felt that the program was valuable. Analysis of the free text statements highlighted themes such as increased connection to colleagues, validation of shared emotions, and acknowledgement of safe space to discuss difficulties faced at work. Responses also highlighted a sentiment of support and camaraderie amongst peers of varying age and clinical experience. Limitations of the study include small group size (on average 8-12 participants,) and variable attendance. In addition, no baseline survey was obtained to look for trends in burnout or compassion fatigue. **Conclusions:** Formation of a guided lunch discussion group positively impacted sense of shared connection in outpatient and inpatient NPs/PAs. Signals beyond connection included impacts on perceived burnout, skill sharing and a safe outlet to reflect on work/life difficulties with colleagues outside of a typical clinic setting. **Recommendations:** Additional research opportunities could include larger sample sizes and tailored activities to promote self-reflection and collaboration in the workplace while continuing the basic foundation of APPortunities: connection and support among colleagues.

JL1313C: Beyond Conventional Neurosurgery in the Oncology Patient: Development of a Neurovascular Interventional Radiology Program at a Large Academic Center

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Background: Oncology patients frequently face barriers to traditional neurosurgical interventions due to comorbidities such as thrombocytopenia, underlying malignancy, and anticoagulation therapy. As a result, many were historically excluded from potentially life sustaining procedures, including pre-operative embolization, hemorrhage control interventions and advanced chemotherapeutic delivery. The emergence of neurovascular interventional techniques offers a minimally invasive, image guided alternative to conventional surgery, particularly in high risk cancer populations. These procedures can enhance surgical planning, manage acute bleeding and enable direct, targeted delivery of anticancer therapies to intracranial and skull based tumors. **Methods:** In early 2023, a Neurovascular Interventional Radiology Program was launched at a large academic oncology center through the collaboration between Neurosurgery and Interventional Radiology. Initially, the program focused on intra-arterial chemotherapy delivery for skull based tumors – such as aggressive pituitary adenomas, chordomas and metastases – bypassing the blood brain barrier and improved drug bioavailability. Over time, the program expanded to include: - Middle meningeal artery (MMA) embolization in thrombocytopenic cancer patients to address chronic subdural hematomas and spontaneous hemorrhage - Pre-operative angiography to aid surgical planning and reduce intraoperative bleeding risk - Head and neck tumor embolization (facial, internal maxillary and lingual arteries) for acute or recurrent tumor -associated hemorrhage and epistaxis. All patients underwent standardized pre-procedural evaluation to assess candidacy and procedural safety. A dedicated post-procedural care pathway was implemented emphasizing frequent neurological assessments, neurovascular checks and clinical monitoring. **Results/Outcomes:** Since its inception in Janu-

ary 2023, over 150 neurovascular procedures have been successfully performed in oncology patients who otherwise may not have been candidates for traditional neurosurgical care. These included: - 60 MMA embolization - 38 Head & Neck embolization - 18 intra-arterial chemotherapy infusions - 42 Pre-op spine embolization - 22 Pre-operative Angiograms Procedural indications included refractory bleeding in thrombocytopenic patients, traumatic or spontaneous hemorrhage, tumor progressions and recurrent epistaxis. The minimally invasive nature of the interventions allowed access to care for patients who could not tolerate open surgery. Clinical outcomes demonstrated high technical success, minimal complications and improved symptoms control or surgical readiness in many cases. **Conclusion:** The implementation of a dedicated Neurovascular Interventional Radiology Program with a cancer center has significantly expanded treatment options for oncology patients traditionally excluded from neurosurgical interventions. These advanced, image guided techniques offer an effective alternative for tumor-directed therapy, hemorrhage control and surgical planning – particularly in high risk or coagulopathic populations. **Recommendations/ Implications for Practice:** This program highlights the importance of multidisciplinary collaboration and innovation in expanding the scope of care for oncology patients with CNS involvement. The model can be replicated in other high-volume cancer centers to improve access to life-sustaining therapies, reduce mobility and support more comprehensive oncological management. Further work is needed to quantify long-term outcomes and integrate neuro-interventional strategies for oncology patients with stroke.

JL1314C: Building an Advanced Practice Provider-Led Whole Person Care Survivorship Clinic

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Background: Cancer survivors have traditionally been provided care plans focused on risk reduction and prevention of recurrence, yet patients desire plans that include a whole person approach to their recovery needs. In 2023, our cancer team, serving five hospitals with over 1,500 beds, moved to create a whole person care survivorship clinic to equip patients with the tools and resources to promote recovery and overall well-being. An advanced practice provider (APP) was selected for the sole clinician-coordinator role. Prior to this effort, our system had no structured survivorship clinic. Our exploration led us to build a holistic approach to assist patients in coping with and managing emotional, spiritual, social, and physical changes experienced within cancer treatment. **Methods:** To develop the clinic, the McKinsey 7-S model was utilized over 12 months. We first established strategy (1) and structure (2) and identified dedicated champions (staff-3). To ensure alignment with national standards of survivorship, we referenced the National Standards for Cancer Survivorship Care Toolkit, published in 2016. To guide the whole person care conversations and document patients' needs and goals, each patient completed the personal health inventory, adapted for use in oncology, to document health goals in the medical record (systems-4). Prework included the advanced practice provider's completion of additional training in palliative and whole person care (skills-5) and 20 hours spent with a grant-funded consultant with expertise in whole person cancer care. To gain additional support, the advanced practice provider connected with stakeholders to educate and explain the clinic's unique approach (style-6) and alignment with the team's shared values (7). **Results:** By July 2025, six weeks into the clinic rollout, 12 patients completed whole person care survivorship visits and ten additional patients await scheduling; all patients completed personal health inventories to inform care planning and document what mattered most to them in their record. At follow-up, all patients reported the intake visit was beneficial, and all had documented SMART goals in the electronic health record and reported continued progress toward meeting their goals. The most reported patient goal is to become stronger and/or increase physical activity. Five patients were referred to the local exercise program. Additionally, three were referred to physical therapy and two to the clinic's co-located oncology dietitian. One patient was referred to mental health counseling. **Conclusions:** Whole person cancer care provided in a new APP-led survivorship clin-

ic is feasible and beneficial for patients. Referrals to physical therapy and exercise programs assist survivors in meeting goals of increased activity. To drive additional referrals, more communication is needed to help oncology providers and patients better understand the benefits of a supportive survivorship clinic. Leadership support is integral to moving from shared values to structure and allowed for whole person care in survivorship to expand within our large health system. **Recommendations:** Increase communication beyond the oncology service line to help primary care providers identify patients appropriate for referral. Additionally, oncology nurse navigators can educate patients on whole person care and identify and refer patients interested in a recovery model of care.

JL1315C: Caring for the Caregiver: How an Enrichment Committee Has Improved Morale for Outpatient Medical Oncology Advanced Practice Providers

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Background: The Medical Oncology Outpatient Advanced Practice Provider (APP) Enrichment Committee (EC) was established in January 2023. Like most, the pandemic weighed on APPs at our academic center. While our main campus and satellite locations had previously had enrichment committees, there had never been a specific one for the APP group. At that time, we had approximately 46 APPs. I decided to create our own EC and asked for volunteers to help with giving care to our peers. **Intervention:** The EC is described across our institution as one that strives to celebrate achievements and milestones, bring an element of fun and comradery to staff by organizing seasonal festivities and setting up fun events outside work. This committee also focuses on how to best appreciate the efforts of staff members and minimize compassion fatigue. Each January, we collect donations for EC funds from anyone in our group that wants to. For the past 2.5 years, we have had quarterly happy hours, fun giveaways, and we recognize everyone's birthday with a treat. We put together "ASCO survival kits" for our APPs that stay behind during this busy time of year when the oncologists attend ASCO and we are covering clinics. We put together gifts for APP week. We put on our first APP Gala last fall and had a silent auction where we donated all the funds raised to our patient care fund. We adopt a local family around the holidays and last year we collected more than we had previously. We give shoutouts when we get a new AOCNP in our group, new baby, new marriage, etc. **Findings:** At the end of the year, I send out a survey asking what we should change, what were the biggest hits, etc. What we've found is people love having events outside of work so that they can interact with colleagues that they don't typically see because of alternating clinic schedules, different practice locations, etc. This has helped to build more comradery within our group of APPs, especially when we are asked to help in other clinics. We have found that receiving a coffee on their birthday or just having someone say, "Happy Birthday!" has made our providers feeling appreciated at work. We have an APP support group called "what you can't take home." This support group is a monthly meeting where APPs can share some of the things they are dealing with in the oncology clinics, challenging cases, venting about being working parents, etc. We're there to lend an ear as a peer. **Summary and Recommendation:** APPs in oncology are often overlooked for all that we are. Our EC has served a need for taking care of one another. The work we do is meaningful. The time we give is valuable. Everything we pour out of our cups for our patients needs to be refilled, and we can help to do that for one another. My recommendation is to establish an EC at your own institutions and take care of the caregivers.

JL1316C: Developing a Signature of Evidence-Based Care Across a Large Comprehensive Cancer Center Utilizing Clinical Decision Pathways

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Background: This large comprehensive cancer center is comprised of 5 hospitals and 15 ambulatory centers. Traditionally, each center has been responsible for developing their own clinical practice guidelines (CPG) and workflows. There was no mechanism to ensure standardization of care

between centers and there were significant variations of care particularly in areas that lacked strong national guidelines. To ensure that patients are getting the same evidence-based care across each center, pathway creation became essential. A pilot initiative began in July 2023 with 3 disease specific committees to standardize practice across centers through the development of clinical decision pathways (CDPs). Other disease teams expressed interest in this process and broad themes that impacted the entire cancer population were identified. **Methods:** An Advanced Practice Provider (APP) leadership established a general cancer council (GGC) in August 2024 with support from the cancer center leadership. The GCC was developed using project management methodology and a charter was created. Multidisciplinary stakeholders across the organization were invited to participate. A process for identifying and prioritizing pathways was created by the APP leads. A pathway request form was constructed that incorporated five domains: 1) impact/potential benefits, 2) best practice, 3) feasibility/implementation, 4) user experience/adoption and 5) investment/funding availability. Each domain was scored by the APP leads and presented to the GCC to help prioritize each request. Institutional stakeholders (ie. APPs, MDs, PharmDs), from each clinical setting, were identified to participate in APP led clinical consensus groups (CCGs) to develop CDPs. The CDPs are fully integrated into the electronic medical record (EMR) to improve access to evidence-based recommendations. The CDPs allow for a comprehensive tool at the point of care. The integration is specific to institutional workflows and allows for interventions linked to EMR ordering, patient education and other tools. They encourage interdepartmental collaboration across the trajectory of care to view the patient as an individual rather than treating the patient in department silos. **Results:** The GCC has supported the development of 40 CDPs spanning multiple specialties and departments with over 150 stakeholders participating in the CCGs. Since July 2023, CDPs have been utilized 86,332 times by 2,457 distinct providers impacting care for 8,650 patients. The scope of CDPs are beyond disease specific management. They provide an opportunity for integration and modification of existing system policies. CDPs focus on standardization of care, workflow efficiency, disease management and treatment related complications. CDPs are comprehensive tools integrated into the EMR. CDPs have increased access to care, inter-departmental collaboration as well as ensured evidence-based practice across the system. **Conclusion:** The development of the council, using a project management methodology, as well as the creation of the pathways, has led to standardization of care, workflow efficiency and more individualized care. The pathways are used as tools for training and orientation and have empowered APPs to have evidence-based conversations with their APP and physician colleagues. These pathways are easily accessible, dynamic and allow for changes when new research is published, making our institute early adapters of new cancer treatments and technology.

JL1318C: Development and Implementation of an Advanced Practice Provider Oncology and Hematology Fellowship at a Large Community Oncology Practice

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Background: Advanced practice providers (APPs) play an increasingly vital role in meeting the growing demand for cancer care. Most nurse practitioner and physician assistant programs cover limited content in the specialty areas of oncology and hematology. Accelerated onboarding of APPs without addressing the need for specialty education can lead to frustration and costly turnover. Fellowships which provide educational experiences in oncology and hematology have traditionally been centered in academic institutions. There is a need for structured educational programs to better prepare new graduate APPs for specialty practice in the community oncology setting. **Purpose:** The purpose of this pilot project is to develop and implement an APP Oncology and Hematology Fellowship in a large community oncology practice. The goals of the fellowship are to prepare new graduate APPs to provide high quality cancer care,

to increase job satisfaction, and to improve retention among graduates of the fellowship. **Methods:** The APP Director and APP Education Lead for the practice were identified as primary leaders for the fellowship. A Fellowship Planning Committee was established with nurse practitioners and physician assistants from a variety of practice areas including medical oncology, hematology, radiation oncology, and palliative care. Physician champions also participated in the planning process. The structure and curriculum for a twelve-month fellowship was developed using current literature and Advanced Practice Provider Fellowship Accreditation (APPFA) guidelines for certification. This structure included classroom and self-guided didactic experiences aligned with 11 clinical rotations. Professional development activities were incorporated in the curriculum and the fellow was expected to complete a quality improvement project. APPs and physicians across several clinical areas served as faculty for classroom days. Experienced APPs completed preceptor training prior to serving as clinical preceptor or mentor. There were prespecified metrics to evaluate the education component of the fellowship pilot including didactic day, clinical rotation and preceptor evaluations by the fellow. A tool was developed for fellows' self-evaluation of knowledge and confidence in multiple clinical areas administered at three time points. **Evaluation:** The pilot cohort of one fellow started in October 2024 and is expected to complete the fellowship in September 2025. Findings from self-evaluation tool demonstrate significant improvement in knowledge and clinical confidence from baseline to 6 month timepoints including key disease states and caring for patients on treatment. Feedback from classroom day, clinical rotation and preceptor evaluations will be used to improve the fellowship in the future. Feedback from physicians who serve on the faculty and at clinical rotation sites has been overwhelmingly favorable. **Discussion and Recommendations:** An APP Oncology and Hematology Fellowship can be successfully implemented in a large community cancer practice. A fellowship coordinator with dedicated administrative time, physician champions, and a thoughtful process for fellow selection contributed to the success of this pilot which is now an enduring program. APPFA guidelines and resources from specialty professional organizations are essential for program development and implementation. An APP fellowship is a pipeline of clinical talent into a cancer practice and helps new graduate APPs become well-prepared for a career in oncology and hematology.

JL1319C: Empowering Change: A Multidisciplinary Model for Tobacco Cessation in Community Oncology

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Background: Despite a significant decline in smoking rates in the US over the past three decades, cigarette smoking continues to be the leading cause of preventable and premature death in the US, accounting for approximately 30% of all cancer deaths (Lowy et al., 2022). With a concurrent cancer diagnosis, cigarette smoking increases the risk of recurrence, risk of secondary cancers, and all-cause mortality. It raises the risk of surgical complications, including infection and impaired wound healing, as well as increased risk of radiation toxicity, chemotherapy side effects, poor pain control, respiratory distress, and reduced treatment effectiveness (Peppone et al., 2011). A cancer diagnosis can be a motivational factor in quitting; however, many patients are not offered evidenced based cessation treatment (Lowy et al., 2022). **Intervention:** At Astera Cancer Care, our aim was to improve smoking cessation efforts. Our practice lacked any tangible efforts to aid patients in this process. A multidisciplinary approach was decided upon, including the Advanced Practice Provider (APP) and Social Work teams. An initial group of staff, including three social workers and one APP, attended a 2-day skills-based workshop in tobacco cessation in October 2024. Assessment and Treatment of Tobacco dependence in Cancer Care provided education on evidence-based methods of cessation, including behavioral interventions and medication management. This includes empathic assessment, cessation attempt history and developing personalized advice on cessation. Role-playing with patient "actors" reinforced learning through real time practice. A second group of three APPs attended the

program in May 2025. The workshop is followed up by monthly videoconference calls to allow for ongoing collaboration. The Tobacco Cessation Program at Astera was designed to apply these elements in a multidisciplinary approach. A referral is placed by a provider in the electronic medical record for tobacco cessation. The patient is contacted by social work and offered enrollment. The program includes initial assessment by social work followed by a visit with an APP within 48-72 business hours. They are scheduled for routine follow up, meeting the APP weekly for four weeks and then as needed, and with social work weekly for ongoing behavioral and motivational intervention. **Findings:** We began advertising and outreach in January 2025. The first patient was enrolled on 3/4/2025. In the first three months, twelve patients have enrolled in Tobacco Cessation. Three patients withdrew before starting the program; five patients have completed and successfully quit, and four are currently enrolled. **Implications/ Barriers:** Barriers to enrollment in tobacco cessation include accurate tobacco use assessment, lack of adequate insurance reimbursement for visits, provider referral and awareness of the program, patient engagement/follow up and readiness to quit. Initial barriers did include lack of APP availability for medication management; however, with the training of more APPs this has improved. We plan to grow the program with expanded advertising and provider education and engagement.

JL1320C: Enhancing Emergency Preparedness: Implementation of a Rapid Response System in a Community Oncology Outpatient Setting

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Background: Patients receiving chemotherapy, immunotherapy and other complex drugs in outpatient oncology clinics are at risk of acute clinical decompensation. Following the COVID-19 pandemic, prolonged emergency medical services (EMS) response times were noted with an average of 13.25-minute response time documented for the time frame November 2021-August 2022. Historically, delays in escalation of care have led to prolonged hospitalizations, patient distress, and poorer patient outcomes. In a community setting, the lack of on-site inpatient support amplifies this risk. These factors highlighted a critical need for on-site emergency readiness. **Methods:** Clinical staff were required to undergo life-saving training courses including Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or both. All Advanced Practice Providers (APPs) were required to maintain ACLS certification as of September 2020. Internal ACLS courses were implemented starting in June 2021, with crash carts being placed at each clinic site as of April 2022. Quarterly mock codes were introduced starting in June 2023 to maintain clinical skills and confidence. Daily pre-assigned rapid response roles were proposed in all clinical areas. A survey regarding staff confidence in rapid response situations was distributed in July 2025. The survey contained questions regarding staff confidence in rapid response situations. The survey also aimed to rate the impact of training and mock code drills on team responses. **Results:** 22 rapid response events were recorded via Incident/Accident (IA) report during 2024. As of July 2025, there have been 16 recorded rapid response events in 2025. A survey of 58 employees including APPs, nurses and site coordinators used a rating system where 1 represents 'not confident at all' and 5 represents 'very confident'. Results showed an average rating of 4.36 for overall staff confidence in responding to a rapid response event. 79% of those surveyed were involved in one or more rapid response event within the last 12 months. Of those involved, an average rating of 4.63 was given as confidence in the level of care the patient received during the rapid response event. 100% of those surveyed felt that ACLS and/or BLS training somewhat or significantly improves overall team response during rapid response events. 98% of those surveyed felt that mock code drills somewhat or significantly improve overall team response during rapid response events. 50% of those surveyed said their team utilizes pre-assigned rapid response roles, and 86% of those feel that preassigned roles increase team performance and coordination. **Conclusions:** The implementation of an internal rapid response system supported by structured training and quarterly mock codes reduced time to life-saving measures and strengthened staff prepared-

ness. Staff reported improved confidence levels and satisfaction in managing acutely ill patients. This approach offers a scalable and sustainable model for enhancing patient outcomes and safety in community-based outpatient oncology care. **Implications for Practice:** Outpatient community oncology clinics can benefit from implementing on-site rapid response protocols to bridge gaps in emergency care. Investing in life-saving training courses and regular simulation exercises improves team performance and confidence leading to improved patient outcomes and patient safety.

JL1321C: Establishing and Sustaining Hepatic Artery Infusion Programs: The Essential Role of Advanced Practice Providers

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Background: Hepatic artery infusion (HAI) therapy is a promising liver-directed treatment recognized by The National Comprehensive Cancer Network (NCCN) for select patients with colorectal liver metastases and intrahepatic cholangiocarcinoma. While successful outcomes have been demonstrated at high-volume institutions, many centers lack a structured framework to support HAI program implementation and long-term sustainability. As utilization of HAI therapy grows, challenges persist in integrating this complex modality into practice due to the need for seamless collaboration across multidisciplinary teams, including surgical oncology, medical oncology, pharmacy, infusion services, and radiology. Advanced Practice Providers (APPs) are uniquely equipped to address these gaps. Through clinical expertise, operational insight and cross-functional communication, APPs enhance care coordination and program continuity. In successful programs, they frequently serve as the consistent point of contact throughout a patient's HAI treatment journey. Despite this, their contributions are often informally defined and standardized institutional workflows are lacking. A structured APP-led framework is needed to guide comprehensive program development. **Context:** APPs play a central role in both establishing and sustaining HAI programs. Their responsibilities commonly include: patient identification and eligibility evaluation, pre- and post-operative care coordination, scheduling and workflow management, pharmacy collaboration and refill planning, pump troubleshooting and symptom triage, interdisciplinary staff and patient education. By bridging clinical and operational workflows, APPs improve efficiency, strengthen interdisciplinary communication, and support high-quality patient care, particularly in the absence of a formal implementation model. **Methodology:** This abstract outlines critical APP touchpoints across the HAI therapy continuum, incorporating perspectives from a Medical Oncology APP and a Surgical Oncology APP. Both individuals participate as leaders in program development at high-volume academic centers. A visual workflow will be presented to illustrate the stages of care where APPs demonstrate the highest clinical impact. To further assess interdisciplinary perspectives on the role of an APP in an HAI program, an anonymous survey was distributed to physicians, pharmacists, APPs, infusion nurses, and nuclear medicine technologists. The survey aimed to evaluate the perceived value, feasibility, and clinical impact of APP-led workflows within HAI programs, particularly in the absence of standardized institutional models. Results: Across programs, a consistent framework emerged in which APPs were engaged in every phase of care from patient selection through refill coordination and administration, demonstrating their role as anchors of continuity and interdisciplinary collaboration. A visual model outlining this workflow will be shared to illustrate the replicable nature of this APP-led approach. Among 21 survey participants, 95% agreed that APPs are essential to a successful HAI program. Key contributions identified included patient education, coordination of care, refill support, and pump troubleshooting. One respondent cited variability in APP familiarity with workflows, underscoring the importance of standardized training and role clarity. **Conclusion:** APPs are pivotal to the implementation and durability of HAI programs, particularly in the absence of a universal operational framework. Their multidisciplinary engagement enhances care delivery, team coordination, and patient outcomes which was evident among surveyed participants at these organizations. Continued institutional support

for APP training, leadership, and collaboration is critical to advancing scalable, sustainable HAI program models.

JL1322C: Evaluation of an Oral, Skin, and Line-Care Bundle to Reduce Gram-Positive Bacteremia Readmissions in Patients with High-Grade Myeloid Neoplasms Undergoing Induction Therapy Managed in the Outpatient Setting: A Quality Improvement Pilot Study

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Background: At our center, adults with high-grade myeloid neoplasms are routinely discharged immediately following receipt of intensive induction chemotherapy ("early hospital discharge" [EHD]) and managed until blood count recovery in the outpatient setting. We have previously shown EHD to be safe and associated with shorter hospital lengths of stay and decreased health care resource utilization. However, while overall infection rates were similar between EHD patients and those remaining inpatient, gram-positive bacteremias were more common in EHD patients. Given gram-positive bacteremias most commonly arise from central venous catheters (CVC), skin, and mucosal sites, we hypothesized that differences between CVC and skin care in the outpatient vs. inpatient setting (e.g., daily chlorhexidine gluconate [CHG] baths used inpatient are not continued outpatient; lack of standard education for CVC and oral care after discharge) might account for this difference. **Methods:** We implemented a QI project which included an oral, skin, and CVC care bundle focused on decreasing the risk of gram positive bacteremias by extending current inpatient standards to the outpatient setting, including provision of CHG wipes for outpatient use, standardization of patient education on CVC, and oral care. Data were collected from medical records and patient surveys. The primary outcome was the rate of readmissions for gram-positive bacteremias as compared to historical control; secondary outcomes included wipe adherence, and wipe toxicities. **Results:** We enrolled 50 patients, 28 (56%) of whom adhered to the intervention as planned. Of the 22 who did not receive the intervention, 7 did not use the wipes due to skin rash from prior therapy, not receiving the wipes or feeling too poorly, 10 did not have any documentation of using the wipes, and 5 were hospitalized within 48 hours of discharge and thus did not have the opportunity to use the wipes. In the 28 evaluable patients (median age 61), 22 had PICC lines and 6 had tunneled CVCs. Twenty-four patients received antibacterial prophylaxis with levofloxacin, 3 with cefpodoxime, and 1 with cefdinir; all were on antiviral and antifungal prophylaxis. Eleven (39%) of the patients were admitted for gram positive bacteremia compared to 48% of historical control. More specifically, the most common gram-positive infection types were streptococcus mitis and coagulase negative staphylococcus. Eleven further patients were admitted for other reasons such as other infections and chemotherapy toxicity. Non-gram-positive infections varied, with some being gram negative bacteremia or fungal infections. No toxicities were reported from wipe use. **Conclusions:** Based on the results in this small cohort, despite poor adherence with the use of the CHG wipes, this QI bundle was associated with decreased rates of gram-positive bacteremia compared to the historical control in AML patients discharged after intensive chemotherapy. **Recommendations:** Our next steps will include enrolling 50 patients who actually receive the full intervention to better evaluate its efficacy. If these results confirm decreased rates of gram-positive bacteremias, we will plan to implement this QI bundle as the standard of care at our institution with the goal of decreasing hospital readmissions in AML patients.

JL1323C: Expanding Access to Oncology Infusion Centers Through a Clinical Decision Pathway

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Background: This large comprehensive cancer center is comprised of 5 hospitals and 15 ambulatory centers. Traditionally, infusion treatments are scheduled at the location of the treating provider and linked to provider visits. At times, patients prefer to see providers at one site but get treated closer to home at alternative infusion site

particularly when frequent infusions do not require a provider visit; however, this was difficult due to the significant variation in workflows between sites. This leads to delays in treatment, longer appointments, limited provider access and, at times, increased commutes for patients. This inefficient workflow is a patient dissatisfier and limits the number of treatments due to chair availability and causes treatment delays. The Advanced Practice Providers (APPs) identified a need to improve workflow, decrease treatment delays and enhance access to alternative infusion sites based on patient preference or location. **Method:** An APP lead clinical consensus group (CCG) was established, including institutional leadership stakeholders (APPs, RNs, MDs), from the infusion centers and hospitals. The goal was to standardize a process for patients to receive treatment at alternative sites. A clinical pathway was developed as a tool to provide clinical guidance and facilitate documentation through EHR flowsheets. The APP lead CCG convened bi-weekly. The initial part of the pathway includes identifying the treating team that is responsible for treatment selection, ordering of treatment plans, modifications and clearance to treat. It guides the physicians and APPs in documentation of treatment requirements (ie frequency, length of treatment, selection of alternative infusion site, provider contact information). This populates a flowsheet in the EHR for communication to the alternative infusion site and opportunity for data analysis. Step two outlines the required elements of care that must be completed prior to referral to an alternative site. Providers are encouraged to utilize unlinked visits and see patients 24-48 hours prior to treatment for lab review and clearance to treat. The pathway designates the covering APP or physician for the day of treatment toxicity assessment and acute emergency management. A "boarding pass" was created to inform APPs of the requirements necessary to facilitate subsequent visits. **Results:** The pathway was launched March 2025 and has been utilized 48 times in the first 8 weeks, decoupling visits and improving workflow efficiency. The initial feedback from APPs and RNs is that the pathway improves inter-site collaboration and communication and enhances patient satisfaction. The plan is to reassess the workflow in 6 months. **Conclusions:** The tools incorporated into this pathway have the potential to increase chair availability and workflow efficiency by guiding providers towards unlinked visits that require clearance to treat, orders signed, and labs resulted prior to treatment. It also increases patient satisfaction when care is standardized and streamlined. Patients will now have the choice to be treated closer to home while continuing with their preferred provider. Utilizing this all-encompassing pathway provides the source that will ultimately lead to improved workflow, increased documentation, better communication between sites and increased patient satisfaction.

JL1324C: Expanding the Advanced Practice Provider Footprint: Bridging Clinical Care and Oncology Informatics

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Background: The integration of Advanced Practice Providers (APPs) into medical informatics is an underutilized opportunity, particularly in oncology. Traditionally, provider informaticist roles have been physician-dominated, despite the growing presence and expertise of APPs in clinical operations and workflow optimization. This abstract describes the professional journey of a clinical PA at a comprehensive cancer center who transitioned into the role of an oncology provider informaticist. As the institution's first APP to hold this position, this abstract highlights the continued professional growth of the APP role while advocating for increased representation in such transformative initiatives. **Methods:** Professional development into the role of an oncology provider informaticist was achieved through a multifaceted approach grounded in formal education, longitudinal mentorship, and system-level collaboration. The role involved completion of a 40-hour builder course to develop foundational knowledge in data structure, clinical content customization, and system workflows. Simultaneously, the oncology provider informaticist engaged in longitudinal one-on-one mentorship with the Associate Chief Medical Information Officer, focusing on the practical application of informatics principles to oncology workflows. To ensure alignment with institutional priorities and provider needs,

routine meetings were also held between the informaticist and oncology leadership. This strategic positioning allowed for the identification of high-impact gaps and the streamlined development of advanced clinical decision support tools to enhance patient care processes and outcomes. **Results:** The integration of an oncology APP into the informatics leadership structure has led to: 1. Improved provider satisfaction and reduced documentation and cognitive burden across the oncology service line 2. Increased standardization in disease-specific workflows through implementation of optimized clinical decision support tools 3. Successful implementation of an interdisciplinary workflow that enhanced patient access and infusion capacity 4. Recognition of APPs as key clinical and operational stakeholders within a large institution's informatics space. **Conclusions:** Throughout the history of medicine, APPs have demonstrated the meaningful impact they have on institutional growth. By bridging the gap between clinical operations and IT, oncology APPs elevate the quality, safety, and sustainability of cancer care delivery—while expanding the APP footprint in healthcare leadership. **Recommendations:** The expansion of oncology APP informatics is being further developed with the creation of new roles, such as provider champions who serve as front-line clinical support for the development of new decision support tools and the exploration of AI-focused pathways. APP-led informatics projects in quality improvement should be encouraged. Furthermore, the informatics leadership pathway should be recognized as part of the APP clinical ladder advancement.

JL1325C: Exploring the Impact of Evening Dosing on Venetoclax-Related Gastrointestinal Toxicities in Patients With Chronic Lymphocytic Leukemia

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Background: Venetoclax is an effective BCL-2 inhibitor, indicated for the treatment of chronic lymphocytic leukemia (CLL). Patients treated with venetoclax complete 1-2 years of therapy and are instructed to take venetoclax once daily by mouth with a high fat meal. While therapy is generally well tolerated, gastrointestinal (GI) toxicities such as diarrhea, nausea, flatulence, and bloating are commonly reported non-hematologic toxicities, occurring in >20% of patients. Supportive medications, including anti-emetics and anti-diarrheal agents are often prescribed to manage GI toxicities. However, numerous anecdotal reports suggest that GI symptoms can be effectively managed by adjusting venetoclax dosing to the evening with a meal. There is currently no published data on the efficacy of this intervention. At a large academic cancer center, where over 300 CLL patients were treated with venetoclax between 2018-2024, nurse practitioners observed an improvement in GI symptoms when the time of dosing was adjusted. As such, a retrospective chart review was performed to better characterize the GI toxicities associated with venetoclax, and understand the impact of dosing with an evening meal. **Methods:** This was a retrospective chart review. A list of CLL patients treated with venetoclax between 2018 – 2024 was generated using medication reconciliation lists in the EMR. A manual chart audit was then performed to identify patients who developed GI toxicity on treatment. **Results:** 163 CLL patients were included in this analysis. Of those treated with venetoclax, 60.12% (n=98) reported a GI toxicity of any grade attributed to venetoclax. Of those patients reporting GI symptoms, 60.2% (n=59) experienced diarrhea, 51.0% (n=50) nausea, 14.3% (n=14) flatulence, and 13.3% (n=13) dyspepsia. The onset of these symptoms most frequently occurred during the dose escalation period or within the first 3 months on full dose venetoclax. The most common strategy documented for managing GI toxicities was prescribing supportive medications alone, occurring in 37.8% (n=37) of cases. 20.4% (n=20) of patients received no intervention for their GI symptoms. Adjusting venetoclax dosing to evening dosing alone was recommended in 17.4% (n=17) of patients and 16.3% (n=16) of patients were advised to trial evening venetoclax dosing along with an additional intervention (i.e. supportive medications). Of the patients who transitioned venetoclax dosing to evening, 76.74% (n=33) reported improvement and/or resolution of their GI symptoms. **Discussion:** The results illustrate the high prevalence and variability of GI toxicities

reported amongst patients treated with venetoclax. Dosing with an evening meal appeared to be an effective strategy in managing GI symptoms, with >75% of patients reporting improvement and/or resolution of GI toxicities after transitioning to evening dosing. This intervention was also effective in addressing various GI toxicities, highlighting this intervention is multipurpose and may reduce the number of additional supportive medications that patients require to address each individual GI side effect. A limitation of this study was the small number of patients who trialed evening dosing. Future efforts should be made to study the effect of evening dosing in a more controlled setting and with a larger population to further validate the results of this study.

JL1326C: Facilitating Evaluation of Potential Hematology Diagnoses and Prioritizing Referrals to Classical Benign Hematology Utilizing Clinical Decision Pathways

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Background: This large academic medical center (AMC) comprises 5 hospital delivery networks, including hundreds of ambulatory care offices providing care for a wide range of diagnoses. Benign hematologic laboratory findings are common, particularly in patients with comorbid medical conditions. Providers throughout the AMC historically refer most patients with abnormal hematologic labs to the Classical Hematology Department (CHD) within the Cancer Center. CHD providers specialize in the management of nonmalignant hematologic disorders. The CHD receives over a hundred referrals per month from diverse providers (eg inpatient, ambulatory, PCPs, specialists, etc) via fax, email, telephone, and electronically. Many referrals lack relevant medical information. There is wide variability in preliminary evaluation of the abnormality or differential diagnosis, including potential for malignant hematologic disorders. The CHD, General Cancer Council (GCC) and the Advance Practice Providers (APPs) identified that there lacked a systematic method of prioritizing scheduling of patients based on risk, often leading to delays in evaluation and management. **Method:** The CHD, GCC and APPs prioritized the development of integrated clinical decision pathways (CDPs) to facilitate early evaluation, risk stratification, treatment, and referral scheduling for common benign hematologic diagnoses. It was recognized that a strong partnership with the Primary Care Council (PCC) was necessary to ensure success. An Oncology and PCC APP collaborated to lead clinical consensus groups (CCG) of stakeholders in the development of the CDPs. The initiative began in July 2023. CHD identified the top twenty referral diagnoses. The CCG utilized a robust project management methodology to assure evidence-based CDPs. CDPs were developed for iron deficiency anemia, erythrocytosis, lymphocytosis, thrombocytosis, elevated ferritin and concern for bleeding disorders. CDPs are integrated into the electronic medical record (EMR). CDPs guide the referring providers in ordering evaluation strategies (e.g., labs, diagnostics) and appropriate placement of referrals (e.g., benign hematology, malignant hematology, other) based on risk stratification. The iron deficiency anemia pathway guides initial enteral and parenteral iron supplementation with treatment orders embedded into the CDP, which decreases time to treatment and possibly decreasing the need for CHD referral. **Results:** During 2024 the six pathways were developed, integrated into the EMR and launched. The APP leads utilized several strategies to educate stakeholders about the CDPs. Dissemination efforts included specialty town halls, internal medicine and primary care grand rounds, mass email, site visits and departmental staff meetings. During the first six months the CDPs have been used 538 times by 182 distinct providers. Stakeholder feedback, including the CHD, has been positive in facilitating patient evaluation and prioritization of referrals. **Conclusion:** These CDPs provide evidence-based guidance on the initial evaluation of abnormal hematology findings at the point of care. They incorporate tools to facilitate timely introduction of diagnostic strategies, treatment, and recommendations for monitoring patient progress. The CCG plans to develop CDPs for several additional abnormal hematology conditions over the next year. Metrics for use will be assessed every three months.

JL1327C: Hospital-Based Outpatient Delivery of Chimeric Antigen Receptor T-Cell Therapies in Hematologic Malignancies: An Advanced Practice Provider-Led Model

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Background: Hospital-based outpatient programs have enabled the safe administration of chimeric antigen receptor T-cell (CAR T-cell) therapies in the ambulatory setting, reducing the need for inpatient hospitalization. At a large academic cancer center, an outpatient immunotherapy program led and staffed entirely by advanced practice providers (APPs) delivers these therapies to patients with lymphoma and multiple myeloma. This initiative expands upon previously presented data to offer updated real-world outcomes and highlights the critical role of APPs in care coordination, treatment delivery, and clinical decision-making. **Methods:** A retrospective review was conducted of all patients who received U.S. Food and Drug Administration (FDA)–approved CAR T-cell therapy at a large academic medical center between January 1, 2018, and January 27, 2023. Data were abstracted from HBO tracking tools, clinical documentation, and pharmacy records. Key outcomes included: 1. Visit volumes and practice patterns in APP-led care 2. Hospital admission rates following outpatient HBO treatment 3. Utilization of community paramedic (CPM) services and their impact on outcomes and resource use This abstract presents interim findings; final results will be shared at the conference as part of an ongoing practice-based outcomes project. **Results:** APP Visit Volume: APPs led 1,937 total visits over this time for 171 patients, averaging approximately 11 visits per patient over the 30-day monitoring period. Hospital Admissions: Out of the 171 patients, approximately 15% (n: 26) of patients were managed entirely in the HBO setting and never required admission; these visits were entirely led by APPs. The remainder of patients were admitted for a variety of reasons including neutropenic fevers, electrolyte abnormalities, cytokine release syndrome, immune effector cell-associated neurotoxicity syndrome, and failure to thrive. Community Paramedic Collaboration: 80 patients were considered eligible for the community monitoring program that collaborates with local paramedics. Out of the 80 patients a total of 26% (n: 21) were enrolled in the program and reduced overall visits. **Conclusion:** This analysis reinforces the central role of APPs in delivering safe, high-volume outpatient care for CAR-T recipients. Their timely recognition and management of CRS, along with collaboration with CPMs, supports a scalable care model that minimizes hospital utilization without compromising safety. Initial findings from our cohort provide compelling evidence to support expanded APP roles in outpatient immunotherapy management; final data and subgroup analysis will be available at the time of presentation. Comprehensive results from the expanded 2024 dataset, including subgroup comparisons and outcome trends, will be presented at the conference.

JL1329C: Implementation of an Interdisciplinary Clinical Pathway to Treat Chemotherapy-Induced Peripheral Neuropathy

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Background: Chemotherapy-induced peripheral neuropathy (CIPN) affects approximately 30% to 60% of cancer patients undergoing treatment. CIPN is often resistant to medication, manifesting as chronic pain and sensory symptoms that may persist for years after the completion of chemotherapy. This condition significantly affects patients' quality of life, safety, and overall functioning. Due to its complex pathophysiology and the limited effectiveness of current single-modality treatments, CIPN poses challenges for healthcare providers. A structured, collaborative, multimodal, and interdisciplinary approach to pain management can enhance the quality of care. Despite consistent recommendations advocating for the interdisciplinary management of cancer pain, barriers such as providers' lack of knowledge, inadequate care coordination, and poor communication hinder effective implementation. This project introduced an evidence-based, interdisciplinary CIPN clinical pathway to improve advanced practice providers' (APPs') understanding of the in-

terdisciplinary management of CIPN, increase referrals to appropriate specialty services by identifying key disciplines and simplifying the referral process, and assess the feasibility of this intervention in this ambulatory oncologic setting with this population of APPs. **Methods:** A CIPN interdisciplinary clinical decision pathway based on best practices from the ASCO and ESMO-EONS-EANO Clinical Practice Guidelines was implemented using a prospective pre-test and post-test quality improvement design over 12 weeks. The clinical pathway was adapted with permission from the authors and refined based on stakeholder feedback to align with organizational needs and available resources. The project involved 53 ambulatory APPs at a comprehensive cancer center who care for adult patients with CIPN, of which 89% were nurse practitioners, 74% worked in primary oncology services, and 91% held their roles for six years or more. Data collection encompassed APP participant characteristics, APP role understanding of the interdisciplinary team using an adapted Challenge Team Member Survey, perceived feasibility assessed by the Feasibility of Intervention Measure (FIM), and patient referrals obtained through electronic health record (EHR) data abstraction. Data analysis included descriptive statistics, the Wilcoxon Signed Rank test, and the Pearson Chi-Square test. **Results:** Post-intervention survey analysis revealed a statistically significant improvement in APPs' understanding, as indicated by the median summary scores, which increased from a pre-test score of 19.00 to a post-test score of 25.00 ($Z = -4.228$, $p < 0.001$). EHR data showed a clinically significant 43.48% increase in total patient referrals and a statistically significant association between APP participation and the entry of one or more referrals to appropriate services ($X2$ (1, $N=31$)=7.86, $p= 0.006$). Finally, the mean FIM post-test summary score was 17.13, suggesting that participants found the intervention feasible for this setting and population. **Conclusions:** The findings support the integration of an evidence-based, interdisciplinary CIPN clinical pathway to improve APPs' role understanding and referral behavior. Limitations include a small sample size, a 41.5% attrition rate at post-test, a single-institution setting, and a 12-week follow-up period. **Recommendations:** This intervention may be implemented in comparable clinical settings; however, further adaptations may be needed based on organizational resources and evolving evidence-based recommendations. Facilitators to implementation include adapting the pathway to the local context and involving key stakeholders in project planning.

JL1330C: Improving Clinical Documentation Among Advanced Practice Providers in Oncology: Implementation of a Note Writing Workshop at a Large Academic Cancer Center

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Background: In oncology care, precise clinical documentation is essential for tracking disease progression, coordinating multidisciplinary treatment plans, and ensuring compliance with regulatory and billing standards. Despite their pivotal role in patient management, Advanced Practice Providers (APPs) often receive limited formal training in medical note writing within oncology-specific contexts. **Objective:** To implement and evaluate a targeted educational workshop designed to improve the clarity, consistency, and compliance of clinical documentation among newly hired and experienced APP staff at a large academic cancer center. **Methods:** A mandatory two-hour workshop entitled "APP Note Writing Workshop: Enhance your Documentation Skills!" was created in October 2024 for APP staff on the solid tumor services at a large academic medical center. The workshop incorporated strategies to improve note content and clarity, identify best practices for medical documentation and also reviewed skills to help providers summarize and synthesize notes. Concepts of note writing basics were then incorporated into the new hire APP orientation. A one-hour class entitled "Note Writing Basics and Presenting Pearls" was developed for newly hired APPs that was given during their orientation day. This lecture outlined the key components in documentation tailored to oncology care, visits for symptom management, EMR optimization, and synthesis of key information. Following this initial orientation lecture, new hires meet

again at week eight of orientation for a 2-hour in depth workshop entitled "New Hire APP Note Writing Workshop" to further review, enhance and optimize key components in notes, documentation strategies, approaches to summarizing and synthesizing information, and documentation as it relates to medical billing. This workshop included real-time feedback on de-identified patient notes, in addition to interactive practice revising inpatient, outpatient, and urgent visit notes provided by faculty. **Results:** A total of 75 oncology APPs have participated thus far. Pre and post-workshop assessments were conducted using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) to measure self-confidence in note writing, to understand what sections of the note providers found most difficult and to gain insight into the perceived quality of team documentation among new staff. Pre-workshop surveys demonstrated a knowledge gap. APPs who participated shared what they find most difficult with documentation including "Making it understandable to everyone," Keeping it clear and concise, and "Synthesizing what is most important." Post-intervention data demonstrated an increase in documentation confidence and improved adherence to institutional documentation standards. Participants reported enhanced ability to synthesize complex oncology data and improved interprofessional communication through clearer documentation. **Conclusion:** The workshop effectively addressed documentation gaps in a specialized oncology setting. Integrating structured note writing education into APP onboarding and ongoing training can strengthen communication, regulatory compliance, and quality of care in cancer centers. The workshops continue to be an integral part of APP Onboarding and ongoing professional development for APPs.

JL1331C: Improving Continuity and Efficiency through Standardization of Documentation for Inpatient Consult Service Advanced Practitioners

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Background: Year over year growth in Hematology Oncology consults at a large community hospital led to expansion of our Advanced Practitioner (AP) team. New to practice, new to the specialty, part time, and PRN APs, raised efficiency and continuity concerns. Lengthy notes did not always convey pertinent information in a concise manner. Members of the care team were becoming increasingly frustrated with the variability in the location of recommendations. These issues were compounded with the addition of APs rotating to weekends, further disrupting weekday continuity. APs were using several different templates to write their notes, which did not translate well for cross-coverage. APs grew frustrated with the perceived increase in time documenting rather than caring for patients, and burnout symptoms were noted. **Methods:** We researched internal documentation options available to us through Epic including dot phrases, templates, note writer, and problem-oriented charting (POC). Based on feedback from the team and specialty specific needs, POC provided the most comprehensive solution to decreasing repetitive charting. It allowed for a brief, specialty specific, history of present illness, and individual diagnosis and plans, to be updated and carried over in a standardized template Job aids were already available for training on POC process within our system, allowing for ease of implementation as well as zero budgetary concerns. To ensure stakeholder engagement, the APs along with the support of the leadership team surveyed ten attendings and two of our consulting colleagues to assess their preferences for inclusion criteria and layout of our notes. A template was created which included interval HPI, pertinent lab and imaging, physical assessment and POC. Links to pull in POC directly to template were created and POC is presented first in note allowing for ease of review amongst multidisciplinary team. POC was rolled out mid-January 2025, followed by a newly organized template a few days later. Note length and time in notes were measured. **Results:** Among our team of several APs, average note length prior to intervention was 5700 characters. This dropped to an average of 4266 as of April 2025, approximately two months post intervention. Time in note prior to intervention was 10.45 minutes per patient, and has dropped to 7.97 minutes per patient, a decrease of 23.7%. Anecdotally there is positive feedback from both APs and staff physicians regarding ease of new note style,

clarity of assessment and plan as well as perceived time spent charting. **Conclusion:** Volume growth and staffing changes can lead to continuity and efficiency challenges. Optimal utilization of available technology can help address these challenges. Documentation standardization led to improved efficiency, continuity, and improved provider satisfaction. APs collaborating with and getting buy-in from attendings, Leadership and consulting providers was critical to the initiative's success. **Recommendations:** Growth and its subsequent challenges are something that many of our colleagues struggle with. There is potential to expand this work to other sites and services in the future. Additionally, formal satisfaction surveys and burnout scores could be assessed as well as implementation of AI note writing software.

JL1332C: Increasing Advanced Practitioner-Delivered Survivorship Visits Through Order Standardization

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Background: In a large health system, survivorship visits averaged 1,925 per year from 2019-2024. This is significantly lower than the 11,500 survivors expected out of the 14,000 new cancer diagnosis seen annually by the system. Identification of survivorship eligible patients is complex and organizational factors like staffing turnover, site specific survivorship awareness and staff buy-in and training, differ significantly between disease groups and practice sites. Practice surveys revealed that identification of patients was largely a manual effort by a dedicated few. This resulted in increased workload, ultimately detracting from patient care, and missed patients, leading to lack of or delayed care for patients. Once patients were identified, scheduling was often delayed or absent, with a high no show and cancelation rate for visits that were scheduled. **Methods:** The Advanced Practice (AP) group worked with the Epic IT specialists to create a survivorship order that could filter patients into 3 categories: eligible, potentially in future, or not eligible. Hospice patients were designated as ineligible. Patients undergoing treatment with an uncertain course were filtered to potential. All other patients were eligible. Anyone on the care team could enter the order and all members were educated on survivorship, eligibility, visits, and the consult order. The order then automatically routed, based on selection, to site specific schedulers or to an Epic dashboard that could be filtered for tracking potentially eligible patients. Order utilization, survivorship visits numbers, and treatment plan numbers were tracked. **Results:** From March 2024 to March 2025, the survivorship order utilization reflected 77% eligible, 19% no eligible, and 4% potentially in future. From March 2024 to March 2025, there was an 8% increase in treatment summaries delivered and a 7% increase in survivorship visits with an AP. **Conclusions:** There has been successful adoption of this order into many practices with subsequent increases in survivorship visits being scheduled with and delivered by an AP. This work has laid the foundation for future work in this area. The "potentially in future" option has not been well utilized as expected with few people using the dashboard to track patients. Barriers to use need to be explored and addressed. Patient and staff education on survivorship care is needed to improve buy-in and decrease cancelations and no shows.

OUTSTANDING POSTER AWARD WINNER
JL1333C: Infusion-Based Advanced Practice Provider Covering Unexpected Infusion and Symptomatic Needs of Oncology Patients Results in Decreased Clinic Interruptions and Higher Quality Patient Care and Teamwork

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Background: The Oncology Evaluation Center (OEC) is an Advanced Practice Provider (APP) led service which provides same day symptom management for oncology patients. The role of the Infusion APP will be to support nursing and providers when a patient reports unplanned symptoms during their infusion visit, as well as provide support during infusion reactions. The RNs directly contact the Infusion APP. The Infusion APP will be an extension of the OEC. Methods: We surveyed providers and RNs within the hematology/oncology clinic and infusion services to evaluate

the need for an Infusion APP role to support providers and nursing staff with unplanned symptomatic needs that arise during infusion appointments. During the pre-evaluation phase, 46 providers and 77 Infusion RNs completed surveys with negative responses. Throughout the intervention, data was collected through chart review to analyze the impact on provider satisfaction, interpreted clinic and patient support and interruptions to clinic, ability to provide quality patient-centered care, and overall teamwork between providers and clinical staff in infusion. Additional data was collected detailing the number of daily infusion requests, the type of request (labs/orders, symptom management, infusion reactions, escalation of care, blood consents, etc.), the number of provider evaluations scheduled, the home floor of the patient, and the interventions provided. **Intervention:** In April 2025 we implemented the Infusion APP as an extension of the OEC to provide clinic providers and nurses with support and help coordinate further monitoring or workup needs of patients receiving infusion services from 7 am – 7pm Monday- Friday. The staffing included 1 APP, as an extension of the 2 APPs serving in the OEC role. Services included placing labs/supportive care orders, symptom management, management of infusion reactions, escalation of care, and blood consents. **Results:** We collected data from 4/21/25 through 7/23/25 utilizing a dot phrase in patient care notes to track patients requiring services from the Infusion APP. There were 470 total infusion requests: 31% being symptomatic care, 40% being reaction assessment/management, and 29% being lab/supportive care orders. The requests resulted in 154 unexpected Infusion APP visits being scheduled. Most patients were discharged home following their infusion visit (93%), the remainder were sent to the OEC, ED, or directly admitted to the inpatient hospital oncology service for further workup and monitoring. Only 46 patients were missed given the Infusion APP was with another patient or unable to address the infusion request. **Conclusion:** This intervention can serve any of the hundreds of patients receiving oncology infusion services at this hospital. It improves provider and nursing satisfaction, increases clinic and patient support, minimizes interruptions to clinic providers, and improves the quality of patient-centered care and overall teamwork between providers and infusion staff. The project also improves patient satisfaction and response time to patients' infusion needs on a day to day basis. The interventions have resulted in improved escalation of patient care needs during their infusion services. Based on the early successes of this model, the Infusion APP services will continue indefinitely as an extension of the OEC services.

JL1334C: One Year in: Reviewing a Multidisciplinary Approach to Outpatient Bispecific T-Cell Engager Therapy

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Background: Bispecific T-Cell Engager therapies (BCE) have emerged as an important treatment modality for patients with relapsed and refractory disease. While predominantly within the world of hematology currently, BCEs are quickly crossing into the solid tumor space. As BCEs become more common, additional focus has been placed on administering in the outpatient setting to avoid hospitalization and improve patient access and quality of life. This brings its own set of complexities to ensure safe administration, consistent monitoring, and immediate action when side effects such as cytokine release syndrome (CRS) and immune effector cell associated neurotoxicity syndrome (ICANS) arise. Multidisciplinary care is of the utmost importance for the safe administration of outpatient BCEs so that every facet of the patient experience is accounted for. **Methods:** A community oncology private practice in Michigan developed an outpatient BCE program in April 2024. One year post go-live, a multidisciplinary review meeting was completed to review the prior year and consider successes and areas for growth. Members of the meeting included APP lead, lead pharmacists, chief operations officer, the director of research, the director of nursing, and APP management. The topics included protocol, patient and CRS review, and discussion on opportunities for growth including a bracelet initiative and enhancement of caregiver support. Time was also given for each discipline to give feedback respective of their team. **Results:** As of April 2025, 31 pa-

tients had been treated in the outpatient setting for their BCE step-up dosing. Five BCE therapies are currently available for outpatient dosing with plans to onboard another product in the coming year. Outpatient BCE is available at 4 clinic locations on the west side of Michigan with plan for further expansion to four other clinics in late 2025/early 2026 as facilities are prepared. Multidisciplinary team review determined that initial protocol and program building has been successful for the patients and program. Identified areas of success included staff education efforts, ability of the research team to support novel multidrug regimens including outpatient BCEs, and infusion pharmacy preparedness. Several initiatives were determined for the next year. One initiative will be to improve emergency department preparedness through creation of a patient bracelet with QR code denoting CRS/ICANS treatment protocols to streamline patient care and avoid delays. Further incorporation of social workers will also occur as their discipline is pulled into earlier stages of patient and caregiver eligibility and education. Finally, plans to review the protocol every 6 months with yearly full program review will continue. **Conclusions/Recommendations:** BCE therapies are an exciting modality available to an increasing number of disease states and patients. A robust program with a full multidisciplinary team is needed to support outpatient administration. While initial protocol and rollout was successful from 2024-2025 at a community practice, the importance of ongoing monitoring and routine multidisciplinary meeting is crucial to ensure that patient and caregiver needs continue to be met in this evolving treatment landscape.

JL1335C: Optimizing Advanced Practice Provider Integration in Oncology: Insights from a Multistate Initiative

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Background: Advanced practice providers (APPs) are critical members of the cancer care team. Effective integration of oncology APPs requires structured onboarding, clearly defined scope of practice, peer support, and foundational education and training. In response to this need, six state oncology societies launched a national initiative to highlight effective training programs, continuing education opportunities, and role optimization strategies that support APPs in practicing at the top of their licensure. **Methods:** In early 2025, the state oncology societies facilitated seven focus group sessions and key informant interviews with a small committee of APPs representing each society. These discussions aimed to better understand the APP role, state-specific nuances influencing scope-of-practice, available APP resources, and gaps in education and support. Based on the focus group findings, the societies created a national and state-level APP resource library featuring educational tools, training programs, and professional development opportunities to support APP integration into the cancer care team. Additionally, three live webinars were conducted to spotlight effective onboarding and retention models, the role of the APP across diverse practice settings, and strategies for practicing at the top of licensure and engaging in leadership. **Results:** Key themes that emerged from the focus groups and key informant interviews included the absence of structured onboarding, limited standardized training resources, gaps in mentorship, scope-of-practice restrictions, and burnout. Insights from webinar discussions and attendee feedback emphasized the need for oncology-specific training for APPs new to the field, communicating the value of non-billable work to leadership, and the importance of investing in professional development to expand APP contributions across clinical and leadership roles. **Conclusions:** This multistate initiative uncovered actionable insights and scalable resources to support oncology APPs in thriving across various care settings. Future directions include developing an APP onboarding guide that cancer programs can adapt into their

practice, creating a forum for ongoing knowledge exchange and peer support among APPs across institutions, and continuing to include APPs in state oncology society participation and leadership. Looking ahead, sustained investment in onboarding, mentorship, and education will be essential to strengthening the oncology workforce and optimizing APP contributions to deliver high-quality, patient-centered care.

JL1336C: Optimizing Advanced Practice Provider Utilization in Community Oncology: A Scalable Model for Enhanced Patient Access and Operational Efficiency

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Background: Community oncology practices are under increasing pressure to deliver timely, high-quality cancer care amid rising demands and limited resources. Strategically optimizing the role of Advanced Practice Providers (APPs) has become a pivotal approach to expanding patient access, enhancing quality care, and improving operational efficiency. This multi-site initiative demonstrates a scalable and structured framework that leverages data-driven insights, workflow redesign, and leadership development to optimize APP utilization. This approach drives sustainable improvements in care quality and operational performance, supporting long-term practice growth. **Methods:** The APP Optimization Model offers a structured, practice-specific approach that begins with a review of analytics and an on-site assessment by clinical and operational experts. Stakeholder engagement, including physicians, APPs, leadership, and frontline staff ensures that workflow insights and patient-centered solutions are grounded in daily practice realities. National benchmarks were used to guide scheduling and productivity targets. A tailored business case is then developed with strategic recommendations. Practices are encouraged to pilot initiatives and are given ongoing support for implementation and key performance metrics tracking. Key focus areas include scheduling optimization, scope of practice expansion, role delineation, innovative clinics, leadership and retention, and standardizing onboarding and education. **Results:** APP productivity improved through optimized scheduling and clear role definition. Implementation of tailored templates, contingency slots, and direct APP scheduling led to increased daily visit volumes, with APPs seeing ≥12 patients/day, exceeding financial break-even points. At one practice, total APP volume rose 7% and average APP visits/day increased by 14% within four months of a site visit and subsequent implementation. Scope expansion, including APP new visit benign hematology clinics, APP hospital consults, and rapid diagnostic clinics, enhanced patient throughput and reduced time-to-first (T2F) visits. At another practice where APPs began managing new visit benign hematology patients, T2F improved by 13.7% or a reduction of 2 days, and the practice saw a 15% year-over-year increase in new oncology patients from Q1 FY24 to Q1 FY25. Notably, APP visits for new benign hematology markedly increased from 5% to 23% of total practice volume in May 2025, representing a 360% relative increase. APP leadership development and standardized onboarding contributed to improved morale, retention, and operational efficiency. Data dashboards align APP productivity with financial sustainability. **Conclusion:** Across multiple sites, the model delivered significant improvements in clinical capacity, operational efficiency, and financial sustainability. Targeted enhancements in scheduling, scope of practice, and leadership development translate directly into higher APP productivity, faster patient access, and improved retention. Given the projected 40% growth in the APP workforce and the simultaneous decline in the physician pipeline, this approach offers a scalable, replicable solution to an urgent workforce challenge. Optimizing APP utilization is no longer optional; it is a strategic and operational imperative for oncology practices committed to delivering high-quality, sustainable care.

JL1337C: Optimizing Vaccination Guidance for Individuals with Primary Brain Tumors

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Background: Patients undergoing treatments for their primary brain tumors are at increased

risk for infections which can lead to treatment interruptions and delays, dose reductions and increased hospitalizations (Weller et al, 2023). One preventive strategy to mitigate the risk of infection in oncology patients is vaccination. Commonly recommended vaccines for patients with cancer include influenza, COVID-19, pneumonia and RSV (Kamboj et al, 2024). However, the timing of vaccine administration is crucial in order to maximize efficacy and ensure that they have an adequate immune response. At our institution, we noted a significant increase in the volume of inquiries from both patients and providers, via phone calls and patient portal messages, regarding optimal timing of vaccinations for individuals undergoing cancer therapy. Additionally, all Advanced Practitioners (AP's) and nurses frequently reported uncertainty and sought clarification how to best guide patients. This confirmed the need for standardized, evidence-based recommendations. **Methods:** To address these concerns, we developed a comprehensive tool identifying the most common treatments for patients with brain tumors and their corresponding recommended vaccination schedule. The vaccination schedule was based off guidance from the Centers for Disease Control (2024). Timing recommendations were further refined using expected blood count nadirs specific to each chemotherapy regimen. The tool offers clear guidance on vaccine administration across various scenarios, including post-surgery, during clinical trial participation and for those receiving chemotherapy or targeted therapy. Additionally, a tip sheet was created for staff to address frequent questions that arose including administration of simultaneous vaccinations and vaccination of patients on corticosteroids. **Conclusions:** Implementation of this vaccination guidance tool empowered our team to effectively address patient and staff inquiries regarding timing of immunizations. Utilization of this tool in our clinic resulted in verbal reports of improved knowledge and confidence of AP's and nurses when providing patients with information on vaccination timing and cancer therapy. Staff consistently described the tool as helpful in facilitating timely and accurate responses to patient inquiries. Although this project was developed for use in patients with primary brain tumors, the framework is adaptable for broader application among diverse oncology populations. **Recommendations:** This evidence-based tool, which is available for use by AP's and nursing staff, provides recommendations on vaccination timing guidance to optimize the immune response in our patients. With known data to support the importance of vaccinations, it is imperative that patients with cancer not only receive these vaccines but do so at a point in their treatment cycle where their blood counts and immune system will ultimately allow them to elicit an effective response. Implementation of this tool has streamlined vaccination guidance and empowers the clinical team with evidence-based recommendations which enhance patient care and supports safe and effective delivery of vaccines to those with primary brain tumors.

JL1338C: Piloting an Advanced Practice Provider-Led Inpatient Consultation Service for Unintended Hospitalizations in Early Drug Development Clinical Trial Participants

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Background: Patients enrolled in early-phase oncology clinical trials often have advanced cancers and limited treatment options, placing them at increased risk for serious adverse events (SAEs) and unintended hospitalizations. Advanced Practice Providers (APPs) are uniquely positioned to bridge care gaps by facilitating timely assessments of these hospitalizations, ensuring continuity of care between inpatient and outpatient teams, and fostering a collaborative approach to managing complications. To address this need, APP sub-investigators within the Early Drug Development (EDD) program at an NCI-designated academic medical center piloted an inpatient consultation service from January 1 to July 11, 2025. **Methods:** In December 2024, APP sub-investigators met with the Principal Investigator (PI), APP Cancer Center leadership, and billing department to develop a standardized workflow for an APP-led inpatient consultation service. The workflow involved notification of unintended hospitalizations by the clinical research coordinator, followed by scheduling inpatient consultations us-

ing a designated visit encounter code on the EDD providers' clinic templates. This code promoted standardized scheduling and allowed tracking of consultation volume. APPs documented consultations using a newly created Epic SmartPhrase note template. During consultations, EDD providers reviewed medical records, including external documentation, and communicated directly with admitting providers to offer protocol-specific recommendations (e.g. prohibited concomitant medications). Updates were shared with the EDD team during daily clinic meetings. Consultations were repeated as needed based on hospitalization duration, medical complexity, or clinical research coordinator requests for SAE updates. A retrospective chart review from January 1 to July 11, 2025 assessed the volume and characteristics of inpatient consultations. Data collected included patient demographics (age, sex), hospitalization location (primary institution/outside hospital), consultation type (initial/follow-up), hospitalization related to a SAE (yes/no), SAE related to study drug (yes/possibly/unlikely/no), action taken with the study drug (none/dose reduction/dose held/interrupted/discontinued) and consulting provider (APP/Physician). Descriptive statistics summarized the data. **Results:** The standardized workflow was successfully implemented. Between January 1 and July 11, 2025, 23 of 34 (68%) EDD patients experienced 38 unintended hospitalizations. Of these 23 patients, 52% were over 60 years old and 57% were female. Five patients were consented but had not yet started study drug. Most hospitalizations (n=34, 89%) were related to a SAE (e.g. disease burden or progression), but only five cases (15%) were related to the study drug, resulting in drug discontinuation in two patients. The majority (61%) of hospitalizations occurred at the primary institution where patients were actively enrolled. During this period, the EDD team provided 71 inpatient consultations (54% initial, 46% follow-up visits), with APPs performing 94% of the consultations. **Conclusion/Recommendations:** This APP-led inpatient consultation service successfully established a standardized workflow for managing unintended hospitalizations among early-phase clinical trial patients. This pilot demonstrated that unintended hospitalizations are common among early-phase oncology clinical trial patients, highlighting the importance of timely inpatient consultations, and demonstrating feasibility and the critical role of APP sub-investigators in supporting clinical research programs. It also underscored necessary infrastructure, such as creating specific encounter types and documentation templates. Future studies should evaluate the model's impact on hospital length of stay and readmission rates.

JL1339C: Promoting Clinical Trials Advanced Practitioner Autonomy Through Implementation of a Scheduling Algorithm

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Background: Oncology advanced practitioners (APs) are integral to high quality cancer care. Research has shown that APs provide safe patient care with excellent patient outcomes. Despite this, role confusion and resulting perceived competition between professions has resulted in limited independence of APs. Within clinical trials, physicians remain heavily involved in clinics despite their inherent Principal Investigator (PI) responsibilities which restrict their abilities to perform extended clinic visits and follow up on complex clinical issues. When practicing autonomously, APs improve clinical capacity, department efficiency, workflow optimization, and increase downstream revenue, thus filling the gaps left by physicians to ensure trial success. Furthermore, clinical independence is reported to be a top factor in job satisfaction and retention. **Methods:** We implemented a scheduling algorithm in 2020 on a busy clinical trials service with independent visits alternating between AP and physician. Visits for adverse event evaluation and management were prioritized with APs while consent and imaging review visits were prioritized with physicians. We retrospectively reviewed visit volume, including shared versus independent visits, from pre-implementation in 2019 through 2023. We surveyed the service APs regarding impact on inter-department professional relations and job satisfaction. **Results:** AP visit volume increased significantly over the first three years of implementation with APs conducting 55% of patient evaluations within the department by the end of 2023, up from 15% in

2019. Shared AP-MD visits decreased from 36% in 2019 to less than 2% of visits in 2023. Overall departmental visit volume by all providers increased by more than 35%. APs reported increased job satisfaction and improved collegiality with physicians and CTNs post implementation. **Conclusions:** The implementation of a scheduling algorithm promotes AP autonomy within an AP-MD shared care model. Increasing AP visit volume can support overall departmental visit growth without negatively impacting MD visit volume. Alternating independent visits between providers can alleviate physician clinical demands and allow for overall program expansion while simultaneously improving AP work environments. **Recommendations:** Future research is needed to examine clinical outcomes for patients and the financial impact of this intervention. Additionally, physician and nurse feedback should be evaluated to determine how a scheduling algorithm contributes to a team care environment.

JL1340C: Safeguarding Excellence: Insights from a Novel Advanced Practice Provider-Led Quality Assurance Committee

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Background: Quality assurance (QA) and patient safety are paramount in oncology, where complex care often involves multiple specialties, high-risk therapies, and transitions of care (1). Most healthcare QA and safety models rely on staff voluntarily reporting patient safety events (PSEs) (3). While there are reports of physician or nurse peer review committees, there is a lack of Advanced Practice Provider (APP) peer review programs (4). At a major metropolitan, non-profit, academic, National Cancer Institute-designated cancer center, APPs lacked a dedicated QA peer review committee. Instead, cases were referred to various department-specific QA Committees, where APP care might not have been reviewed by an APP. This report outlines the development and implementation of a novel APP-led QA Committee and presents trends in the volume, types, and interventions related to PSEs. **Methods:** In June 2023, an APP-led QA Committee was established to review adverse PSEs, near-misses, and/or grievances related to APP care. The Committee includes a Chair, Leadership Subcommittee, and 33 members across 8 disciplines and 19 specialties. The full Committee meets monthly to assess cases and review standards of care. The Leadership Subcommittee meets weekly to triage PSEs, investigate cases, and track action items. In February 2025, an APP QA Lead role was added to oversee APP-related PSEs and contribute to organizational-wide quality and safety initiatives. Data on number and type of PSEs, location, and action items were collected. **Results:** From June 2023 through April 2025, 1,083 PSEs were reviewed by the APP QA Committee. These PSEs could be reported by any discipline; however, all involved APP-delivered care. The number of cases grew from 289 (2023) to 582 (2024) and 216 (April 2025). Most (35%) occurred in the main hospital, ambulatory/clinic (33%), perioperative (14%), and remaining (18%) in radiology, pharmacy, phlebotomy, laboratory, or non-clinical areas. Common event classifications were care coordination (49%), medication/fluid (18%), and lab specimen (10%). Among 526 care coordination events, 14% involved care delays, 8% service miscoordination, 5% policy violations, and 2% handoff issues. A total of 38 cases were presented at the Committee meetings (2023=6; 2024=25; 2025=7). Action items from case reviews included guideline development, educational modules, APP Grand Rounds presentations, changes to the electronic medical record, documentation optimization workshop, and APP competency development. **Conclusions:** An APP-led peer review QA structure is feasible, increases APP engagement in PSE reporting, and establishes accountability throughout a healthcare system. This formal infrastructure allows for comprehensive case reviews and ensures APP perspectives are represented in the development of meaningful outcomes to address quality and safety challenges. Metrics collected have led to targeted educational and safety initiatives. **Recommendations:** APPs require a structured framework to effectively contribute to quality care and patient safety. Collaboration with existing quality and safety structures and leadership support from the highest levels are needed to create an APP-led QA Committee within a large health care organization. Modeling the QA

structure of other disciplines and the creation of dedicated APP leadership positions can strengthen APP engagement in quality and patient safety.

JL1341C: Standardizing the Management of Cytokine Release Syndrome and Immune Effector Cell-Associated Neurotoxicity Syndrome in Patients Treated With Bispecific T-cell Engager Therapies Across a Large Health Care Network Utilizing Clinical Pathways

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Background: Bispecific T-cell engager Therapies (BiTEs) are novel engineered cellular antibodies that harnesses the immune system to attack cancer cells. BiTEs have been developed to target antigens specific to hematologic malignancies and various solid tumors. BiTEs have unique adverse side effects (AEs) including cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS). The majority of patients will develop these AEs during the initial phases of treatment. AEs can progress from mild to life threatening rapidly. Historically, BiTEs have been administered at large academic medical centers by inpatient teams that have expertise in assessment and management of CRS and ICANS. However, with expanded indications and targets, some BiTEs have transitioned to ambulatory settings. Patients who develop complex AEs may present to providers in community and emergency departments who do not have experience managing these AEs. This can result in significant safety events and poor patient outcomes. The Cellular Therapy Leadership Team recognized this knowledge gap among ambulatory providers. They sought to develop a strategy to assure that patients with AEs were triaged appropriately and transitions of care were standardized to minimize morbidity and mortality. **Method:** The General Oncology Council (GCC) and Advanced Practice Providers (APPs) prioritized the development of an electronic medical record (EMR) integrated clinical decision pathway (CDP) to incorporate evidence based clinical practice guidelines, enhance safety and decrease variability across settings. An APP led clinical consensus group (CCG) was established, including institutional stakeholders (ie. APPs, RNs, MDs, PharmDs), from each clinical setting. The group met bi-weekly over six months. EMR best practice advisories were created to alert providers across settings if patients had received BiTEs. Distinct CDPs were developed to guide AE management of each BiTE in alignment with product recommendations. Severity based AE management interventions with links to EMR orders for medications, diagnostics and consults were incorporated. The CDP provided guidance on transitions of care from ambulatory to inpatient and ICU level care. Patient specific AE grading was pulled into the CDP from clinical flowsheets. APPs provided education sessions for providers in all settings. The CDP provides a structure to help minimize significant safety events in this complex patient population. **Results:** The CDP launched in November 2024. It has been utilized 960 times by 140 providers in 7 months, for 68 distinct patients. The initial feedback from all providers is that the pathway improve workflow, standardization of CRS & ICANS management across settings and BiTEs across the network. The plan is to assess outcome metrics at three month intervals. **Conclusions:** This CDP provides evidence-based guidance on the management of CRS and ICANS in patients treated with BiTES. It incorporates several tools to facilitate timely treatment, diagnostic strategies and recommendations for monitoring of patients progress. Utilizing this pathway leads to improved workflow, patient outcomes and provider satisfaction as well as decreased risk of severe safety events through interdepartmental collaboration. The CCG will update the CDP consistent with advances in knowledge of AE management. Additional CDPs will be developed as new BiTES are engineered.

JL1342C: Standardizing the Management of Neutropenic Fever Across a Large Comprehensive Cancer Center Utilizing Clinical Decision Pathways

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Background: Febrile neutropenia (FN) is a serious adverse event faced by many cancer patients

receiving systemic oncologic therapies. The incidence, morbidity and mortality rate from FN varies by malignancy type (ie solid tumor, hematologic malignancy) and therapeutic administered. The General Cancer Council (GCC) and the Advance Practice Providers (APPs) from a large comprehensive cancer center network spanning 5 hospitals & 15 ambulatory centers recognized that there was variation in the care of patients with FN across the sites. Variations were found in general work-up, organ site specific evaluation, empiric antibiotic selection, initiation, escalation and de-escalation of culture guided therapy. The majority of patients were admitted for all aspects of management. Variations led to prolonged evaluation, unnecessary admissions, increased length of stay, and prolonged antibiotic exposure. Several clinical practice guidelines (CPGs), algorithms and tools are available from professional organizations to guide practice. However, they are not available at the point of care, integrated into the EMR, specific to EMR ordering or institutional workflows and did not limit variability. **Method:** The APPs and GCC prioritized the development of an integrated clinical decision pathway (CDP) to standardize care, incorporate CPGs and decrease variability across centers. An APP lead clinical consensus group (CCG) was established, including institutional stakeholders (ie. APPs, RNs, MDs, PharmD, Infectious Disease), from each of the centers. The group met bi-weekly over six months. The goal was to standardize a process for initial evaluation strategies, timely initiation of antibiotics, risk stratification to guide inpatient and ambulatory management, and therapeutic de-escalation strategies. Distinct CDPs were developed for inpatient and ambulatory management of solid tumor and hematologic malignancies. Those with hematologic diagnoses were to be admitted for inpatient care. Clinically stable solid tumor would be managed in the ambulatory setting. Each CDP incorporated FN order sets for empiric antibiotics and blood cultures. Referrals to the Oncology Urgent Clinic, Emergency Department and subspecialists were integrated. Diagnostic orders were created that pre-populated urgency due to FN diagnosis and suspected site of infection. The CDPs provided links to national guidelines as well as patient education materials. The ambulatory CDPs include risk stratification grading to encourage outpatient treatment of low-risk patients and provide guidance on clinical follow-up, triage and scheduling. **Results:** The ambulatory CDPs was launched in May 2024 and the inpatient CDPs in April 2025. Several dissemination strategies were used to inform providers of the CDPs to enhance utilization. These CDPs have been utilized 811 times by 354 providers impacting 368 patients. The initial feedback is that the CDP improves standardization of FN care across the network and encourages risk-stratified care. The plan is to assess outcome metrics at three-month intervals. **Conclusions:** These CDPs provide evidence-based guidance for FN patients at the point of care. They incorporate several tools to facilitate the timely introduction of treatment, diagnostic strategies and recommendations for monitoring of patients progress. Utilizing these CDPs leads to improved workflow, timely evaluation, decreased admissions, length of stay and prolonged antibiotic exposure; hence improving overall patient outcomes by standardizing care.

JL1343C: The First 90 Days: A Strategic Approach to Advanced Practice Provider Onboarding and Practice Readiness

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Background: Advanced Practice Providers (APPs) play a critical role in the delivery of high-quality, patient-centered care. Despite the increasing employment of APPs within oncology, onboarding practices often lack consistency and structure. This variability can lead to delays in clinical integration, hinder skill acquisition, and diminish satisfaction. Given the complexity of oncology care, a structured APP onboarding program is essential to provide safe, patient-centered care, while developing specialized oncologic competencies. At a comprehensive cancer center, a formalized APP onboarding program was developed to promote a cohesive and supportive entry into the institution's clinical environment, foster professional enculturation, and promote long-term retention. **Methods:** The

APP Orientation (APPO) Program at a metropolitan academic cancer center was designed as a structured, multi-faceted initiative designed to support the successful integration of newly hired APPs. Onboarding begins with a formal one-day in-person session introducing institutional values, clinical standards, and interprofessional collaboration. This is followed by 24 virtual, self-directed modules covering various clinical topics completed asynchronously over four weeks. The process also includes bi-weekly check-ins to assess progress, address concerns, set goals, and provide mentorship. Additionally, orientees and preceptors' complete institutional objectives on a phased APP Orientation Map and service-specific checklist. **Results/Outcomes:** From September 2023 to June 2025, 264 APPs (151 Nurse Practitioners, 79 Physician Assistants, 34 APP Fellows) underwent APPO, and 35 (13.26%) APPs completed the post-APPO survey, rating the helpfulness of course content and instructors on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Across all surveys, the mean rating was 4.33 (SD=0.63), indicating a high level of perceived helpfulness. Participants noted that APPO was informative, concise yet comprehensive, and praised the hybrid format combining in-person, virtual, and self-paced learning. Common concerns included repetitive content, technical issues, and information overload. Suggestions included more interactive and updated, streamlined lectures. Since inception, APPO has been regularly refined based on participant feedback to foster a culture of continuous improvement. To enhance interactivity, a hands-on note writing workshop was implemented in Oct 2024. In addition, to reduce redundancies and ensure relevance, all content is peer-reviewed and updated every 2-3 years. **Conclusions:** A structured and comprehensive onboarding program plays a vital role in facilitating the successful transition of newly hired APPs into their clinical role. Standardizing the onboarding process minimizes variability in clinical training, promotes alignment with institutional expectations, and ensures that all APPs receive equitable exposure to essential policies, procedures, and resources. A structured approach fosters a culture of engagement, accelerates role integration, and lays the foundation for long-term success within the organization. **Recommendations/Implications for Practice:** A structured APP onboarding program significantly improves role clarity, clinical readiness, and retention. Its success underscores the importance of investing in a standardized multi-layer model that includes support of the APP, standardized accountability, and a formal onboarding structure. Continued evaluation and iterative refinement of onboarding processes will further enhance APP care delivery in the complex oncology population.

JL1344C: The Impact of an Embedded Oncology Pharmacist in an Outpatient Oncology Center in the Treatment of Hematologic Malignancies

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Background: The growing demand for clinicians in the ambulatory oncology setting to reduce fragmentation of care and improve patient outcomes represents a need for oncology pharmacists as advanced practitioners in the provision of direct patient-centered care. These provisions can include supportive care management, drug-drug interaction evaluation, and selection of appropriate chemotherapy regimens to reduce physician workload in a cost-effective manner, while increasing physician and patient satisfaction. However, robust data are currently lacking to support the impact of pharmacists in the ambulatory oncology setting. The primary objective of this study is to justify the benefit of a full-time clinical pharmacist in the ambulatory oncology setting through documenting pharmacist-driven clinical interventions, correspondence of those interventions with cost avoidance, and perceived benefit from provider and patient satisfaction surveys. **Objectives:** The primary objectives of this study were to (1) document the number of interventions made by a pharmacist in the ambulatory oncology setting, (2) correlate the resulting financial impact of interventions by calculating the total cost avoidance, and (3) assess patient and provider satisfaction regarding the pharmacist in the treatment team. The secondary objectives of this study were to (1) evaluate the subcategories of supportive care and order clarification interventions, (2) identify the amount of visit types conducted, (3) average the time spent

per intervention, and (4) determine provider time saved. **Methods:** In this observational single-center pilot study, pharmacist interventions were documented and quantified from March 4, 2019, to March 9, 2021. This study evaluated the impact of these interventions through correlating cost avoidance and overall patient and provider satisfaction surveys regarding oncology pharmacists embedded in the outpatient clinic. **Results:** During the study period, a total of 545 diverse interventions were made by pharmacists. The estimated cost avoidance during the study period was $363,760, resulting in a net benefit of $753,150 per year. Both provider (n = 5) and patient (n = 8) surveys indicated strong agreement to the benefits of an oncology pharmacist's involvement in clinic. **Conclusion:** The benefits of a clinical pharmacist in the ambulatory oncology setting are demonstrated in this observational pilot study through a total of 545 interventions made in the clinic by a pharmacist over the 2-year time frame, which corresponds to a net benefit of $753,150 per year. This study demonstrated the impact of diverse pharmacist-driven clinical interventions and illustrated the financial and humanistic value of an embedded pharmacist in ambulatory oncology.