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JL1201C: 2024 Oncology Advanced Practitioner Intensive Clinical Investigator Course

Gayle S. Jameson,[1] MSN, ACNP-BC, AOCN®, Carol Guarnieri,[1] MSN, FNP-C, Sarah Danielle LeGrand,[1] MSN, AGACNP-BC®, Stephanie Franz,[1] MSN-Ed, RN, Amy Mirabella,[1] PhD, RN, CHPN, Erin M. Pierce,[2] MSN, APRN, FNP-C; [1]HonorHealth Research Institute, [2]Oschner Health

Background: Oncology Advanced Practitioners (OAPs) often participate in the care of patients in early drug development clinical trials but rarely have the opportunity to lead an early phase clinical trial as the Principal Investigator (PI). Typically, physicians function in this role, but OAPs are capable and effective as PIs if given education and mentoring. However, there are no established training or fellowship programs specifically designed for OAPs to prepare for the role of PI. Given the ongoing acceleration in bench to bedside drug discoveries and the anticipated decline in the number of physicians, there is a growing need for well-prepared PIs and sub-investigators (sub-Is). OAPs as clinical experts are well suited and permitted by the FDA to serve as a PI in drug studies. A recent study concluded that the majority of OAPs surveyed see the importance of research and want to become more involved in clinical trials. **Methods:** In February of 2024, OAPs at our Research Institute hosted a 4-day educational course for OAPs working in a clinical trial environment and interested in learning the role of the PI. With 25 faculty, the course included 25 didactic sessions and 3 round table discussions. This course was modeled after the AACR/ASCO Methods in Clinical Cancer Research which educates physicians in the role of PI and protocol development. Pilot nurse practitioner courses were offered in 2018 and 2020. Applicants were required to submit a curriculum vitae, letter of intent, a letter of support from a sponsoring physician, and were interviewed by phone. Grant funding was secured for full scholarships to 21 selected OAPs representing 16 major cancer centers (1 in Australia). Sixteen nurse practitioners, 4 physician assistants and 1 clinical nurse specialist attended. Twenty-two CME units were offered for course completion. The purpose of the course was to provide OAPs the foundational knowledge of the role and responsibilities of the PI, sub-I and research team members in clinical trials. Development and presentation of a protocol synopsis with guidance from our research team was required at course completion. On days 1 through 3, participants completed a pre- and post-test questionnaire via QR code. **Results:** Quantitative data demonstrated a 65% improvement in clinical trial knowledge; all stated the course was worthwhile for their professional practice; 92% agreed course content facilitated their protocol synopsis; and 100% of participants completed and presented a protocol synopsis. Eighty-two to 95% of participants noted that the quality of their patient care will improve as they have a greater understanding of clinical trial indications, risks, treatment options, enrollment process and the roles of OAPs in clinical trials. Qualitative themes at one and three months included that the course improved knowledge and confidence in the investigator role. Challenges some participants noted

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in implementing their protocol synopsis included time limitations, scheduling, personnel changes, and support from administration. **Conclusions/Recommendations:** Overall feedback from participants reflected the course was a positive learning experience and should be repeated. Grant funding has been secured and plans are underway for a course in 2025.

JL1202C: A Care Gaps Initiative to Improve Lung Cancer Screening Rates for Patients at a Rural Cancer Institute

Adrienne Duckworth,[1] MSN, APRN, NP-C, AOCNP®, Marquis Demniak,[1] APRN, Melanie Moccaldi,[1] RN, BSN, Patricia A. Policicchio,[1] MSW, Sabina Nduaguba,[2] PhD, Nicole L. Stout,[2] DPT, FAPTA; [1]WVU Medicine Cancer Institute, [2]West Virginia University

Context: Low dose computed tomography (LDCT) is recommended for lung cancer screening by the United States Preventative Services Task Force (USPSTF). However, national estimates suggest that < 6% of those eligible are screened. Screening contributes to earlier stage diagnosis and reduces mortality, which is of importance in rural Appalachia, as the region experiences late-stage lung cancer incidence and deaths at rates higher than the national average. Our cancer institute conducted a quality initiative to identify individuals eligible for LDCT and encourage screening referrals through a shared decision-making approach. **Methods:** The Care Gap initiative, developed by the survivorship team, used a multilevel approach to improving lung cancer screening. We operationalized the electronic medical record (EMR), using LDCT criteria, to automate identification of patients who were eligible for, but had not received, lung cancer screening after a completed visit at our cancer center. When the Care Gap was identified, the patient record was sent to an in-basket pool through the EMR and alert the lung team. The pool was managed by an advanced practice professional (APP) and a registered nurse (RN) on the lung cancer team. Records were reviewed and patients were individually contacted via telephone to conduct a shared decision-making visit. These visits included patient education about the benefits and risks of LDCT and provided information and referrals so the patient could be scheduled for imaging if they chose to pursue screening. In-basket pools were tracked from June 2022 through June 2024 to identify volume of Care Gaps, number screened, and resulting confirmed cancer diagnoses. Due to challenges with project roll out and EMR tracking, total Care Gap counts for June 2022-December 2022 are missing. **Results:** The Care Gap approach resulted in 227 patients screened with four confirmed lung cancer diagnoses. By year: 2022, 75 patients screened, one diagnosis; 2023, 258 Care Gaps identified, 86 patients screened (33.3%), two confirmed diagnoses; January-June 30, 2024, 303 Care Gaps identified, 66 patients screened (21.8%) one confirmed diagnosis. This represents a 27.1% screening rate among eligible patients in 2023-2024. **Conclusions:** By automating EMR processes, using evidence-based screening criteria, our initiative successfully notified the lung cancer team of LDCT eligible patients in the cancer institute. Using a shared decision-making approach, led by lung APPs and nurses, our lung cancer screening rates are markedly higher than national average rates for eligible individuals. This was conducted among individuals under active cancer treatment or being followed for a high risk or hematologic condition and therefore may represent a population already receptive to medical screening. Work is ongoing to develop patient-level communication tools, assess economic implications, and explore service line and workflow changes to promote sustainability of this approach.

JL1203C: A Pilot Program Implementing an Evidence-Based Walking Plan to Improve Cancer-Related Fatigue in Adult Patients on Oral Cancer Treatments

Jennifer Bernt[1] DNP, FNP-C, AOCNP®, Rita M. Million,[2] PhD, RN, CNE, PHNA-BC, Nicole S. Pham,[3] MPH; [1]Ironwood Cancer & Research Centers, [2]Missouri State University, [3]Stanford

Background: Fatigue is a prevalent and debilitating symptom among cancer patients, persisting even after the completion of treatment The National Comprehensive Cancer Network guidelines advocate for the incorporation of physical activity as a strategic intervention to alleviate Cancer-Related Fatigue. **Objectives:** This study aimed to develop and implement an evidence-based translational research quality improvement project to improve fatigue in patients starting oral cancer treatment. **Methods:** Outpatient oncology nurses responsible

for patient education at the onset of cancer treatment were provided training about the walking program. This information was subsequently incorporated into the curriculum for patients initiating oral chemotherapy. Nursing knowledge, beliefs, and attitudes were evaluated before and after the subject-intensive education. Patient participants were provided with pedometers and completed the Brief Fatigue Inventory© and a survey about their beliefs and attitudes before and after the implementation of the walking program. **Outcomes:** Post-intervention fatigue scores exhibited a slight reduction; however, the change was not statistically significant. A near-significant correlation was observed between advanced-stage cancer and increased fatigue levels. Participants' self-reported attitudes towards the SWIFT program were positive. Nursing knowledge improved by 13%, with enhanced confidence in six of nine assessed topics. Nursing barriers to education shifted from personal comprehension to a need for additional resources. **Recommendations:** Implementing the SWIFT program, which involves engaging patients in physical activity and utilizing motivational techniques, including inspirational text messages and setting goals with a pedometer, offers a structured plan that can have positive impacts. The findings underscore the importance of advanced practice providers addressing fatigue preemptively in patients with advanced stage through comprehensive fatigue prevention and management education. This proactive approach enables patients to be manage their fatigue effectively by adjusting daily activities, incorporating rest periods, and seeking supportive care interventions like exercise or psychosocial support. Understanding the association between higher-stage cancer and worsening fatigue underscores the necessity for early integration of supportive care measures. The provider can collaborate with multidisciplinary healthcare professionals, including physical therapists or social workers, to develop personalized fatigue management strategies, thereby enhancing overall well-being and optimizing treatment outcomes. This knowledge empowers the oncology advanced practice provider to deliver comprehensive, patient-centered care by identifying, addressing, and managing fatigue as a critical aspect of symptom management in patients with advanced-stage cancer.

JL1204C: A Proactive Intervention to Optimize Nutrition and Reduce Weight Loss in Pancreatic Cancer Patients

Lorraine Drapek, DNP, FNP-BC, AOCNP®, Christian Baglini, RN, MS, Jessica Meurer, RN, BSN; Massachusetts General Hospital

Background: Pancreatic cancer (PC) is the seventh leading cause of death worldwide. Global trends suggest PC incidence is on the rise to become the second leading cause of death in western nations. Treatment paradigms for PC involve a combination of multiagent chemotherapy, radiation, and/or surgical resection. Up to 80% of patients with PC meet criteria for cancer cachexia. Additionally, the prevalence of exocrine pancreatic insufficiency (EPI) in PC patients ranges 50-100%. Appropriate management of EPI in PC patients shows prolonged survival. The goal of this program was to provide early intervention to improve nutritional status, optimize PERT prescribing practices, and minimize weight loss. **Methods:** From January 2021 through January 2023, an early intervention process was implemented for patients with localized pancreatic cancer. A nurse practitioner (NP) initiated an initial assessment and plan at patient entry into the health system. This included EPI diagnosis, nutrition referral, and pancreatic enzyme replacement therapy (PERT) prescribing. Virtual or in-person NP follow-up visits were completed every two months throughout the entirety of the treatment period, and nutrition follow-up per standard of care. Results A total of 41 patients were included in the analysis. All patients (100%) completed Nutrition consultation. PERT was prescribed in 90% of patients, and within the first 3 months of PC diagnosis in 65% of patients. The average initial PERT dose prescribed to patients was 44,700 units lipase with meals. Weight loss from baseline (time of diagnosis) to 3, 6, and 9 months was 5.30%, 6.28%, and 8.97%, respectively. **Conclusions:** This early intervention program successfully diagnosed EPI at an earlier timepoint after PC diagnosis and resulted in early Nutrition counseling and management. EPI was identified and treated with PERT in a high proportion of patients compared available data. PERT dosing more consistently met prescribing guidelines compared to recent literature. Patients

experienced weight loss on a progressive basis, but did not meet severe cachexia criteria (>10% body weight) on average. This data suggests potential efficacy for early intervention in reducing PC weight loss which may lead to prolonged survival. **Recommendations:** The authors recommend early screening for EPI, preferably at the time of initial diagnosis, for patients with pancreatic cancer. It is important to prescribe PERT either at diagnosis or early in treatment with appropriate dosing, in order to minimize weight loss and cachexia. Note: This abstract was completed under the 1440 Clinical Collaborative for Pancreatic Cancer.

JL1205C: Advanced Practice Provider-Led Initiative to Increase Survivorship Care Planning in a Multicentered Community Oncology Practice

Lauren Kiley, APN-BC, AOCNP®, Rachel Carroll, MSN, FNP-BC, AOCNP®, Salma Haj-Ibrahim, PA-C, Natalia M. Kondrat, PA-C, Manasiben Patel, APN-C, Bridget Reddington, PA-C, Shannon Woerner, APN-BC, MBA, AOCNP®, Kristen Benson, APN; Astera Cancer Care, One Oncology

Background: With the rising population of cancer survivors, survivorship care has become critical in oncology. Patients who receive a Survivorship Care Plan (SCP) are more likely to receive better follow-up care, coordination of services, adherence to surveillance guidelines, observation of long-term side effects, and smoother transition back to routine care providers (Sutherby, 2017). Nonetheless, there have been challenges in effectively implementing SCPs due to significant barriers in the identification of eligible patients and scheduling of visits. Traditional methods, such as physician-based ordering, reports based on treatment intent, and staging reports, have proven insufficient, largely due to numerous limitations with incomplete staging documentation, constraints within Electronic Medical Record (EMR), and patients' scheduling resistance. Therefore, increasing visit completion rates has been challenging. In response to these challenges, the team of Advanced Practice Providers (APPs) at Astera Cancer Care, aimed to establish a standardized process for identifying eligible patients for SCP. **Method:** For this initiative, any patient undergoing curative treatment was deemed a candidate for a SCP. Given that APPs conduct all treatment teach visits, a radio button was introduced to the chemotherapy teach note to indicate whether the treatment was palliative or curative intent. Subsequently, a report was generated in the EMR to list all patients who had undergone a teaching session. A manual review of each teaching note was performed to differentiate between palliative and curative treatment intent. Weekly reviews of these reports guided the identification of patients requiring SCP. A survivorship order was placed for each eligible patient, and these patients were tracked on a spreadsheet. This process resulted in a comprehensive list of all patients initiating curative intent treatment. **Results:** Between January 1, 2024, and May 31, 2024, 602 patients underwent treatment teaching visits. Of these, 191 patients received curative intent treatment, and 411 received palliative intent treatment. This method successfully identified 191 patients needing SCP for the first half of 2024. The number of SCPs performed in previous years was as follows: 78 in 2020, 102 in 2021, 180 in 2022, and 126 in 2023. Therefore, this new method has already resulted in a significant increase in identifying SCP candidates within just six months. **Conclusion:** With the improved detection process, the APP team at Astera Cancer Care can now distinguish every patient undergoing treatment with curative intent, while also identifying those who have completed the SCP visits. Based on the statistics from the first half of 2024, we anticipate that the number of identified SCP visits for this year, could potentially double compared to 2023. Due to ongoing limitations with our EMR's inability to automatically generate this data, our detection process remains manual for differentiating between palliative and curative intent treatments. Future goals include transitioning this task to ancillary staff to streamline the process. Furthermore, we intend to increase attendance of SCP visits by presenting its importance during the treatment teaching session.

JL1206C: Advanced Practice Provider Led Oncology Urgent Care Clinics Improve Time to Antibiotic Administration Through Implementation of Intravenous Push Policy in the Prehospital Setting

Cara Fleming, AGPCNP-BC®, Susan K. Seo, MD, FACP, FIDSA, Jeffrey Groeger, MD, Janine Kennedy, DNP, CNS, AOCNS®,

OCN®, NE-BC, John P. Timoney, PharmD, BCOP, Nina Cohen, PharmD, BCIDP, Jungwook Kang, PharmD, BCIDP, Jibran Majeed, DNP, ACNP-BC, CCRN; Memorial Sloan Kettering Cancer Center

Background: Oncology urgent care clinics (OUCCs) have been developed to meet the needs of patients receiving oncology care in the ambulatory setting, (Fleming C, Kelly D. Oncology Urgent Care Clinics: Understanding Utilization and Best Practices. J Adv Pract Oncol. 2022;13(3):265-269. doi:10.6004/jadpro.2022.13.3.17). Patients may present to OUCCs with infection and or sepsis, and there is a vital need to deliver timely antibiotics since a delay in administration is associated with increased morbidity and mortality. In an urgent situation, conventional antibiotic infusion over 30 to 60 minutes is not feasible as there is the competing need to transfer the patient to emergency departments (ED). A quality improvement (QI) project was initiated by a lead OUCC Advanced Practice Provider (APP) to assess whether adopting an intravenous push (IVP) policy at a tertiary cancer hospital's OUCCs could improve the proportion of patients with infection receiving timely antibiotics prior to ED transfer. **Methods:** A multidisciplinary team comprised of OUCC advanced practice providers (APPs), Nursing, Pharmacy, Infectious Diseases, and Information Technology created an IVP policy guideline and electronic order sets that were implemented in April 2022 after education of the OUCC staff. The following outcomes were assessed in the pre- and post-intervention phases: patients with clinical concern for infection receiving timely antibiotics and room dwell time. **Results:** During the pre-intervention phase, 6,231 of 50,860 (12.3%) patients evaluated at OUCCs between April 2019 and March 2022 had clinical concern for severe illness requiring transfer to ED. Only 26.3% (1,640/6,231) received antibiotics prior to ED transfer. In the post-intervention phase, 1,798 of 13,074 (13.8%) patients evaluated between April 2022 and December 2022 had clinical concern for severe illness requiring transfer to ED. The proportion of patients receiving antibiotics prior to transfer increased to 34.9% (628/1798). Average room dwell time decreased from 3 hours 56 minutes to 3 hours in transfers who received IVP antibiotics. Conclusions Implementation of IVP policy increased the proportion of seriously ill patients who received antibiotics prior to transfer and reduced average room dwell time. **Recommendations:** This project demonstrates how oncology APPs can take initiative in actively participating and implementing quality improvement projects in their respective areas of expertise. This project further demonstrates the safety of IVP antibiotics in terms of reaction rates as per prior literature. (Spencer S, Ipema H, Hartke P, et al. Intravenous Push Administration of Antibiotics: Literature and Considerations. Hosp Pharm. 2018;53(3):157-169. doi:10.1177/0018578718760257). Other hospital systems with OUCCs can consider implementing an IVP policy to ensure that seriously ill patients requiring transfer receive timely antibiotics prior to ED transfer.

JL1207C: Advanced Practitioner-Led Undiagnosed Cancer Clinic

Carmela N. Hoefling,[1] MSN, AOCNP®, APN-C, Jeanne Silva,[2] MSN, RN-BC, CN-BN, CMSRN; [1]Rutgers Cancer Institute of New Jersey, [2]RWJ Barnabas Health

Background: Abnormal findings unrelated to the indications for testing are occasionally identified in studies performed on patients presenting to a local emergency department (ED). These patients face potential care delays due to prolonged wait times to see an oncologist and lack of an undiagnosed decision pathway. Without a diagnosis and complete work up, the patient risks not identifying or initiating the next steps for follow up. This may lead to an inaccurately scheduled visit, wasted clinic hours, patient dissatisfaction, and delayed treatment. To close this gap, an Undiagnosed Cancer Clinic (UCC) staffed by an advanced practice provider (APP) offers quick access to a specialty-led diagnostic workup, timely oncology consultation, and a conclusive diagnosis. The aim is to have the Oncology Access Center (OAC) refer patients with incidental findings to an advanced practice nurse in the UCC within 72 hours, to complete the diagnostic workup, confirm a diagnosis and refer to appropriate provider. **Method:** The project design used a plan-do-study-act (PDSA) method. In July 2023, a stakeholder working group convened, and an APP was identified to pilot the project. After an incidental finding, the patient is referred to the pilot using the OAC, which starts a cascade of ser-

vices to guide the patient and remove obstacles. The primary goal is to ensure the APP captures patient visits within 72 hours and start a three-pronged support approach: use direct referrals, obtain dedicated clinic time for undiagnosed patients, and a proactive assessment of visit obstacles. Working at the top of their license, the APP orders the appropriate tests to confirm or dismiss a cancer diagnosis. The expedited bandwidth allows the multidisciplinary care team to review positive pathology and develop the care plan early, and schedule patients with the appropriate disease-specific oncologist. Key Performance Indicators (KPI) to measure success and scalability include the number of patients referred to the program, time from referral to oncology visit, reason for referral, positive results, and completed visits. **Results:** The undiagnosed clinic (UCC) saw 26 patients in 9 months, an average of 3 per month. Eight patients were diagnosed with cancer, 12 had no malignancy, one was admitted to the hospital before their appointment, 1 out-migrated, 1 was lost to follow up, 1 needed radiation, and two are pending workup. Patients in the UCC had early access to care, completed appropriate workups, and avoided unnecessary testing and hospitalizations. The APP UCC reduced the time to visit by an average of 19 days. **Conclusion:** Implementing the APP-led UCC improved access to vital cancer care services by expediting the diagnostic workup to rule out or confirm cancer. The pilot identified eight cancers, opened the availability of an oncology visit by 19 days, and determined the appropriate clinician for scheduling. Recommendations Expanding the APP UCC to additional facilities can improve access to oncology services. APPs practicing at the top of their license increase the capacity for vital services and improve care. Future development of clinical practice guidelines and algorithms for APP UCC would simplify the process from appointment scheduling to patient referral.

JL1208C: Cancer Survivorship in Chronic Lymphocytic Leukemia: A Quality Improvement Project

Jackie B. Broadway-Duren, PhD, DNP, APRN, FNP-BC; University of Texas MD Anderson Cancer Center

Background: The National Cancer Institute (NCI, 2023) described cancer survivorship as navigating life experiences and challenges during and after a cancer diagnosis. Chronic lymphocytic leukemia (CLL) is a chronic disease that affects older predominately white males with a median age of 72 years. Many patients with CLL are living longer with the onset of novel therapy. Currently, CLL treatments are providing longevity and better quality of life. Given that CLL patients are older, many are living with comorbid conditions such as hypertension and cardiovascular disease. The number of leukemia survivors has continued to expand over time though, CLL patients are at increased risk for secondary cancers and predisposition to infections due to suboptimal immune systems. Research findings have shown that cancer survivors often do not receive the appropriate oncology follow up and primary care services. Gaining an understanding of the barriers faced by cancer survivors such as access to care and noncompliance with follow up visits, it is of utmost importance to design and establish long term follow up care strategies. thus, the need for cancer survivorship programs. **Purpose:** In preparation for a CLL cancer survivorship clinic, a quality improvement project was initiated towards improving surveillance of patient compliance with recommended immunizations, cancer screenings, and preventive care. **Methods:** A survey created to obtain information regarding health maintenance including immunizations, cancer screenings, and demographic data was provided to patients electronically through MyChart. Patients were instructed to complete surveys prior to their clinic visit. Surveys that were not completed online were provided to the patient during their clinic visit. The survey results are uploaded and stored in a database to be incorporated into patient's survivorship records. **Results:** A total of 659 surveys were collected between 2019 and 2023. The demographic data revealed slightly more male participants (329) with an average age at time of survey of 69 years. The majority of participants were white (484). The surveys captured the number of patients who received the shingles, pneumonia and Covid-19 vaccines. Several patients reported having the following vaccines: shingles vaccine (43%), pneumonia vaccine (42%) pneumovax (30.4%), influenza vaccine (75.5%),

and at least one Covid vaccination (67.7%). Health maintenance indicators revealed that 113 (21.0%) of participants had a history of smoking, 350 (64.9%) patients had skin cancer screenings and 289 (53.6%) had a colonoscopy. Eighty-six percent of participants reported having a primary care provider. One-hundred forty-three (68.1%) of women reported having received a mammogram and 171 (52%) of males had a PSA level evaluated. Data collection is ongoing with surveys collected annually. **Conclusion:** CLL patients are at risk for infections and secondary cancers. Health maintenance is vital to positive health outcomes and survivorship. It is important for health care providers to be aware that cancer survivorship begins at diagnosis. Data collection is ongoing.

JL1209C: Central Venous Catheter Versus Peripheral Intravenous Access During Apheresis

Ryan Garcia,[1] FNP-BC, Jennifer M. Logue,[2] MD, Shakuntala Shrestha,[3] APRN, DNP, Mary MacKrell,[2] RN, MSN, MEd, OCN®, BMTCN, Marisol Castellanos,[4] BSN, RN; [1]Moffitt Cancer Center, [2]Moffitt Malignant Hematology & Cellular Therapy, [3]Moffitt Cancer Center at Memorial Healthcare System, [4]Memorial Cancer Institute

Background: Central venous catheter (CVC) placement is needed to establish adequate intravenous access for apheresis procedures in patients with poor peripheral veins, albeit with increased risk of central line-associated blood stream infection (CLABSI), bleeding, arrhythmia, pneumothorax, and even death. Patients with adequate peripheral veins may avoid these risks by undergoing peripheral intravenous (PIV) collection. At our institution, all patients proceeding directly to autologous stem cell transplant or chimeric antigen receptor (CAR) T-cell therapy undergo tunneled CVC placement, and the same catheter is used for apheresis, chemotherapy administration, and cell infusion; however, healthy allogeneic peripheral blood stem cell donors and patients undergoing autologous cell collection without proceeding immediately to cell infusion are considered for PIV versus non-tunneled CVC access. In February 2023, we saw that no PIV collections had been performed in over one year, and we instituted a policy that any patient not requiring tunneled CVC placement should undergo documented evaluation by an apheresis nurse regarding candidacy for PIV collection. **Methods:** We retrospectively reviewed all patients who underwent any apheresis procedure at our institution between March 2023 and March 2024 that did not require tunneled CVC placement. We collected data regarding type of apheresis procedure, adequacy of peripheral veins, venous access used, success of apheresis procedure, and any complications. **Results:** There were 34 patients who were considered for PIV versus non-tunneled CVC collection. 21 (62%) were healthy allogeneic stem cell donors, 8 (24%) autologous stem cell donors planned to collect and store, 4 (12%) healthy donor lymphocyte infusion (DLI) donors, and 1 (3%) autologous lymphocyte donor for CAR-T. Based on apheresis nursing assessment, 11 patients (32%) had adequate veins for PIV collection, 19 (56%) did not have adequate veins, and 4 (12%) had no documented vein assessment. Ultimately, 6 (18%) underwent PIV collection, 27 (79%) non-tunneled CVC placement, and 1 (3%) tunneled CVC. Of the patients with adequate veins who did not collect via PIV, 2 (40%) failed PIV collection, one due to insufficient blood return and one due to inability to establish interface; 4 (60%) had non-tunneled CVC placement due to patient misunderstanding the collection plan and proceeding directly to interventional radiology rather than the apheresis unit. 4/27 (15%) with non-tunneled CVC required overnight admission post-procedure, 3 due to risk of bleeding with line remaining in place for second collection and 1 due to extreme anxiety and dizziness post-apheresis. Only 4/34 did not achieve target cell dose, 2 (50%) with PIV and 2 (50%) with non-tunneled CVC, likely from patient-related factors. **Conclusions:** Apheresis procedures are safe and effective via PIV access and decrease risk of major complications compared to CVC access. Staff and patient education is ongoing to enhance adoption of PIV access when feasible. **Recommendations:** We have implemented new trainings for our apheresis nurses, and PIV candidates are now scheduled for two vein assessments prior to apheresis to increase patient education and allow independent assessments by different staff. This is an ongoing project, and further analysis will follow to better understand the outcomes of the adopted practice changes.

JL1210C: Clinical Research Training Raises Confidence in Discussing Trials Among Practicing Advanced Providers and Increases Awareness of the Importance of Diversity

Rochelle Reyes,[1] PA-C, Kathryn Goblirsch,[1] Deepa Shah,[1] Savanna Biederman,[1] BS, Ariel Karwat,[2] MSN, AGNP, Jennifer R. Milan,[3] PA-S, Aja Macias,[4] BS, Khristine Arrieta,[1] DNP, FNP-C; [1]Stanford Health Care, [2]NYU Langone Health, [3]Stanford University School of Medicine, [4]Stanford Cancer Institute

Background: The role of oncology APs in clinical research is expanding but limited by lack of training, time, and opportunity. We agree with literature that supports counseling patients about trials as a means to increase patient access to clinical trials, particularly among underrepresented populations and promote health equity in the short and long term. As part of a quality improvement initiative to engage APs in research, we surveyed all oncology APs about their involvement in research: interest, barriers, training, formal role and training. This was presented at JADPRO Live 2021. We then reviewed the Joint Task Force Competency for Clinical Research Professional and defined leveled competency specific for the AP role in our Cancer Center: Fundamental, Intermediate, Advanced and Expert. We aimed to level-set all oncology APs in fundamental clinical research competency by the end of 2024. **Methods:** In a joint effort with the Clinical Trials Office, we developed a 4-hour training workshop, offered quarterly between November 2022 – 2024. The workshop is required on-boarding for new hires, and working APs were provided time for mandatory participation. The overall objectives of the workshop are to: Confidently and comfortably discuss clinical research with patients; Understand the importance of diversity in clinical research; Identify and overcome barriers to trial enrollment. The curriculum consists of six 30-min segments: Shared Mission, APP Leadership in Clinical Research, Scientific Design, Vulnerable Populations, Informed Consent. Each segment introduced the topic with a 10 min lecture followed by small group role play and case studies which were led by APs. Acknowledging varying levels of experiences with oncology and/or research, APs were encouraged to mentor one another in their small groups to develop practical skills they can use to increase access to clinical trials. Themes were reiterated in each segment and reinforced with activities: Clinical trials are standard of care, Education is an equalizer, trial participation must align with a patient's Goals of Care, APs have the skills to increase access to trials. We discuss informed consent in the context of past human research and wrongdoings and challenge one another to be better. **Results:** As of July 2024, 133 APs have participated in the workshop, and we are on track for every oncology AP in our Cancer Center to have fundamental competency clinical research training by the end of 2024. Qualitative data from post-workshop surveys were largely favorable. 92% APs felt somewhat more or more confident and comfortable in discussing clinical trials. 90% had somewhat more or more understanding of the importance of diversity in clinical trials. **Conclusions:** APs can employ their current skillset to increase access to trials and promote health equity, particularly among underrepresented groups. The interactive pedagogical model was effective with a group with varying research experience.

JL1211C: Closer To Home: Building a Fully Outpatient Bispecific Program in a Community Setting

Marlee Bogema, MSN, APRN, FNP-C, Kimberly Melgarejo, PharmD, MHA, Christin Molnar, PharmD, BCOP, Miranda Iacopelli, FNP, Brett T. Brinker, MD, MS; The Cancer and Hematology Centers

Background: The addition of bispecific antibodies (BsAb) has revolutionized the oncology treatment landscape, providing an off-the-shelf targeted therapy to heavily pretreated patients. Due to the risk of toxicity associated with immune activation, specifically cytokine release syndrome (CRS), most BsAb products require an inpatient monitoring period to allow for early mitigation of CRS. This inpatient monitoring period can range from one to 10 days depending on the product. Unfortunately, the inpatient requirement for step-up dosing can be taxing for patients due to financial strain in addition to reducing quality of life by removing patients from home and community. There is also the risk of developing a nosocomial infection, which increases based on the overall length of stay. With this in mind, a community oncology practice in Michigan developed a protocol to allow for safe administration of BsAb therapy in the outpatient setting without the

need for empiric hospitalization. **Method:** Starting in February 2024, an interdisciplinary team lead by an advanced practice nurse (APRN), two pharmacists, and nursing leadership convened to bring several BsAb therapeutics to the outpatient setting. An outpatient protocol delineating patient eligibility, education, staff responsibilities, provider on-call, and CRS grading and management was developed. Rigorous staff education was completed on BsAb products and CRS by the APRN and a pharmacist. Patient safety protocols were created including home vitals monitoring equipment, wallet cards, and triage systems. Clinic monitoring protocols were based on rates of CRS and time to onset. All patients were required to have a caregiver during the step-up period and were sent home with oral dexamethasone and an anti-pyretic. **Results:** On April 15, 2024, the outpatient bispecific program went live. To date, 10 patients (ages 53-83) successfully underwent fully outpatient administration of bispecific therapy. Six patients received teclistamab, three patients talquetamab, and one patient epcoritamab. No unexpected toxicities were encountered. One patient experienced grade 1 CRS which was managed with oral dexamethasone and an antipyretic. Due to disease-related neutropenia, they did have a 24-hour hospital stay to rule out infectious complications. Otherwise, no patients required hospitalization. Accounting for the current hospital requirements for the step-up period (teclistamab 7 days, talquetamab 7 days, and epicoritamab 2 days), there was a significant reduction in inpatient days from an anticipated 65 total days between all patients down to 1 day. **Conclusions:** It was demonstrated that outpatient administration of bispecific antibodies in a community setting is safe and well-tolerated and reduces the number of inpatient days. Advanced practice (AP) support was crucial in program development, staff education, and patient management. While there are considerations surrounding outpatient costs, the implications of reduced inpatient days during step-up dosing are significant in terms of quality of life, preventing nosocomial infections, and reducing financial burden for both healthcare systems and patients. Further research into these specific areas is being done to better understand the magnitude of impact.

JL1212C: Comparisons of Advanced Practitioner Compensation

Lisa Kottschade,[1] MSN, APRN, CNP, FAPO, Beth Faiman,[2] PhD, MSN, APN-BC, AOCN®, BMTCN, FAAN, FAPO, Camille Petraitis,[3] DNP, FNP-BC, Sandra Kurtin,[4] PhD, ANP-BC, FAPO, Wendy Vogel,[5] MSN, FNP, AOCNP®; [1]Mayo Clinic, [2]Cleveland Clinic, [3]Levine Cancer Center, Atrium Health, [3]The University of Arizona Cancer Center, [4]Advanced Practitioner Society for Hematology and Oncology

Background: Advanced Practitioners (APs) in the field of Oncology/Hematology are highly specialized through their education, training and clinical experience. These include nurse practitioners (NPs), physician assistants (PAs), pharmacists, and other advanced practice nurses (APNs). With the continued and anticipated shortage of physician oncologists, the increasing population of cancer survivors and the continued complexity of care, the demand for APs who specialize in Oncology Hematology will continue to expand. However, compensation amongst APs both inside and outside of Oncology continues to widely vary with many being below fair market value. To better understand and address this issue, the Advanced Practitioner Society for Hematology and Oncology (APSHO) conducted its first compensation survey in 2022. **Methods:** The APSHO compensation survey was a self-reported survey consisting of 74 questions addressing salary, incentive structures and consulting rates. Additionally, burnout rates and the desire to leave one's current practice were also collected. A task force was formed to compare the results of the APSHO compensation survey to that of the wider AP workforce as well as against that of physicians. We gathered data from different sub-specialties, for both APs and physicians. **Results:** Universally, pharmacists were the highest paid of the AP job roles. However, PAs continue to outpace NPs in salary in most categories (geographic, subspecialty). There continues to remain a gender gap with males making anywhere from 7.5% (in PA roles) to 14.6% (in NP roles) more than their female counterparts. Data on salary based on ethnicity continues to remain mixed with some surveys showing Caucasian NPs making significantly more than their Black NP counterparts, while others including the APSHO survey, have reported that Caucasian NPs earned less than nonwhite or Hispanic NPs. When specifically looking at PAs non-Hispanic Black PAs

and Hispanic PAs are reported to earn less than a Caucasian PAs. Nationally, Emergency Medicine/Hospital Critical care/Anesthesia had the highest mean salary for both NPs and PAs. Primary/Rural care continued to have the lowest mean salaries for both groups. Oncology/Hematology APs are generally somewhere in the middle, which is consistent with APSHO survey results. Nationally, California had the highest mean salary for NPs and PAs, with Hawaii ranked second, similar with our survey (CA 1st, AK 2nd). Interestingly NPs working in the VA setting had the highest mean compensation whereas PAs with the highest compensation were those who were independent contractors or worked for HMOs. When compared to physician salaries, APs continue to make roughly 1/4 to 1/2 that of their physician colleagues within the same subspecialty/clinical setting, with the widest gap between medical and procedure-based specialties (e.g., cardiology/surgery). **Conclusion:** The results of the APSHO compensation survey were consistent with other national NP/PA salary surveys in terms of gender, geographic location, and practice type. Race and ethnicity were mixed and somewhat inconsistent to that of national results. Physician-to-AP pay ratio was also consistent across subspecialties. In conclusion, these results continue to show that further work needs to be done by societies such as APSHO towards closing the gender and ethnic/racial gaps that still exist amongst NPs and PAs.

JL1213C: Comprehensive Biomarker Testing Among Patients With Advanced Non-Small Cell Lung Cancer: An Initiative Led by Advanced Practice Providers to Address Knowledge and National Guideline Adherence Gaps Among a Multidisciplinary Group of Oncology Clinicians

Shivani Pandya,[1] DNP, AGPCNP-BC®, Gayathri S. Moorthy,[2] PhD, MSN, APRN, AOCNP®, Annette Sereika,[2] MSN, APRN, AOCNP®, Patricia Friend,[3] PhD, APRN-CNS, AOCNS®, AGN-BC; [1]NorthShore University Health System, [2]Endeavor Health, [3]Loyola University Chicago

Background: Guideline-concordant comprehensive biomarker testing in patients with advanced non-small cell lung cancer (aNSCLC) directs treatment selection and improves survival. Practice gaps in biomarker test ordering process exist. Strategies to address knowledge deficits and ordering process can bridge the gaps. The aims of this initiative are twofold: 1) to conduct a chart review to determine baseline guideline-concordance with comprehensive biomarker testing in patients with aNSCLC at a community cancer center, and 2) to design, deliver, and evaluate an interactive educational intervention to improve both confidence and knowledge in providing genomically-informed cancer care among a MDT (multidisciplinary team) of oncology clinicians. **Methods:** An IRB-approved retrospective chart review of 275 patients with aNSCLC was conducted to determine baseline guideline-concordance – to assess biomarker testing at diagnosis and disease progression. This data informed the educational initiative. A comprehensive biomarker testing educational initiative was developed and implemented. The educational session consisted of findings from the retrospective chart review, discussion of communication gaps among a MDT of oncology clinicians, sample pathology reports, case studies with questions and answers, resources to navigate barriers in testing for clinicians and patients to refer to, and it addressed the importance of cancer genomics and national guideline-concordance with biomarker testing. Knowledge (0-15) and confidence (poor-excellent) were measured before and after the education through an online test reviewed by oncology APRN experts. **Results:** Retrospective chart review (N=222 patients with aNSCLC diagnosed in the years 2020-2022 after exclusion criteria) revealed high baseline concordance (213/222 patients; 96%) for testing at diagnosis. Repeat biomarker testing upon disease progression if the patient is on targeted therapy is guideline-recommended, and this retrospective sample demonstrated that 9 patients (n=9) of 222 had no evidence of repeat biomarker testing. Attendance at the virtual education was encouraging, with 51 participants consisting of nurses, advanced practice registered nurses, physician assistants, pharmacists, and social workers who completed the pre-test and 29/51 participants completed the post-test. The mean pretest score was 10.71 and mean posttest score was 13.86 [range from 0-15], and an unmatched T-test showed statistically significant increase in knowledge after the educational initiative ($p < 0.00001$). Confidence (poor-

excellent) in providing genomically-informed care among patients with aNSCLC improved as well. At baseline, 46 participants rated confidence as poor (N=23) or fair (26). This improved to a majority of participants rating confidence as good (N=16) or excellent (7) after the education. A chi-square test showed statistically significant increase in confidence ($p < 0.00001$). **Conclusion:** The chart review demonstrates that majority of the patients had biomarker testing done on diagnosis and progression. Discussion of gaps in the ordering process such as fostering communication among the MDT may increase awareness of barriers to testing. Furthermore, the educational initiative demonstrates enhanced knowledge and confidence among MDT of oncology clinicians. Due to the statistically significant findings, further interactive educational sessions should be conducted across cancer settings with discussion of other tumor types, while incorporating evolving guidelines. This also has significant implications for advanced practitioners - leaders of the oncology MDT – as they may attend/conduct further sessions to promote guideline concordance.

JL1214C: Creating a New Front Door for the Cancer Center: An Advanced Practice Provider-Led Diagnostics Service

Patricia Zendejas, NP, Gabriel Schwartz, MSN, NP, AOCNP®; University of California San Francisco

Background: Approximately 70 patients per month presenting to a large academic cancer center are refused care due to incomplete diagnostic workup. Time to cancer treatment initiation correlates with increased mortality risk ranging from 1.2–3.2% per week in some curative settings. Delaying cancer treatment by four weeks can increase the risk of death by 6-13%. Patients with findings concerning for malignancy may present with symptoms that are not well managed, which can lead to unnecessary emergency department (ED) visits or lengthy in-patient management. Patients are often lost to follow up. A study found that in one hospital, only 27% of discharge summaries mentioned a radiographic finding suspicious for malignancy, documented an in-hospital workup, or noted referral for outpatient follow-up. Only one-half of suspected malignancies were referred for follow-up. When patients are referred to Primary Care Providers (PCP) for further diagnosis, they may receive suboptimal and delayed workup due to PCPs' generalist nature. **Intervention:** Two oncology APPs identified barriers to access to cancer care and created a cancer diagnostics service, which launched in late March 2024. Identified populations that are denied timely access, mainly patients with possible digestive and hematologic cancers, and patients seen in the inpatient and ED settings. Established a medical director, APP, practice nurse, and administrative support. Created a process wherein patients are seen by the APP within 3-5 business days of initial referral. Clinic personnel conducted targeted outreach to clinical and administrative personnel involved in the care of patients with suspected new cancer diagnoses. Collaborative relationships with Interventional Radiology, Gastroenterology, and Interventional Pulmonology were established and streamlined referral processes were created. **Goals:** Reduce diagnostic delays by 4 weeks and bridge patients to definitive care faster resulting in decreased time to treatment initiation. Provide prompt supportive care and symptom management, reducing hospital re-admissions. Reduce hospital length of stay. Reduce patient loss to follow-up. **Results:** Within the first 13 weeks of launching, 15 patients were referred. An initial consultation with the APP was completed within 1-6 business days from the day of the referral. A definitive diagnosis was finalized within 2-15 business days for most patients. Patients saw a specialist within 10-23 business days. Patients avoided ED visits. These patients might have otherwise waited 4-8 weeks before arriving at a definitive diagnosis. **Evaluation:** Obstacles encountered during the planning period and soon after launching: Some patients were initially reluctant to meet with the APP and requested a consultation with a physician. Resistance from some subspecialists when a streamlined referral process for procedures was requested. During the initial roll-out, the service will not accept self-referrals and patients with possible hematologic cancers. **Recommendations:** Plans for continued program growth: A second APP and co-medical director specializing in hematology-oncology. Accept self-referrals and patients presenting with possible hematologic malignancies. Comprehensive internal and external marketing campaign to ensure widespread awareness of this service.

JL1215C: Development of an Oncology Advanced Practice Provider-Driven Germline Testing Program for Myeloid Malignancies

Meredith G. Beaton,[1] RN, MSN, AG-ACNP, Michelle Springer,[1] MS, CGC, Daniel Pollyea,[1] MD, Christine McMahon,[1] MD, Jaycee Gaspar,[2] MLS (ASCP)CM, Lisen Axell,[3] MS, CGC, Tyler Anstett,[4] DO; [1]University of Colorado, [2]University of Colorado Hospital, [3]University of Colorado Cancer Center, [4]University of Colorado School of Medicine

Background: Germline predisposition to hematological malignancies is a topic of increasing importance and concern to the research community and clinicians, particularly regarding treatment and hematopoietic stem cell donor selection. The 2016 Revision to the World Health Organization Classification of Myeloid Neoplasms and Acute Leukemia included a new category for myeloid neoplasms with germline predisposition. The European Leukemia Net (ELN) and National Comprehensive Cancer Network (NCCN) both recommend germline testing for certain subsets of Acute Myeloid Leukemia (AML) patients. Yet nearly 10 years later, genetic testing for myeloid malignancies lags behind solid tumors, likely due to a number of historical misconceptions regarding germline predisposition to myeloid neoplasms, including that they are uncommon, that they are primarily seen in pediatric and young adult patients, and that patients always have a strong family history of hematologic malignancies. However, with more patients undergoing germline testing and a better understanding of the predisposition syndromes associated with AML, these historical assumptions are being debunked. The implications of increased testing, on the other hand, are enormous as they can impact stem cell donor selection for patients as well as have myriad implications for families and potential surveillance or prophylactic therapy. **Interventions:** At our center, we have developed a new pilot germline testing program for AML patients. This process was developed collaboratively between Advanced Practice Providers (APPs), MDs, genetics counselors, nurses, and laboratory technicians. In this process, all newly diagnosed patients with AML are screened by the admitting APP to assess whether germline testing is indicated based on NCCN guidelines. If genetic testing is indicated, the patient is consented for germline testing with their first bone marrow. As part of their bone marrow biopsy, they receive a skin punch biopsy that is sent out for skin fibroblast culture and germline testing for all mutations recommended by NCCN guidelines. If the patient has a positive variant, they are automatically referred for genetic counseling. **Results:** We have thus far successfully screened over 20 newly diagnosed AML patients, 16 of whom met criteria for germline testing, and 15 of whom consented for testing. Of those that were tested, two have had germline mutations and have subsequently been referred to our genetic counselors. By offering testing with the initial bone marrow biopsy, we have reduced the need for additional procedures and appointments and impacted donor selection for patients. By providing this testing, we bring our center in line with NCCN and ELN guidelines. By creating simplified screening criteria and tips sheets, we have made it possible for hematology/oncology APPs to screen, consent, and test patients. And, by creating a standardized process within this pilot program, we have made germline testing accessible for patients and their families. Ultimately, our goal is to expand testing to patients with other hematologic malignancies as screening guidelines become clearer and more standardized across the field. **Conclusions:** Germline testing is an important testing option for patients with hematologic malignancies and their families. As the field has increased awareness of the implications for treatment and potentially transplant donors based on the results of germline testing, it is important that clinicians provide this testing to patients in standardized ways. It's also critical to develop screening methodologies for patients that allow for consistent identification and access to testing. **Recommendations:** Diagnosing an inherited predisposition to hematologic malignancy has several important implications, including treatment choices, donor selection for transplant, and identification and surveillance of at-risk family members. We recommend the creation of standardized processes for offering and testing AML patients for germline mutations, the development of a surveillance process for family members who carry germline mutations but may not have evidence of disease, and collaboration between oncology and transplant teams to ensure appropriate donor selection for patients who require stem cell transplant. Lastly, we recommend

developing a consistent, standardized, and accessible testing process that can be broadened to all hematologic malignancies in the future.

JL1216C: Enhanced Role of The Advanced Practice Provider to Improve Outcomes and Quality of Life for the Cutaneous T-Cell Lymphoma Patient

Patricia Gerber, APRN, CNP; Mayo Clinic

Background: Cutaneous T-cell lymphomas (CTCL) are a heterogeneous group of Non-Hodgkin Lymphomas (NHL). CTCL is rare, constituting ~4% of NHL diagnoses in the United States. Characterized by infiltration of the skin by neoplastic T-lymphocytes, CTCLs are primarily an indolent disease associated with a poorer prognosis in late-stage disease (≥ IIB). The two most common subtypes of CTCL are mycosis fungoides (MF) and Sézary syndrome (SS), accounting for 60% of primary cutaneous lymphoma. Staging is vital in directing treatment and requires a multidisciplinary team. Topical corticosteroids are the most used first-line treatments for early MF. Advanced stage MF will require systemic therapies. Treatment for MF/SS has a 30-50% response rate. Complete response is rare. Patients commonly progress through multiple treatments. The objective of this case study is to discuss clinical trial influence and expanded role of the APP on treatment decisions in patients with a rare subtype of CTCL MF. This case also highlights the need for a multidisciplinary team for ongoing management and symptom control. **Intervention:** A 71-year-old Caucasian male presented with skin lesions and cellulitis of his lower extremity. Punch biopsy showed atypical epidermaltrophic T-cell lymphoid infiltrate consistent with CD8 positive CTCL lymphoproliferative disorder with positive T cell gene rearrangement studies. Repeated biopsy of the lesion one month later again showed CD8 positive T-cell lymphoproliferative disorder with large cell transformation and weak CD30 staining. Flow cytometry was negative. Biopsy of abdominal rash showed CD8 positive cutaneous T-cell lymphoma without large cell transformation. Patient participated in a clinical trial exploring in vivo patient tumor sensitivity testing with injections completed by a trained APP. **Results:** Patient had skin limited stage IA disease, but with large-cell transformation that was CD30 negative, which portends a poorer prognosis. Recommendation was to treat the patient as if he were stage IIB with limited tumor disease. The clinical trial utilized microinjection into three areas of clustered lesions. Medications injected included pembrolizumab, romidepsin, and copanlisib. One week post injection, the lesion injected with pembrolizumab had decreased in size, was flatter and appeared to be healing. Patient initiated systemic treatment with pembrolizumab in March 2022. After cycle 10 there was resolution of skin lesions except for left foot lesions which impacted daily activities. After cycle 11, patient appeared to have disease progression. Alternative treatment was considered but unfortunately insurance approval was denied. Pembrolizumab was continued. Skin lesions improved with continued pembrolizumab infusions. Our patient has continued systemic treatment with pembrolizumab since March 2022. Disease has been overall controlled with pembrolizumab, intermittent radiation and topical management of painful lesions. The multidisciplinary approach has allowed the patient to continue his daily activities. **Conclusions/Implications:** This case study shows the expanded role of the APP in clinical trials. APP was trained in the new skill of providing injections and response assessment allowing for prediction of precise treatments which are more likely to work for specific patients. This case also highlights the role of the APP in a multidisciplinary team in management of a rare disease to improve the patient's quality of life.

JL1217C: Enhancing Cancer Screening Accessibility: The Advance Practitioner's Role in Serving Vulnerable Populations

Stacy Mathews,[1] MSN, Heather Koniarczyk,[2] MSN, APRN-CNP, AOCNP®; [1]Cleveland Clinic Foundation, [2]Advanced Practitioner Society for Hematology and Oncology

Background: Cancer remains a significant public health concern, particularly among vulnerable populations who face barriers to accessing preventive care. Advance Practitioners (APs) can play a crucial role in bridging this gap by providing comprehensive cancer screenings to underserved communities, with a goal to reduce late-stage cancer diagnoses. This abstract explores the unique role of an Oncology AP in delivering cancer

screening services and follow up care to vulnerable populations, emphasizing the importance of their expertise, accessibility, and patient-centered approach to improving patient outcomes. **Methods:** The role of the community AP is to address cancer disparities through research, education, prevention, navigation, and improving access to healthcare resources in the under-represented populations, with a team of patient navigators. The population served are 57% black: 90% female and 77% from an urban county in Ohio. Cancer screenings offered include mammography, colonoscopy, prostate specific antigen (PSA), lung cancer screening imaging, human papilloma virus (HPV) vaccination clinics/PAP testing, and a research study on the impact of screening black Americans for multiple myeloma. The AP provides individual education on screening processes, explains techniques, orders screening exams, discusses results, facilitates timely referrals for abnormal screening results. **Results:** Since 2021, the number of individual patients served, and screening order completed is growing, 1,004 in 2021, 1746 in 2022, 1570 in 2023, and 2114 annualized in 2024. In 2023, patient volume decreased as did patients served, and orders entered when there was a vacancy of the AP position and rebounded nicely with rehiring an AP at the end of 2023. Additionally, the % of screening orders completed has increased year over year as well from 39 to 44%. The AP has managed and navigated 17 patients with a new cancer diagnosis over a 3-year period. **Discussion:** Early detection and treatment of cancer can improve survival rates, reduce the need for more aggressive and expensive interventions, and enhance the quality of life of patients and caregivers. AP's expertise, accessibility, and patient-centered approach make them invaluable assets in the fight against cancer disparities. An APs role in a community outreach program has proven to support the programs growth, assist patients in overcoming barriers such as trust in healthcare providers, health literacy, transportation issues, financial constraints, and language barriers, lost to follow-up cases, which disproportionately affect marginalized communities. The community benefit, prevention of late-stage cancer diagnoses, and higher cost of care downstream cannot be overlooked. Summary A unique model housed in a large Midwest academic medical center is showing positive patient outcomes with the utilization of an oncology AP embedded within a community outreach program. APs improve quality and effectiveness of cancer screening services by ensuring evidence-based screening and referral guidelines are followed. Future research and policy efforts should continue to support and expand the involvement of APs in cancer screening initiatives to ensure equitable access to preventive care for all individuals, regardless of socioeconomic status or background.

JL1218C: Enhancing Early-Stage Non-Small Cell Lung Cancer Care: Streamlining Biomarker Testing and Multidisciplinary Coordination Through Quality Improvement Initiatives

Jennifer Aversano,[1] MSN, RN, OCN®, ONN-CG, Jennifer Tseng,[2] MD, Stephanie Brinton,[3] MD, Jose Galeas,[4] MD, Bianca Alvarez,[5] MPH, Ashley Lile,[5] MPH, Molly Kisiel,[5] NP, Joseph Kim,[6] MD, MPH, MBA, FACHE, Matthew P. Smeltzer,[7] PhD, Elana Plotkin5; [1]Endeavor Health, [2]Orlando Health, [3]Wake Forest, [4]Infirmary Health, 5ACCC, [6]Xaf Solutions, [7]The University of Memphis

Background: Early-stage non-small cell lung cancer (NSCLC) is a heterogeneous disease with diverse molecular profiles and treatment options. Recent advances in targeted therapies and immunotherapy have improved patient outcomes. However, some patients experience delays in treatment planning as cancer centers face challenges in timely and appropriate biomarker testing and coordination among the multidisciplinary care team to effectively deliver multimodal treatment, including neoadjuvant and/or adjuvant therapy for appropriate patients. **Methods:** The Association of Cancer Care Centers (ACCC) collaborated with 4 cancer centers on a quality improvement (QI) project aimed at improving care for patients with early-stage NSCLC. Sites in Alabama, Florida, Texas, and North Carolina participated, representing a mix of community hospitals and academic medical centers. Each site reviewed workflows and baseline data on biomarker testing in patients with early-stage NSCLC and implemented interventions to streamline testing processes, increase testing rates, and reduce delays. Nurse navigators and advanced practice providers (APPs) facilitated and implemented interventions using QI methods, National Comprehensive Cancer Network® (NCCN®)

guidelines and engaged members of the multidisciplinary care team to ensure optimal treatment planning. **Results:** Interim project data reveal that sites improved EGFR and PD-L1 testing by 25%, improved timely (< 4 weeks from the date of diagnosis) biomarker testing by 11%, and increased the proportion of patients discussed in tumor boards by 20%. ALK testing was not included when the project began but has since been incorporated into updated clinical workflows. Nurse navigators and APPs achieved these improvements by engaging key stakeholders with the pathology and thoracic oncology departments, streamlining workflows, standardizing biomarker test ordering pathways, and reinforcing the need to have test results prior to neoadjuvant/adjuvant treatment planning. Multidisciplinary care members also identified and explored ways to navigate complex barriers such as the Medicare 14-day rule for inpatients, vetting and selecting reference labs, incorporating liquid biopsy when tissue quantity is not sufficient (QNS), and providing ongoing education as new data emerges. **Conclusion:** Nurse navigators and APPs are key members of the multidisciplinary team who can lead and implement QI efforts to ensure timely and effective biomarker testing for patients with early-stage NSCLC. Findings from these QI programs demonstrate that cancer centers can increase biomarker testing rates and adherence to guideline concordant care through multidisciplinary team engagement, optimizing care for patients with early-stage NSCLC. **Recommendations:** Provide opportunities for nurse navigators and APPs to lead QI initiatives around biomarker testing in patients with early-stage lung cancer. Current clinical guidelines recommend EGFR, ALK, and PD-L1 testing in patients with resectable early-stage NSCLC. These test results can guide clinical decisions regarding neoadjuvant and/or adjuvant therapy for patients undergoing surgical resection.

JL1219C: Go With the Patient Flow: The Triage Advanced Practice Provider

Margaret Canjura, DNP, FNP-BC, Rachael O'Donnell, DNPc, AGNP-C, OCN®, Jessica Cerulli, DNP, FNP-C, RN; Memorial Sloan Kettering Cancer Center

Background: Advanced Practice Provider (APP) leadership at a large metropolitan academic cancer center identified many inefficiencies in the inpatient admissions process. Specific issues include the lack of transparency and equity in patient assignment, consideration of inpatient provider staffing, hospital census, and patient acuity in admission decisions. Evidence suggests the creation and adherence to a standardized process may increase hospital efficiency, improve patient safety, enhance patient and staff satisfaction and improve patient flow. The creation of the Triage APP fulfilled the organizational need for a standardized admissions process. The utilization of an APP in this role allowed for a global perspective of the hospital intricacies which helped to close the gaps on these inefficiencies through their detailed lens. **Methods:** A working group consisting of Department of Medicine and APP Leadership was assembled to review the current state of the admissions process. The initial process, overseen by a rotational chief resident, based patient assignment on solely cancer origin. Admission decisions did not account for hospital census, patient acuity, and inpatient provider staffing. This group developed a standardized admission workflow with specific criteria for admission to inpatient teams. A group of experienced inpatient APPs were identified and selected by APP Leadership to this new role. Their responsibilities include, but are not limited to, ensuring appropriate and safe staffing ratios, balancing census amongst inpatient teams, and enhancing inpatient care by assisting with appropriate escalation of care and allocation of resources. An important function of this team is disseminating updates and pertinent clinical information to inpatient staff in an ever-changing healthcare environment. **Results:** The creation of this new role, uniquely utilized by an APP, led to the development of several inpatient overflow teams. This allowed disposition of increasing number of admissions based on staffing and census, as opposed to patient cancer diagnosis, which was a historical driver of patient placement. The Triage APP maintains full control over identification of these patients for overflow teams and is responsible for the rebalancing of inpatient teams' census, ensuring safe patient/provider ratios. Previously there could be large discrepancies amongst inpatient team census, 30 patients on one team and 10 on the other, this process allowed each team to have 15. The addition of these new teams and restructur-

ing of the admission pathway allows the hospital to maintain patient to provider ratios (approx. 6:1). The Triage APP role led to the creation of many initiatives including a pathway to transfer stable patients to other satellites in times of high census and new order sets that allow for prompt notification of patient readiness to transfer between services. The ability to assign admissions through the utilization of a Triage APP supports closed loop communication and ensures safe, correct & prompt patient handoff. **Conclusion:** The Triage APP role improves the efficiency of the admission process and has undoubtably proven itself a central resource to all inpatient teams. The role of Triage APP is instrumental in managing inpatient flow throughout the hospital with their unique global perspective. Recommendations Continued expansion of this distinct APP role.

JL1220C: Identifying Post Procedural Adverse Events in Mobile Interventional Radiology

Laura C. Kounev, MSN, FNP-C, Alexis Fowler, MSN, RN, CMSRN, Eunhye Newman, ACNP; Memorial Sloan Kettering Cancer Center

Background: In today's healthcare environment, the underutilization of data in adverse event (AE) identification poses significant challenges. While manual chart review serves as a prevalent method for AE identification, it lacks a consistent gold standard tool for data capture. To address this issue, a systematic review of PubMed, CINAHL, and Cochrane identified 502 relevant articles, of which 22 offered insights into various AE reporting methods, including hybrid approaches combining automated systems and manual reviews. To gauge the time investment in manual chart reviews, a sample of random days in April 2022 was examined, revealing an average of 45 minutes per review across 5.5 average daily cases, with no complications detected. Recently, a surge in daily procedures, averaging 6.73 daily from 9/1/23 – 10/31/23, indicating potential increased time constraints for manual reviews. Leveraging Advanced Practice Providers (APPs) for manual chart audits reduces daily procedural availability, reducing the APPs' time spent bedside. **Methods:** To address these challenges, we propose a hybrid alert system designed to optimize proceduralists' time and enhance patient care. This system utilizes systematic audits of patient charts post-procedure, integrating vital signs, laboratory results, and order sets to discern AE trends. A predefined data line using these data points triggers automatic alerts for potential complications, prompting manual chart audits only when necessary. Collaborating closely with the IT department, our team developed and validated the data line using historical data, ensuring its efficacy. When tested against the archived patient charts, this data line captured all known AEs. **Results:** Results indicate a bleeding complication rate of 0.12% (4 out of 3401 procedures) since the inception of the Mobile Interventional Radiology (IR) team in January 2020. In 2023 alone, 3 manual chart audits were prompted out of 1180 procedures, conserving approximately 160.5 proceduralists' hours and augmenting APPs' availability for bedside procedures. **Conclusions:** This study underscores the imperative of optimizing proceduralists' productivity amidst escalating procedural volumes. By leveraging automated data lines to streamline AE identification, manual chart reviews are minimized, APPs' bedside presence is maximized, and AE detection is systematized, ensuring valuable patient safety practices. Recommendations Based on our findings, the adoption of hybrid AE reporting systems emerges as an effective strategy in capturing post-procedural complications within Mobile IR settings, signifying a pivotal step towards enhanced patient care and safety.

JL1221C: Impact of Peer-Developed Education on the Clinical Utility of Liquid Biopsy for Advanced Practitioners

Lauren Welch, MSN, NP-C, Candice Graham-Adderton, DNP, MPH, FNP-C, Kelsie Hankins, MSN, APRN, CNPN-AC, Jessica L. Anderson, RNc, MS, WHNP-BC, AGN-BC, Cristin O'Neal, MSN, ANP-C, Gretchen D. Suk, DMSc, PA-C, Leslie Bucheit, MS, CGC; Guardant Health

Background: Next generation sequencing (NGS) has expanded identification of genomic biomarkers to inform treatment selection in solid tumor malignancies. NGS is commonly performed on tissue but is increasingly performed on circulating tumor DNA (ctDNA) via liquid biopsy (LB). Given rapid advances and various testing modalities, it is essential that oncology advanced practitioners (APs) properly identify patients to undergo com-

prehensive genomic profiling (CGP) and accurately interpret results for patient care. Here, we describe implementation and impact of a case-based learning (CBL) education program for APs focused on utility of LB-based CGP. **Methods:** A team of APs within the Medical Affairs (MA) organization of a precision oncology company developed CBL materials to educate APs on the utility of LB-based CGP for advanced-stage cancer patients. Educational materials incorporated Mayer's Multimedia Learning Theory principles and a constructivist instructional design to improve understanding of the clinical utility of LB (1) at diagnosis, (2) disease progression, and (3) treatment response monitoring. Participants attended educational sessions in-person or remotely and completed a survey before and after the intervention to assess impact. Comparisons were measured using Chi squared and/or t-tests with significance defined as $p < 0.05$. **Results:** The survey was completed by 106 APs from >15 institutions. Most participants reported working in a community setting (80/106, 75%) and having 4-10 (43%) or 0-3 years (33%) experience as oncology APs. There was no significant difference in distribution of settings (academic/community) across years of experience categories ($p=0.48$). Where provided, the most common paradigms for CGP were tissue-first with reflex to LB if quantity not sufficient (36%, 38/105) and concurrent tissue/LB testing (35%, 37/105). Many APs reported use of LB–based CGP at the time of new diagnosis (n=64) or progression (n=78), alone or with other settings. After education, 23% (24/104) reported they would consider LB for expanded indications: of those who reported prior use of LB at clinical progression only (n=26), 62% (16/26) reported they would consider at new diagnosis; of those who reported use at new diagnosis only (n=12), nearly all reported consideration of use at progression (11/12, 92%). All groups across years' experience and setting experienced statistically significant increase in confidence to identify patients appropriate for CGP post-education compared to pre-education ($p < 0.01$), the greatest numeric increase observed for APs with 0-3 years' experience. Similarly, all groups across years' experience and setting reported statistically significant increase in confidence interpreting / explaining CGP results to patients post-education ($p < 0.01$). Following the education program, nearly all participants (97%,103/106) reported being able to identify patients suitable for CGP. Additionally, 99% (105/106) reported education would impact their clinical practice and would recommend the education program to APs. Conclusion: In this study, peer-developed case-based education of APs increased confidence and understanding of the utility of CGP via LB for therapy selection. Given CGP's increased relevance to clinical practice and AP integration throughout the patient journey, increased understanding is critical to inform patient care. Ongoing AP training and/or onboarding may benefit from inclusion of peer-developed education to ensure patient access to and understanding of CGP.

JL1222C: Implementation of an Advanced Practice Provider-Led Scholarly Project Review Committee: Pathway to Success

Shila Pandey, DNP, AGPCNP-BC®, ACHPN, Leigh McGrath Ehinger, DNP, AGPCNP-BC®, Helen Jacob, DNP, RN, FNP-BC, Caroll Tipian, DNP, RN, AGACNP-BC®, Jessica I. Goldberg, PhD, AGPCNP-BC®, ACHPN, Kelly E. Preti, MSN, RN, AGACNP-BC®, OCN®, Nkechi Fearon, MSN, RN, AGPCNP-BC®, AOCNS®, Naomi Cazeau, MSN, ANP-BC, AOCNP®, Nicole Zakak, MS, RN, CPNP, Kelly S. Haviland, PhD, MSN, FNP-BC, TGNB-C; Memorial Sloan Kettering Cancer Center

Objective: To describe the development and implementation a novel advanced practice provider (APP)-led review committee that tracks and reviews scholarly project proposals including evidence-based practice (EBP), quality improvement (QI), and research projects. **Background:** APPs express strong interest in participating and leading QI, EBP and research activities to improve patient care (Austin et al., 2021). While APPs may be involved in the clinical care of oncology patients on clinical trials, they may lack experience with EBP/QI and research methods (Braun-Inglis et al., 2024). Barriers to engagement in scholarly work include a lack of mentorship, knowledge of QI/EBP processes and research methods, protected administrative time, funding, and organizational incentives (Blok et al., 2022). A gap was identified by organizational leadership, whereby APPs seeking to lead scholarly work lacked formal direction and mentorship. **Methods:** In December 2020, the APP QI, EBP, and Research Review Committee was established as a peer-review

panel for APP-led scholarly project proposals. The Committee serves 950 APPs at a major metropolitan, non-profit, academic, National Cancer Institute-designated cancer center. The Committee created a step-by-step guide for APPs leading each type of project (EBP/QI, research), an algorithm for project submission and approval process, and a Research Electronic Data Capture (REDCap) project proposal form (Harris et al., 2019). All APPs practicing within the APP division are required to follow this process. The Committee meets bimonthly to review project proposals using a standardized evidenced-based approach. They provide detailed feedback to improve the quality of proposals and offer individualized guidance on next steps. Additionally, the Committee offers ad-hoc office hours prior to REDCap submission and virtual meetings to review Committee feedback and obtain project clarification. The Committee collaborates closely with the Department of Nursing Research to determine whether submissions require review by Institutional Review Board (IRB) for human subjects research. To promote dissemination, the Committee distributes follow-up surveys at 6- and 12-months post-implementation and offers 1:1 mentorship for abstract development for conference presentations. **Results:** Since inception in December 2020, 70 project proposals were submitted to the Committee. Of these, five were excluded from review process. Proposals were reviewed within 2 weeks after submission. Three (5%) of the 65 were directed to IRB. In total, 39 (60%) projects have been completed, 18 (28%) are ongoing, and 8 (12%) were abandoned or postponed. Thirty-three (51%) have completed dissemination in the form of a poster, podium presentation, or publication. **Conclusions:** An APP-led peer-review process to provide guidance on scholarly project development, implementation, and dissemination is feasible and improves the quantity and quality of scholarly work among APPs. With this standardized process, the organization is better able to capture data on APP professional development activities and offer support and resources to facilitate scholarship. Future data will help identify facilitators and barriers to scholarly project completion. **Recommendations:** To achieve greater APP involvement with scholarly work, APPs require organizational support and structure. Committees such as the one described ensure APPs follow appropriate steps for project approval and have access to the resources and mentorship needed for project development and implementation.

JL1223C: Implementation of Virtual Meditation Sessions to Impact Advanced Practice Provider Self Care

Ashley Linington, DNP, ACNP-BC, OCN®; Memorial Sloan Kettering Cancer Center

Background: Advanced Practice Providers (APPs) are experiencing poor job satisfaction due to demands for productivity and role strain, with burnout levels seen as high as 59%. In 2021, a wellness survey was conducted at a National Comprehensive Cancer Network (NCCN) hospital in New York, NY to assess the level of burnout within their organization. Results showed that 57.5 % of their APPs reported feeling burned out as compared to the benchmark of 34% set by other organizations. Upon further review, it was identified that the organization lacked evidence-based self-care interventions readily available to their providers. A review of the literature identified best practices to help to combat burnout and focused on three themes: self-care, community, and organizational wide initiatives. In five out of the eight studies reviewed, mindfulness interventions such as meditation was identified as impactful. **Methodology:** A series of virtual meditations sessions, conducted via Microsoft Teams by a trained mind body specialist, was offered to a subset of inpatient surgical and medical APPs three days a week (Monday, Wednesday & Thursday) from 2:00-2:15pm for a total of three months. Pre- and post-implementation surveys was designed by the author and reviewed by content experts. The eight questions pertaining to APP well-being and self-care practices were analyzed using separate chi-square tests to compare the proportion of responses pre- and post-intervention. For the ten evaluation questions, descriptive statistics of frequency and percentage of responses were reported. **Results:** A total of 54 APPs were sent the pre-implementation survey with a total response rate of 61%. After three months, a post-implementation survey was sent. A total of 33 APPs were sent the post-implementation survey with a total

response rate of 52%. A statistically significant difference was seen in the categories of leadership support of self-care practices (p=0.02), the accessibility of self-care practices within the organization (p=0.02), how impactful the sessions were to the APPs self-care (p=0.13), as well as the APPs being able to prioritize their self-care throughout the workday post intervention (p=0.01). Regarding the use of Microsoft Teams, 88% of the participants found that platform to be easily accessible and the length of the sessions as adequate. A total of 65% of the participants felt the timing of the sessions made it easy for them to attend. Seventy-six percent of participants reported that if offered, they would continue participating in the sessions, and 88% said they would recommend this intervention to a colleague. **Conclusions/Limitations:** Staff that participated in the virtual meditation sessions reported an improvement in overall self-care. Limitations of this study included lower staff participation on days when the inpatient hospital census was greater than 105%. Given the daytime hours of the sessions, the night APP staff were not able to participate. **Recommendations:** Healthcare organizations facing burnout amongst their frontline staff should offer easily accessible, self-care interventions, such as virtual meditation sessions to help to positively impact APP self-care and well-being. Future studies using evidenced based interventions is needed to move the needle on this important topic.

JL1224C: Implementing A Telehealth-Based Survivorship Program

Diane M. Sneed, MSN, WHNP-BC, Tennessee Oncology

Background: The experience of surviving cancer is sweeping--from attention to isolation, the ultimate adrenaline surge to a significant identity crisis. The aftershock that comes with completing treatment is largely ignored and misunderstood. This ever-growing population has ongoing emotional and psychological needs that often need to be addressed outside of their routine surveillance appointments. **Procedures:** The advanced practice providers (APP) within a community-based oncology practice consisting of thirty clinics across the state recognized an opportunity to utilize telehealth appointments to expand the existing Survivorship program. Due to lacking physician referrals, orders were strategically placed within the treatment regimens of patients with Stages I, II, and III cancers within one year of diagnosis. The order was put (a) at the end of the last cycle of chemotherapy; (b) before the first three-month follow-up appointment; or (c) at the beginning of an extended oral regimen. A Survivorship coordinator contacted patients who had completed curative intent treatments to offer a one time, hour long, comprehensive appointment with an APP via telehealth. If the patient declined an appointment or was unable to be reached, an individualized Survivorship care plan was created and sent to both the primary oncology team and primary care physician (PCP) for distribution at the next follow-up appointment. **Findings:** From 2021 to 2023, a total of 3,529 patients were offered a Survivorship appointment. During the observed time, there was a 21% acceptance rate, 38% declined, 38% were unable to be reached, and 3% were non-eligible for a telehealth appointment. The majority of accepted visits were by females with breast cancer, followed by females with colorectal cancer. The most common reasons for accepting the visit were fears of recurrence and post-treatment anxiety, as well as education on side effects, when to call the oncologist for new issues, and community resources. The APPs described the Survivorship visits as "very emotional" for patients, and referrals were frequently made to psychology, palliative care, and integrative oncology providers within the practice. **Conclusions:** Survivorship visits provided an opportunity for patients to feel emotionally supported by the practice beyond completion of curative intent treatment. They were efficient, cost effective, and covered by most major insurance companies. They also allowed for continued communication with the PCP, as all visit notes and care plans were shared with them. The barriers noted were lack of access to technology and lack of patient understanding of the visit due to little physician engagement. **Recommendations:** Support from the primary oncology team is a critical component of a thriving Survivorship program. Starting the discussion about Survivorship at the beginning or even middle of treatment could help increase interest and participation, as well as minimize no shows. Consideration should be given to ongoing follow-up appointments to ad-

dress progress with the referrals made and education given.

JL1225C: Implementing an Advanced Practice Provider-Led Diagnostic Clinic: Lessons Learned

Lauren Brister, APRN-CNP, Helen Foley, APRN-CNS; University Hospitals Seidman Cancer Center

Background: In early 2023, advanced practice provider (APP) leadership at University Hospitals Seidman Cancer Center, an NCI-designated cancer center, was charged with implementing an APP led diagnostic clinic for patients with concern for malignancy. Historically, patients with concern for malignancy either had an extended inpatient hospitalization to complete an oncology work-up or were discharged from the emergency department (ED) and instructed to follow-up with their primary care provider (PCP). The goal in implementing a diagnostic clinic was to serve our community by providing a single access point to Seidman for hemodynamically stable patients who required an oncology work-up. The Diagnostic Clinic evaluated the patient, expedited testing, and arranged the appropriate follow-up with an oncologist, or their PCP depending on the outcome. **Method:** Using existing full-time equivalents (FTEs), two APPs reviewed and accepted referrals via email distribution list for patients with a new mass or lymphadenopathy seen in the ED and inpatient medicine services across the health system. Patient followed one of three paths, 1) APP ordered necessary testing, navigates them through the work-up via phone, 2) APP arranged appointment with specific specialty (ENT, Urology, etc.), or 3) APP saw patient for in-person visit, coordinated appropriate testing. Regardless of the path, patients received patient education and symptom management by APP throughout the process. Once diagnostic work-up completed, the referring provider was updated on the outcome and the patient was scheduled with an oncologist or their PCP depending on the results of the work-up. **Results:** Total Referrals: 564 patient referrals from June 2023-June 2024. Top 5 Referral Sources: ED, Nurse Navigator, Trauma, Inpatient, PCP. Top 5 Reasons for Referral: Lymphadenopathy, GI, Incidental Findings, Lung Mass, Lung Nodule. Time Spent Per Patient Referral: 1 hr if patient directly referred to specialist. 2 hr if arranging diagnostic testing, following results, and coordination of oncology visit. 5 hrs if patient seen in-person, arrange diagnostic testing, follow results, manage symptoms, and care coordination. **Conclusions/Lessons Learned:** The Diagnostic Clinic addressed a large unmet need both for referring providers and patients navigating a complex health system in a time of clinical uncertainty. As a result, the diagnostic clinic expanded beyond original intention and capacity. A stepwise rollout of referral source was critical in our learning process. Relying on expertise of experienced academic APPs, the clinic was able to evaluate a larger volume of patients with a variety of findings. Physician collaborators, formal and informal, were helpful in addressing diagnostic challenges. Institutional support was essential in both establishing the clinic as well as planning future directions and additional FTEs. Implementing a Diagnostic Clinic within the cancer center improved both the patient experience and referring provider satisfaction. In conclusion, APPs can play a vital role in the timely diagnostic work-up of cancer patients in an academic medical center.

JL1226C: Improving Documentation of Oncofertility Discussions at a Single Institution

Leslie Goebel, DNP, RN, ACNP-BC, Siobhan Bissonette, RN, Heather J. Jackson, PhD, FNP-BC, NEA-BC, FAANP, David S. Morgan, MD; Vanderbilt University Medical Center

Background: Provider-led oncofertility documentation is recommended by multiple national guidelines with demonstrated positive impact on young adult cancer survivors' quality of life. However, less than 50% of these patients have oncofertility documentation and most report poor quality discussions. Improving documentation of quality elements such as fertility risk (FR) and fertility preservation (FP) counseling may optimize oncofertility discussions. Malignant hematology patients may have fewer oncofertility discussions due to prioritizing treatment and sparse data for FP strategies in this population. The purpose of this quality improvement (QI) project was to develop a documentation tool to increase the rate and quality of provider-led oncofertility discussions at an academic cancer center. **Methods:** An

advanced practice provider (APP) led team developed an electronic health record (EHR) based fertility screening tool (FST) incorporating validated FR tools and FP counseling recommendations based on published algorithms. Oncofertility education and training was provided prior to implementation. To evaluate the effectiveness of the QI project, a retrospective chart analysis was performed of two independent groups, pre- and post FST implementation. A quality score (QS) was created to assess documentation quality. A convenience sample of outpatient malignant hematology patients, ages 18-45, with exposure to an anticancer agent was utilized. Documentation rates were compared using counts and relative frequencies and analyzed using Pearson's Chi Square by patient, provider and disease characteristics. Descriptive statistics were used to compare QS. **Results:** There were 93 patients in the pre-intervention group and 86 in the post-intervention group with no significant differences in demographics. Oncofertility documentation, with or without the use of the FST, improved between the pre- and post-intervention groups from 29% (n=27) to 64% (n=55; p < .001). Median value of QS prior to FST implementation was 0 (IQR 0-1) and 71% (n=66) had no quality elements documented. After FST implementation, median value of QS was 2 (IQR 0-3) and those lacking quality elements were 36% (n=31). In the post-implementation group, FST was used in 38% (n=33) and in those, median value of QS was 3 (IQR 3-3). Males had lower rates of oncofertility documentation than females (50%, n=19 compared to 75%, n=36; p=.016). Patients aged 31-45 had oncofertility documentation less often than younger patients (56%, n=31 compared to 77%, n=24; p=.015) and less frequent documentation of FR and FP counseling (27%, n=15 compared to 58%, n=18; p=.005, and 51%, n=28 compared to 74%, n=23; p=.035.) Documentation rates were lower for patients receiving low FR treatment than those who received significant risk therapy (60%, n=25 compared to 87%, n=26; p < .001) and lower by attendings (52%, n=32, p < .001) than physician fellows (100%, n=9) and APPs (93%, n=14). Overall, FP documentation was most frequently performed by APPs (93%, n=14; p < .001). **Conclusions:** Oncofertility documentation improved following FST implementation. Population gaps were noted, consistent with previous studies. Poor FST adoption may be improved by implementing evidence-based reminders within the EHR. Optimized oncofertility documentation facilitates guideline adherence and may improve survivors' quality of life. APPs may lead oncofertility initiatives and serve as resources to other members of the health care team.

JL1227C: Improving Hypocalcemia Symptom Management during Apheresis

George L. Valiente,[1] MSN, APRN-BC, BMTCN, Marisol Castellanos,[2] BSN, RN, Audra Lopez,[2] MSN, RN, APRN-BC, CNS-C, Elibel Borges,[2] MSN, RN, CDEO, CRC, Giselle F. Bacallao,[3] RN, OCN®, BMTCN, Mary MacKrell,[1] RN, MSN, MEd, OCN®, BMTCN, Diana Martinez,[4] PharmD, BCOP, Shakuntala Shrestha,[1] APRN, DNP, Jennifer M. Logue,[1] MD; [1]Moffitt Malignant Hematology & Cellular Therapy at Memorial Healthcare, [2]Memorial Cancer Institute, [3]Memorial Healthcare System, [4]Memorial Hospital West

Background: Hypocalcemia is a common adverse event (ADEs) during apheresis due to the need for anticoagulation with Anticoagulant Citrate Dextrose (ACD) as part of the extracorporeal circuit. ACD binds to ionized calcium (iCa+) ions which are an essential co-factor in the clotting cascade. This inhibits coagulation ex-vivo without causing bleeding in-vivo but does lead to acute hypocalcemia events and accounts for ~ 50% of ADEs during apheresis. Advanced Practice Providers are often tasked with patient assessment and management during cell collection procedures. Potential hypocalcemia symptoms can range from mild perioral paresthesia, flushing or headaches, to moderate symptoms like nausea, vomiting, nervousness, irritability or muscle spasms, to severe symptoms like cardiac arrhythmia and seizures. More severe symptoms might be avoided with prompt intervention. **Methods:** We conducted a retrospective review of all apheresis procedures performed at our community-based academic hospital, from 8/23/22 through 11/6/23. We included patients who underwent apheresis for autologous stem cell transplant (SCT), allogeneic SCT, donor lymphocyte infusion (DLI), or chimeric antigen receptor (CAR) T-cell therapy. With our existing hypocalcemia standard operating procedures, calcium was being orally replaced at the initiation of every apheresis procedure for evidence of baseline hypocalcemia, then iCa+ level was checked and replaced during the procedure upon initial symp-

toms. **Results:** A total of 75 patients were identified as having undergone apheresis. Nine (12%) were asymptomatic and did not receive any intravenous (IV) calcium supplementation. One (1%) had mild symptoms but did not require IV calcium supplementation. Thirty-one patients (41%) had mild symptoms and required 2 gm IV calcium gluconate, while 15 (20%) received 4 gm; 13 (17%) received 6 gm; 4 (5%) received 8 gm; and 2 (3%) received 10 gm. For patients who had any symptoms of hypocalcemia, the average calcium gluconate given was 4 gm. For patients who received >1 bags of ACD, the average calcium gluconate given was 6 gm. **Conclusions:** Our findings indicate that 87% of patients required some form of IV calcium supplementation. After discussing the findings among our cellular therapy team during a dedicated clinical standards meeting, we decided to update our calcium replacement protocol. Patients would now receive 1500 mg of oral calcium carbonate and 1 gm IV calcium gluconate at the start of any apheresis procedure for any evidence of baseline hypocalcemia, defined as serum corrected calcium < 10 mg/dl. We also implemented an early intervention with 4 gm IV calcium gluconate at the first sign of any grade hypocalcemia with plan for additional 1gm IV calcium gluconate on a case-by-case basis for higher severity of symptoms or >1 bag ACD. We added a symptom-based tool for grading hypocalcemia based on Common Terminology Criteria for Adverse Events V.5. **Recommendations:** Preliminary data review indicates a reduction in Grade III and IV hypocalcemia events by 45% and no Grade IV events. This is an ongoing quality improvement project and further research analysis and data collection will be conducted.

JL1228C: Improving Retention Rates and Employee Satisfaction with an Advance Practice Provider Led Onboarding & Education Program

Courtney Sanderson, PA-C, Ashley Clark, PA-C; Fred Hutchinson Cancer Center

Objective: To help foster successful onboarding and education of new bone marrow transplant (BMT) and immunotherapy (IMTX) advance practice providers (APPs) during their 6 months of training throughout the outpatient autologous, allogeneic, immunotherapy and inpatient services. This APP driven role aims to encourage ongoing learning while ensuring new APPs meet institutional objectives as a BMT/ IMTX providers. This position also provides continuous support and professional development for sustained employee retention. **Processes:** The continuum of onboarding new BMT/IMTX APPs comprises several elements as outlined below: Onboarding/ education lead roles during interview process: Candidates are screened by our outpatient BMT/ IMTX manager. After initial screening a group interview is conducted in person or via zoom with onboarding/education lead APPs present. Clinical case scenarios are reviewed to observe decision making and critical thinking skills. Onboarding/education lead roles prior to start date: Our onboarding/education APPs work together with BMT/IMTX administrative assistants to plan orientation schedules. This includes verifying EMR training, clinical department orientations, oncology 101 and various department shadowing to include clinical coordinators office, infectious disease, and intensive care unit. Onboarding/education lead roles after start date: A welcome email is sent to new APPs and respective preceptors at the start of new rotations to include expectations and objectives. These objectives are reviewed on a weekly basis by preceptors to make sure clinical onboarding remains effective. A new hire monthly update email is sent out to attendings for all our BMT/IMTX clinical teams. This includes a brief overview of new APPs prior educational/career background to help promote continued collaboration and teaching throughout the month. Monthly in person check-ins with new APPs to review self-evaluations, preceptor evaluations and attending feedback. These check-ins also include clinical case scenarios to help establish broad differentials and provide feedback. If new APPs are not meeting objectives and or needing additional support remediation and performance improvement plans are developed and reviewed with outpatient manager. Monthly note audits and clinic shadowing are performed to provide feedback, learning opportunities and ensure quality institutional documentation. Upon completion of training setting up individualized mentors for new APPS to facilitate ongoing mentorship program. **Findings:** Since implementation of the onboarding/education APP

lead role in 2022, we have seen our institutional turnover percentage drop from 21.3% in 2022, to 4.4% in 2024. While this decrease is multifactorial, the implementation of the onboarding and education position has helped recruit and retain high quality BMT/IMTX APPs. To date we have onboarded 43 APPs since 2022. This onboarding model has also helped identify APPs who were at risk of attrition prior to completion of the training, helping to mitigate additional training expense. **Conclusions:** Developing a dedicated onboarding/education lead APP position has provided support and mentorship for new BMT/IMTX APPs. It has also provided innovative leadership positions for current APPs at our institution. This role has led to more efficient training and collaboration amongst our attending physicians and ancillary staff. We have also seen an increase in attending driven lectures to help foster new APP engagement. Newly trained BMT/IMTX APPs have expressed gratitude for the support and guidance of the lead onboarding/education role. **Recommendations:** As our institution continues to grow and with the recent development of an inpatient hybrid team the onboarding/education APP role will need to expand. Solutions to this include having a dedicated inpatient onboarding/education lead APP cohort who works directly with new APPs hired specifically for inpatient clinical training.

JL1229C: Incorporating Crucial Conversation Simulation Training into NP PA Onboarding in an Academic Cancer Setting

Jamie L. Carroll, APRN, CNP, MSN, Robin R. Klebig, MSN, APRN, CNP, AOCNP®, Rachel Eiring, PA-C; Mayo Clinic

Background: Clear and concise communication between patients and Nurse Practitioners (NPs) and Physician Assistants (PAs) that specialize in hematology and oncology is critical to developing a strong and trusting relationship. Many NPs and PAs do not receive adequate training surrounding crucial conversations related to cancer practice during their graduate training. This leaves them ill-prepared to deal with complex conversations during care. Simulation training is a well-documented tool for healthcare professionals to improve competency in difficult conversations (1,2,3). This tool has not been directly evaluated for cancer-focused NPs and PAs in large academic centers. This study aimed to evaluate the role of simulation-based training for NP and PA professionals in an academic cancer practice. **Methods:** Three simulated patient situations were created to practice patient centered skills during crucial conversations. Scenarios focused on breaking bad news, goals of care, NP and PA role advocacy and patient expectation setting to address patient misconduct. Defined objectives from each scenario included: Demonstrate steps of the serious conversation guideline (4), demonstrate use of REMAP framework for goals of care setting (5), and explain the NP/PA role within the care and reference SAFER training in response to patient misconduct (6). Learners were provided prereading materials to complement simulation. Post simulation surveys were collected to evaluate simulation experience and ability to meet objectives. **Results:** Two simulation education sessions between April 2022 and Feb 2024 were completed with a total of 26 participants. Post session surveys were sent with a response rate of 46%. Respondents noted objectives were clear. The post experience analysis was overwhelmingly positive that this course provided opportunities to self-reflect on performance and learning, was a safe and inclusive environment, and instructors were prepared. 100% of respondents reported increased confidence to manage similar situations in practice following training. Additionally, learners felt that this format helped them learn to validate patient emotions, improve communication tools, and the learning environment was realistic to actual patient scenarios. Discussion with participants noting the importance of addressing patient behaviors was particularly helpful to practice. **Recommendation:** We recommend that simulation training should be incorporated into hematology and oncology NP and PA onboarding to help bridge the gap between novice and experienced providers allowing increased confidence when holding crucial conversations during real world patient care. This can be a particularly helpful tool in a destination academic center where patient expectations can be mismatched to the modern care team model with frequent visits with NPs and PAs instead of physician colleagues. Simulation training provides a safe learning environment to practice communication tools to provide structure to navigate these crucial conversations.

JL1230C: Increasing Patient Access and Reducing Readmissions by Utilizing Advance Practice Providers

Deepa Shah,[1] PA-C, NP, Lauren Janchenko,[2] FNP-BC, Alison J. Holmes Tisch,[1] MSN, RN, ANP-BC, AOCNP®, Jaime Rees,[2] NP-C, APRN, MSN; [1]Stanford Healthcare, [2]Stanford Medicine

Background: An in-depth analysis of Stanford Healthcare's Cancer Center operations for the Fiscal Year '23 has brought some critical areas of healthcare delivery into sharp focus. Stanford Healthcare had a concerning 30-day readmission rate of approximately 22% for oncology services, with physician surveys indicating that as much as 28% of these readmissions could have been prevented. From July 2022 to June 2023, we observed 1,636 oncology-related ED admissions, with 40% of these cases being discharged directly from the ED. Additionally, it has been observed that, on average, there is a 22-day duration from the time of scheduling to the actual appointment for new patients. **Method:** In response to these issues, Stanford took decisive action to increase access by implementing Advanced Practice Provider (APP) led clinics. These clinics serve as a robust solution, staffed by highly skilled professionals operating within a collaborative framework. The clinics comprise three distinct entities: a Diagnostic clinic, a Cancer Transitional Care Clinic (CTC), and an Oncology Rapid Assessment Clinic (ORAC). The diagnostic clinic, staffed by APPs, expedites the evaluation of patients suspected of malignancies. Typically, at Stanford Health Care, scheduling a new patient visit requires a confirmed cancer diagnosis, which may take weeks. However, with the introduction of the diagnostic clinic, our aim is to enhance patient accessibility, targeting a new patient visit within seven business days of referral. The CTC, our post-discharge clinic, directly addresses the issue of potentially preventable readmissions. Its primary focus lies in facilitating the transition of patients from inpatient to outpatient care settings, thereby mitigating the risk of unnecessary hospitalizations. Lastly, the ORAC, situated within our infusion center, offers expedited care to patients in need of IV therapy or urgent diagnostic workup, with a dedicated APP at the helm. **Results:** Since the implementation of ORAC, 259 oncology patients have been effectively triaged. Of these patients, 8% required ED attention, 7% were direct admission and 85% were discharged home. ORAC has succeeded in averting hospitalization for 86 patients (CMS OP-35 measures). Our GI oncology CTC pilot has seen 220 patient post-hospitalization. The average duration from discharge to appointment stands at 5 days. Further data is pending on patient feedback and reduced readmission rate. The diagnostic clinic, as one of our newer initiatives, is still pending data. **Conclusions:** The establishment of these clinics has yielded promising results, including improved patient access, reduced ED admissions, and a decline in avoidable readmissions. Recommendation: To enhance accessibility, Stanford Health Care plans to extend the operational hours, access to procedures and locations of the Oncology Rapid Assessment Clinic (ORAC). In addition, the Cancer Transitional Care Clinic (CTC) will broaden its spectrum to incorporate all oncology specialties. Moreover, the Diagnostic Clinic will pioneer an innovative approach where patients, who harbor concerns for malignancy, will have the facility to schedule their appointments independently.

JL1231C: Increasing Physical Activity in Older, Rural Cancer Survivors: A Virtual Option

Kaye T. Sturz,[1] DNP, APRN, CNP, Saori I. Braun,[2] PhD, CSCS, ATC, Ruta Kirstein,[1] MS, ANP, Scott Okuno,[1] MD, Jennifer Rich,[1] MPH; [1]Mayo Clinic Health System, [2]University of Wisconsin-Eau Claire

Background: The number of cancer survivors is estimated to reach 22.2 million by 2030. Rural and older cancer survivors are medically and digitally underserved and are underrepresented in cancer research and experience more health disparities. According to the American Associated for Cancer Research, rural counties have 12% higher cancer mortality rates. In terms of modifiable risk factors that can contribute to cancer mortality, there is a 37% ad 39% reduction in cancer specific and all-cause mortality, respectively, in patients engaged in recommended physical activity (PA). This study examined the effectiveness and acceptability of a virtual PA intervention (PAI) among older rural cancer survivors. **Methods:** Participants from a rural Midwest Cancer Center participated in a weekly, 12-week virtual 1:1 exercise program with certified cancer rehabilitation exercise special-

ists (Maple Tree Cancer Alliance). The study was a single-group pre-test and post-test design. Outcome measures included physical functioning using a short physical performance battery (SBBP), moderate-intensity PA (MVPA) using accelerometry; step counts monitored by Fitbit, upper body muscular endurance via arm curl repetitions, flexibility testing, patient-reported outcomes, adherence, and satisfaction. The institution's Research and Innovations Council funded the study. The study was reviewed and approved by the institutional review board and registered through ClinicalTrials.gov - NCT05988892. **Results:** A total of 50 participants (average age = 67.5; BMI 29.7 kg/m-2; 62% rural) with various diagnoses and stages of disease were included. Ninety-two percent of patients completed the study, and 98% of prescribed sessions were adhered to. All participants were highly satisfied and reported being highly likely/likely to refer. Fifty evaluable subjects completed post-intervention testing as of July 10, 2024. Compared to the baseline, there was a 1310 increase in daily Fitbit steps (p=0.0001), an increase in SPPB gait speed score (p=0.0007), and an increase in MVPA by 25 minutes per day (p=0.004). SPPB lower body strength (p=0.0032) and upper body arm curl repetitions (p< 0.0001) improved. Flexibility scores improved by 2.4 inches (p< 0.0001). Balance scores improved from baseline but did not meet statistical significance (p=0.1250). Patient-reported fatigue and physical functioning improved by 5.8 points (p< 0.0001) and 4.3 points (p< 0.0001) respectively. By self-report, 6% of participants met ACS (American Cancer Society) guidelines at baseline, increasing to 50% at PAI completion. **Conclusions:** The virtual PAI provides a feasible, effective, innovative treatment to underserved older and rural populations. It was statistically powered to show an association between the intervention and the outcome. Limitations included a non-Hispanic white population with heavier participation by breast cancer survivors. Including Stage IV patients may have reduced effect size. Nevertheless, this study increased access to clinical trials among underserved populations to transform survivorship care and address outcome disparities. **Recommendations:** The WHO recommends implementing PA programs in settings that can reach and engage vulnerable older and rural communities and the least active people4. Advanced practitioners (APs) can recommend PA to cancer survivors and refer to available in-person or online programs. We recommend considering virtual PAI when other programs are inaccessible or unacceptable to underserved rural and older cancer survivors.

JL1232C: Investment and Mentoring Pipeline Led by Advanced Practice Providers in Collaboration with Community Trainees Program

Deborah Skojac, RN, MS, AOCN®; Tennessee Oncology

Background: The idea for this program evolved from the state oncology practice society meeting in the Spring of 2023 where the focus for advanced practice providers was to highlight their community driven initiatives outside the clinic setting. Three providers presented personal accounts including: setting up a blood drive, development of a breast cancer support group and developing advocacy relationships with state legislators. The feedback from their presentation was overwhelming. Not only advanced practice providers but medical students, oncology fellows, and other professionals were asking how they could help with projects in the future. Thus, the Community APP (Advanced Practice Providers) IMPACT program emerged. **Mission of the Project:** To connect community oncology practice with health sciences trainees and community through sustained hematology/oncology focused service, education, and advocacy projects. **Development Design, Service:** Community oncology practice covers an approximate 120-mile radius around metropolitan area. The two APP IMPACT program leads divided this area into four regions and asked for regional volunteers including regional leads and initially over 20 APPs (Advanced Practice Providers) responded. Each region was asked in the first calendar year to take a quarterly project. Over the past year the following volunteer events have occurred: food drive, development of a patient cancer screening educational infographic, blood drive partnering with local blood bank, and providing monthly dinners at the American Cancer Society Hope Lodge. Each region functions independently under the APP regional leadership and reports to the IMPACT program leads. All four re-

gions meet quarterly to discuss regional updates, concerns, and information from the project leads. Other company departmental employees that engage in this program are invited to the quarterly meeting including Human Resources, Director of Health Equity, and Community Engagement, and Manager Enterprise Project. **Education:** In addition, the two IMPACT program leaders have met with 5 academic institutions and their employee engagement leaders. They discussed our program's mission and provided opportunities for their students to earn service hours by volunteering to help with some of the events. We have had several student volunteers. **Advocacy:** APP IMPACT sponsored an educational event for all company APPs on Nursing Advocacy 101 which was presented by state lobbyist and state nursing association lobbyist. This program was designed to educate nurses on their role in patient advocacy at the State level and preparedness Day on the Hill. **Program Outcome:** Advanced Practice Providers have skills of organization and leadership beyond the clinic setting to drive community engagement programs. This program allotted for collaboration between multiple APPs of varying experience levels allowing for further development of leadership skills, patient advocacy initiatives and fostering relationships within their local communities. APP IMPACT over the past year has developed into a well-respected project by community oncology practice. This poster will more clearly delineate our progress by providing additional data on our efforts over the past year.

JL1233C: Managing Monoclonal Gammopathy of Undetermined Significance in a Virtual Setting

Kelly O'Brien, AANP-C, ACNP-BC, Kelly Sidor, ACNP-BC, Kelsey Watson, AGNP-C, Meredith G. Beaton, RN, MSN, AG-ACNP, Glen Peterson, RN, DNP, ACNP; University of Colorado

Background: Monoclonal gammopathy of undetermined significance (MGUS) is a pre-malignant plasma cell disorder. It is classified by the presence of heavy-chain and/or light-chain involved M-protein and carries a risk for progression to multiple myeloma (MM), amyloidosis, Waldenstrom macroglobulinemia, chronic lymphocytic leukemia, or lymphoma. Smoldering MM (SMM) is a precursor condition with higher risk of progression to MM compared to MGUS. MGUS patients should receive follow-up according to their risk of progression. MGUS is highly heterogenous, and the chance of progression can be risk stratified based on subtype and testing at time of presentation. By brisk identification of newly diagnosed MGUS patients and risk stratification from diagnostic workup, a surveillance plan can be formulated by the Virtual APP (VAPP) allowing prompt determination of progression and initiation of treatment when indicated. **Methods:** A guideline was created to assist with risk stratification of MGUS patients to provide guidance on who would be most appropriate to follow the patient – Blood Disorders Center (BDC) Advanced Practice Provider (APP), BDC physician, or Primary Care Provider (PCP)/community oncologist. Based on the patients' MGUS risk determined in the guideline, higher risk MGUS patients were recommended further testing, including more sensitive imaging with positron emission tomography (PET) scan and/or bone marrow biopsy (BMBX). Follow-up plan and frequency was also determined for each MGUS patient. **Results:** In the past 12 months, 23 patients were seen by the Virtual APP (VAPP), a specialized oncology APP, for a new patient visit (NPV) for MGUS. Based on labs at presentation, 5 of the 23 patients met criteria for additional testing with PET scan and/or BMBX based on our guideline. 1 of the 5 patients declined BMBX initially but agreed to BMBX after the NPV with the VAPP and was found to have smoldering multiple myeloma (SMM). 1 of the 5 patients was found to have lymphoma and referred to the appropriate clinic. 4 of the 23 patients that did not have additional testing on presentation met criteria for further testing with BMBX and/or PET scan due to progression or criteria met after additional lab results, 1 of which was found to have progressed to SMM. Other patients were found to have low risk, stable disease and felt to be appropriate for surveillance in 6 to 12 months. **Conclusions:** The VAPP role has permitted quick assessment of MGUS patients following referral with greater capability to order additional tests based on risk. Additionally, the VAPP provides greater access to patients who live in remote areas with less specialized care. With close monitoring by the VAPP,

signs of progression can be identified followed by discussion of further testing with the patient. Current guidelines recommend lifelong follow-up of MGUS patients to identify malignant transformation before the onset of severe illness. In the future, we anticipate increased awareness of factors contributing to progression of MGUS or SMM to MM. Therefore, further improvement in the identification of patients at high risk of progression will hopefully result in an even more tailored approach with start of therapy before serious complications develop.

JL1234C: Oncology Advance Practitioner Fellows Provide Patient Support and Fulfill Research Requirement for Graduation

Caitlin Bunker,[1] MSN, APRN-CNP, Maddison Amerio,[1] APRN-CNP, Yaxin Liang,[1] APRN-CNP, Heather Koniarczyk,[1,2] MSN, APRN-CNP, AOCNP®; [1]Cleveland Clinic, [2]Advanced Practitioner Society for Hematology and Oncology

Background: Advanced practitioners (AP) historically have lacked formalized training on engaging into clinical research. During a one-year Hematology/Oncology Fellowship program at a large Midwest academic medical center, APs are required to present an abstract related to quality improvement (QI) or research they participated in to fulfill their requirements for graduation. The participation in academic activities, such as research or QI, during the fellowship allows for early immersion and limited intimidation, as opposed to engaging later into the AP's career. **Methods:** AP Fellows participate in didactic education focused on the research process early in their academic year. Next, APs meet with mentors and physician primary investigator (PI) of the group research study, prior to research responsibilities. To enhance training, understanding of expectations and discuss progress, the team met weekly. The class of 2023-2024's project was to create a caregiver written education handout, based on a caregiver needs assessment related to care of their cancer patient. Caregivers consented to participate; were surveyed throughout the handout's development and implementation to understand their comfort learning health information. A multidisciplinary team including Physicians, AP Fellows, pharmacy, and social work students, held discussions as a collaborative group to culminate in the creation of a booklet that would provide resources to caregivers and patients. The multidisciplinary team participated in interdisciplinary coaching where further project feedback was given. Essential skills for effective teamwork and communication were taught throughout the year by the interdisciplinary coach. The hypothesis was caregivers of cancer patients would have less distress and feel more capable to care for their patient through an easy-to-understand caregiver booklet. **Results:** Twenty-five patients were enrolled in this trial, and it is closed to accrual as of April 2024. The caregiver resource has been completed and is being approved by the IRB and printed. Once printed, it will be sent to the caregivers with a follow up survey. The results will be known this fall. Lessons learned by the AP Fellows include: 1. Be prepared for a complicated and time-consuming IRB approval process, highlighting the significance of early preparation and rigorous documentation in research projects. 2. The research process requires more formality in how participants enroll, and how time-consuming it is. 3. To keep a project moving forward and producing good research results, it needs ongoing assessment and modification of procedures based on input and experiences of multiple collaborators. **Conclusion:** In summary, this learning experience provided a valuable opportunity to gain practical knowledge in applying a technique of investigation to real-world practice. While the goal to complete an oncology caregiver resource booklet has not been completed, each roadblock that was encountered has been a great learning opportunity. As new graduate APs, this was a wonderful opportunity to integrate into research and to better understand the time and resources that are needed for research projects.

JL1235C: Oncology Paired Preceptor Program to Support Nurse Practitioner Transition to Practice in Hawaii

Christa Braun-Inglis,[1] DNP, APRN, FNP-BC, AOCNP®, Tyler Workman,[1] MSN, APRN-Rx, RN, AGCNS-BC, Jared Acoba,[1] MD, Karen Rowan,[2] DNP, APRN-Rx, FNP-BC, Ashley Springer,[3] MSN, AGPCNP-BC®, APRN-Rx, Jill Shimabuku,[2] DNP, APRN, FNP-BC, Valerie Ferguson,[4] MS, FNP-C, AOCNP®, Wendy Suetsugu,[5,6] JD, MSN, RN, Courtnee Nunokawa,[5] DNP, APRN-Rex, BCN, Judy Ko,[3] AGNP-C; [1]University of Hawaii Cancer Center, [2]Hawaii Oncology, Inc, [3]Hawaii Cancer Care, [4]Hawaii Pacific Health, [5]University of Hawaii at Manoa, [6]Nancy Atmospera-Walch School of Nursing

Background: Nurse Practitioner (NP) education is population focused, which creates a knowledge gap for NPs entering oncology. Fellowship programs that support the transition into oncology are available at many large cancer centers, however, these programs do not support NPs in smaller communities. At present 85% of oncology care is given in the community, and community positions for APPs have seen the most expansion over the past 10 years. There is a significant need for programs to support NP students who will practice community oncology and care for rural and underserved populations, often as the primary oncology provider. Additionally, Hawaii faces unique challenges with oncology workforce shortages due to its geographical isolation. The purpose of this project is to increase competency of DNP students in Hawaii who are interested in a career in oncology and help close the gap in transition to practice. **Methods:** During 2021-2023, the University of Hawaii Cancer Center (UHCC) partnered with community oncology NPs and oncologists, and the University of Hawaii Nancy Atmosphera-Walch School of Nursing (NAWSON) DNP Program to form an Oncology Paired Preceptor Program (OPPP). The program connected community oncology NPs with DNP students who wished to focus their final clinical rotation on oncology. The program's objectives, which were adapted from the 2018 Oncology Nursing Society's Core Competencies for Nurse Practitioners, addressed cancer diagnosis and treatment, patient counseling, survivorship, palliative care, health maintenance and collaborative practice. Each student completed 135 clinical hours for this rotation. In addition, "Lunch and Learn" sessions and recorded disease specific lectures were available to the DNP students through the UHCC. Students and preceptors completed post program evaluations. **Results:** Eight students completed the Oncology Paired Preceptorship Program during 2021-2023. Fifty percent of these students are now practicing in community oncology in Hawaii. Post program evaluations were extremely positive from students, NP preceptors and collaborating oncologists. Recommendations from the evaluations included offering more opportunities for oncology lectures, increasing the number of clinical hours and incorporating components of clinical oncology research. Conclusion: Academic-community partnerships in high-need settings, such as the OPPP, provide valuable opportunities for DNP students to acquire oncology skills, potentially addressing workforce challenges in smaller communities. Future Directions: Building on the success of the OPPP, leadership teams from UHCC and NAWSON are expanding this program for the 2024-2025 academic year to a total of 274 hours of training. The expanded program includes a four-hour oncology symposium and a two-semester preceptorship, the first semester will focus on an introduction to oncology and team-based care, while the second semester will offer deeper immersion into oncology and introduce clinical research as a key component of oncology care.

JL1236C: Outcomes of a Dedicated Oncology Advanced Practice Provider in the Pancreatic Cancer Prevention Clinic

Samantha B. Foley, MPAS, PA-C; University of Texas Southwestern Medical Center at Dallas

Background: Historically, the Multidisciplinary Pancreatic Cancer Prevention Clinic has not had a dedicated Oncology Advanced Practice Provider (APP) within the Cancer Center to address patient and clinic needs. As patient volumes continue to increase, slot utilization for existing providers (n=7) within the disease-oriented team (DOT) has led to increased wait times and delay in the referral process for new patients to be seen in a timely manner. It is well known that oncology APPs are used in multiple medical settings, and many assume high-level responsibilities to improve organizational efficiency and enhancement in the delivery of health care. Several studies have shown that the role of APPs in cancer screening and prevention will not only meet an increase demand for care but is financially advantageous for the patient. With an effort to increase patient access, it was decided that a dedicated Oncology APP in the Cancer Center could be appropriately trained to expedite new patient referrals while simultaneously improving the patient experience. Aim Statement: To train a surgical oncology APP within the Cancer Center to see new patient referrals independently thereby increasing new patient visits by 250 total over a 12-month period (March 2023 to February 2024). **Interventions and Results:**

A surgical oncology APP was identified to cross-train in the Pancreatic Cancer Prevention Clinic. After 8 weeks of onboarding the APP began to see new patient referrals independently. The APP saw n=481 new patient visits over a 12-month period (March 2023 to February 2024). Slot utilization for the APP continues to be above metric for the Cancer Center at >90% (goal ≥ 85%). On average, ~45% of visits, including new and established, are Telehealth. **Conclusions:** A dedicated Oncology APP in the Pancreatic Cancer Prevention Clinic was able to see a total of 481 new patient visits over a 12-month period, exceeding the targeted benchmark and nearly matching patient volume in 2022 independently, while simultaneously increasing patient satisfaction as measured by Press Ganey scores. **Next Steps:** The Oncology APP will continue to provide care to current cohort of patients and investigate ways to improve slot utilization within existing template. Identify established patients in the clinic that can appropriately be pushed to APP template to improve new patient slots/access on MD template. Train an additional APP to meet growing clinic demands/patient volume. Consider expanding current model to other prevention and survivorship programs within the Cancer Center.

JL1237C: Prophylactic Carboplatin Hypersensitivity Protocol for High-Risk Gynecologic Patients

Noelle Myers, MSN, CRNP, FNP-BC, AOCNP®, Kathleen J. Smith, MSN, CRNP, ANP-BC, AOCNP®, Terri Cuddahy, MSN, RN, OCN®, Caitlin Fanning, RN, MSN, OCN®, Elizabeth Mangold, RN, BSN, OCN®; Fox Chase Cancer Center

Background: Patients with gynecologic (GYN) cancers are living longer and can receive carboplatin-containing regimens in multiple lines of therapy. Risk for HSR increases significantly after more than 6 doses and when resuming after a duration free from platinum treatment. Incidence of HSR can range from 19-23.6% in second-line retreatment and continues to rise to 44-100% in third lines or later. This can lead to the need to discontinue therapy or for a complicated desensitization protocol for future cycles. Various studies have considered additional pre-medications and/or extended duration of carboplatin infusion for hypersensitivity prevention with various results. At this large single academic institution, these authors noted significant increase in incidence and severity of carboplatin hypersensitivity reactions with desire to institute a prophylactic protocol in order to reduce incidence and severity of acute infusion reactions to carboplatin. **Methods:** In 2022, a retrospective chart review reflected that this institution experienced 25 carboplatin infusion-reactions, of which 20 were GYN patients. Therefore, after review of the literature, an evidence-based pilot project was developed to reduce the severity and incidence of carboplatin HSR. Over a 12-month period, twenty-six high-risk GYN patients were identified by a Medical Oncology GYN Nurse Practitioner to be candidates for the pilot. High risk for carboplatin HSR is defined as patients receiving greater than 6 doses or restarting after at least 6-month break from exposure. Patients were then ordered a "Carboplatin Restart Order Set" which includes premedication with corticosteroid, H-1 Blocker, H-2 Blocker, leukotriene receptor antagonist and low dose aspirin. Patients we also prescribed a take-home corticosteroid preparation of dexamethasone 20mg to take by mouth the night before and morning of administration. Finally, the infusion nurse administered the carboplatin with titration for extended duration. Instead of standard 30-minute infusion, the rate was titrated to start at 1/8 rate x 15 mins, ¼ rate x 15 mins, ½ rate x 15 mins, then full rate for remainder of infusion. **Results:** Twenty-six high-risk patients were identified to be acceptable for addition of prophylactic protocol. Of those who received the prophylactic protocol, none of the patients during the 12-month period experienced a carboplatin infusion reaction (0%). **Conclusions:** In the data presented, we propose an effective and low-cost prophylactic measure to reduce or at least delay incidence of carboplatin hypersensitivity reactions for those at highest risk. Advanced practice providers (APPs) in the oncology setting can be vital in identifying patients at high risk for HSR and applying a similar prophylactic model. Standardization of these measures will not only reduce risks of morbidity of an acute potentially anaphylactic reaction, but also can improve outcomes and allow platin-sensitive patients to continue on their life-saving treatments.

JL1238C: Reframing the Conversation: Bridging the Gap between Pharma and Clinical Practice

Mary E. Peterson,[1] MS, APRN, AOCNP®, FAPO, Deborah M. Rust,[2] RN, MSN, CRNP, AOCN®; [1]AbbVie, [2]Self-employed

Current landscape: There are distinct roles in healthcare for advanced practitioners (APs) in clinical practice, industry, and management. One role with significant evolution that remains misunderstood, is the AP role in industry, particularly beyond the traditional educator role. Given the limited understanding evident in existing literature and the demographics of our organization, it is crucial to clarify the role's status, interface with clinical practices, and involvement with professional organizations. Industry APs play a critical role as part of the Hematology Oncology team and these roles are a growing segment of the workforce. Pharmaceutical companies play a crucial role in advancing medical treatments, with the potential to enhance survival rates and overall quality of life for patients. These companies provide a wealth of resources, both personnel and educational, that can keep clinicians up to date and well-informed. It is noteworthy that these resources undergo thorough regulatory review by both the FDA and legal authorities to ensure they provide comprehensive, fair, and balanced, information about the risks and benefits of drugs. **Methodology:** A project team consisting of advanced practice experts, along with a prominent hematology/oncology society was assembled to explore these roles. A survey was conducted among members involved in industry positions to obtain information about their roles and responsibilities. As a first step, this survey obtained information about: 1) types of AP roles, 2) nature of interactions with clinical colleagues, and 3) understanding their participation levels within a professional organization and clinical practice. **Results:** A total of sixty-six industry professionals, who were members of the organization, participated in the survey. The described roles included educators, medical science liaisons, trainers, and individuals in "other" roles. Most respondents reported interacting with APs through appointments, in-services, or programs outside of the clinical setting. Additionally, 93% of respondents reported being able to serve on committees within the organization, while 47% reported being able to provide presentations at national conferences. Lastly, 57% of respondents reported being able to practice as clinicians. **Summary:** The role of APs in the healthcare industry, particularly in Hematology/Oncology, is expanding. A survey conducted with industry professionals revealed diverse roles and responsibilities of APs, including participation in professional organizations, conference presentations, and clinical practice. Clarifying and acknowledging the role of industry APs, was the aim of this study to foster collaboration, strengthen partnerships, and reduce the marginalization of industry APs. By exploring the current and potential roles of these APs, examining changes in peer-to-peer interactions post-pandemic, and identifying untapped areas for improving patient outcomes, this research seeks to contribute to exceptional patient care. **Recommendations:** Further study to explore the current and potential roles of APs, investigate changes in peer-to-peer interactions post pandemic, and identify untapped areas for enhancing patient outcomes. This research should encompass more robust surveys, literature contributions, and developing and submitting sessions that have already garnered positive reception in other organizations. By conducting these studies, clinical and industry APs can play a critical role to help shape the future of healthcare by making contributions through their collaboration.

JL1239C: Shared Governance, Shared Success: Boosting APP Engagement at a Leading NCI-Designated Cancer Center

Dylana Smith, MS, AGPCNP-BC®, HNP, Nicole Zakak, MS, RN, CPNP, Kelly S. Haviland, PhD, MSN, FNP-BC, TBNB-C; Memorial Sloan Kettering Cancer Center

Background: Advanced Practice Practitioners (APPs) have been experiencing increased job turnover, high rates of burnout, and reported poor job satisfaction, especially in oncology. Contributing to the dissatisfaction includes not being able to practice at the top of their license, not feeling empowered to make autonomous decisions, and lack of leadership opportunities. The APP Division at an NCI-designated cancer center in major metropolitan area, established the Nurse Practitioner (NP), Physician Assistant (PA), and professional development Councils to create opportunities for professional advocacy, empowerment, and

engage in scholarly work. While representing over 1000 APPs, these councils were siloed, leading to project overlap without effective collaboration. In 2022, the three councils joined forces creating a single APP Governing Council aimed at recognizing, synchronizing, and expanding efforts with a united front. The structure was derived from the nursing shared governance framework that integrates nurses into the leadership decision-making processes, flattens the decisional hierarchy, promotes collaboration, fosters inclusion and autonomy, and increases both patient and nursing satisfaction. **Methods:** The APP Governing Council is built upon 5 vertical pillars: Education and Research, Advocacy and Practice, Recognition and Recruitment, Community Affairs and Outreach, and Wellness, with NP and PA co-chairs and comprising twenty committees. The APP Governing Council Sponsor, the APP Director of Professional Development and Quality, brings institutional insight and expertise to the broad range of Council initiatives. Two APP managers serve as Council Liaisons, providing professional guidance, facilitating organizational relationships to further Council objectives. The APP Governing Council Bylaws clearly define member rolls and responsibilities. **Results:** Since January 2024, the APP Governing Council has successfully increased APP opportunities to grow their leadership and project management skills. The number of lead positions increased from 21 to 35, it has incorporated the Wellness Council, created five new committees, and saw an increase in membership by 67 APPs. The Governing Council has successfully implemented new divisional programs geared toward professional development, mentorship, networking, and burnout with a new PA Shadow Program, APP Onboarding Buddy Program, and a monthly Social Hour that has attendance between 40 and 104 APPs, providing opportunity for connection and respite. APP Grand Rounds and APP Journal Club, two APP initiatives with a history of suboptimal participation, now have a waitlist of presenters for 2025. The APP Governing Council has expanded representation to all 13 regional locations with APPs across 2 states, spanning over 50 APP services in various settings, increasing division networking, collaboration, and unity. **Conclusion:** The APP Governing Council represents all NP's and PA's, promotes collegiality and collaboration, optimizes initiatives that encourage excellence in practice and professional development, fosters an environment of advancement rooted in leadership, education, and evidence-based practice, and recognizes the professions' contribution to high-quality patient care. The implementation of an APP Governing Council has led to increased division visibility, collaboration, and engagement. **Recommendations:** A shared governance structure within an advanced practice division requires a multifaceted approach that addresses leadership, education, communication, and culture. The APP Governing Council fosters a more empowered, engaged, and collaborative APP workforce.

JL1240C: SDHB Pathogenic Mutation Discovered in a Paraganglioma Patient by a Genetics-Trained AP in a Unique Oncology Opinion Clinic - A Precision Oncology Case Report

Andrew Guinigundo, MSN, RN, CNP, ANP-BC, FAPO; Cincinnati Cancer Advisors

Background: Paragangliomas are rare neuroendocrine tumors that arise from neural crest cells and can occur from the head/neck area down to the abdomen. The incidence of the disease worldwide is ~5 per million. Pathogenic hereditary mutations account for approximately 40% of paragangliomas. The standard of care is to run appropriate genetic testing on anyone with this diagnosis. Recognition of the relationship between diagnosis and genetics is paramount in the care of these patients and their families. **Case Report:** JT is a 67-year-old man originally diagnosed with paraganglioma in 2002 to the spine and liver. He received radiation therapy to the spine and octreotide injections. In 2003, he entered a clinical trial where he was treated with an octreotide-based radiopharmaceutical utilizing lutetium completing therapy in August 2003. He achieved complete remission. He presented to an oncology opinion-only clinic in 2020 and it was noted that he had not had a complete paraganglioma follow up and assessment since 2016. There was question of recurrent disease, but it was found to be acute changes from a lung infection. Unfortunately, he presented once again in 2024 when he was found to have recurrent paraganglioma and it came to light that

his mother also had paraganglioma. **Discussion:** Since 2022, a genetic/genomics-trained advanced practitioner (AP) was hired to the position of Director of Precision Oncology at this opinion-only clinic. The AP reviewed the case and jointly participated in the follow up consultation. Several precision oncology conclusions were made by the AP. In 22 years, under the care of multiple providers, he had not had hereditary genetic testing. It is almost statistically impossible (0.000000004%) that a mother and son could spontaneously both have paraganglioma. The presence of an autosomal dominant pathogenic mutation would have far-reaching hereditary implications including 1st degree relatives (parents, siblings, children) have a 50% risk of having the same mutation, the risk of paraganglioma for some mutations can be >50% lifetime risk, and screening recommendations for some mutations begins as young as 6 years old. A 19-gene paraganglioma-specific panel was sent via blood sample to a large national genetics laboratory. The patient was found to be a heterozygote for a pathogenic SDHB mutation. The patient came in for further discussion with the AP regarding the finding. For the paraganglioma, he was referred to an internationally respected neuroendocrine oncologist at a large academic center. **Conclusion:** Precision oncology, which includes both tumor genomics and hereditary genetics, is a growing subspecialty. Genetic counselors are a skilled group of genetics professionals meeting this demand. Additionally, APs trained in precision oncology can provide further genetics touch points for patients. These APs, perhaps working in non-traditional settings such as an oncology opinion-only clinic, are uniquely positioned to help with growing demand and positively affect families' lives.

JL1241C: Systematic Use of Patient Reported Outcomes in Cancer Patients Receiving Immunotherapy

Jaime E. Pesl,1 DNP, NP-C, AOCNP®, Dilawar Khan,2 MD, Sarah Treat,3 DNP, APRN, FNP-BC; 1Hamilton Peeples Cancer Institute, 2Harbin Oncology, 3University of Tennessee Chattanooga

Background: Immunotherapies are increasingly being used in current cancer treatment regimens. However, immunotherapies can cause a spectrum of adverse events, ranging in severity, incidence, and onset, which require close attention and routine assessment. These immune-related adverse events (irAEs) can negatively impact cancer patients by reducing their quality of life and increasing the need for hospital and emergency department visits, potentially causing treatment delays and adverse outcomes. Advanced practice providers (APPs) in oncology are highly trained in symptom management and are frequently responsible for routine treatment assessment. This quality improvement project addressed a gap in practice related to the assessment and monitoring of irAEs through the systematic use of the National Cancer Institute's (NCIs) Patient-Reported Outcomes - Common Terminology Criteria for Adverse Events (PRO-CTCAE) assessment tool at an outpatient multidisciplinary cancer center. **Methods:** From January 2023 to July 2023, 63 patients were identified as initiating either single or double agent immunotherapy or combination chemotherapy and immunotherapy. NCIs PRO-CTCAE was customized with 14 irAEs selected for assessment based on evidence and provider recommendations. Each irAE had up to three items addressing the frequency, severity, or interference of daily activity and were measured using a 5-point Likert scale. A baseline PRO-CTCAE assessment was administered at the patient's treatment education visit. Patients then completed follow up PRO-CTCAE assessments approximately every three to six weeks during their routine office visits. **Results:** Forty-three (68.3%) of the 63 patients had baseline data available. Fatigue was the most common symptom present at baseline as well as at the end of the intervention. Improvement in fatigue, as related to quality of life, was statistically significant ($p = 0.023$) with use of the PRO-CTCAE. Pre- and post-PRO-CTCAE data was compared and a decrease in death rates with the PRO-CTCAE was found to be statistically significant ($p = 0.049$). Additionally, hospital visits were decreased among the project cohort, though not statistically significant ($p = 0.835$) due to the small sample size. **Conclusions:** The routine use of NCIs PRO-CTCAE assessment tool for patient's receiving immunotherapy improved the irAEs effect on quality of life, decreased hospitalizations, and improved survival. Interestingly, in patients who experienced fatigue at baseline, it was also the irAE that im-

proved the most by the end of the project, perhaps indicating an improvement in disease burden. Enhanced understanding of the subjective nature of irAEs, including their effect on cancer patients' quality of life, will allow Oncology APPs to provide better patient-centered care. **Recommendations:** While this project highlights the benefits of using NCIs PRO-CTCAE assessment tool in routine clinical practice, an electronic version of the PRO-CTCAE tool could not be embedded in the electronic health record (EHR) during the time frame of this project. Utilization of a paper PRO-CTCAE assessment is not recommended and likely led to low staff and patient compliance rates. A dynamic electronic document that is fully EHR integrated would ideally flow into the provider's clinical documentation and recorded in the style of a flowchart to assess and identify trends and responses to recommended interventions or treatments.

JL1242C: The Advanced Practitioner's Role in Managing Long Term Toxicities in Adolescent and Young Adult Patients with Hodgkin's Lymphoma

Haleigh Mistry, MS, PA-C, Paula Barrenechea, PA-C, Alexandra Saldana, PA-C; University of Texas MD Anderson Cancer Center

Background: Advanced practitioners (APs) play an integral role in identifying, managing, and preventing long term toxicities in oncology patients. Adolescent and Young Adult (AYA) patients with Hodgkin's Lymphoma (HL) are at risk for developing unique toxicities and late effects. With a high cure rate, HL, which often affects patients of AYA age range (15-39 years), education and proper management is imperative in preserving quality of life (QOL). While long term survivorship guidelines currently exist, more research is needed focusing directly on the AYA population and in providing long term survivorship care. **Methods:** A comprehensive review of English literature (using PubMed) published between 2018-2024 and the Children's Oncology Group Long-Term Follow-Up Guidelines for Survivors of Childhood, Adolescent and Young Adult Cancers was performed. The following terms were searched: Hodgkin's Lymphoma (HL), Adolescent and Young Adult (AYA), survivorship, late effects, long term toxicity, management, advanced practitioners (APs). Only Food and Drug Administration (FDA) approved regimens were included and used to identify late effects in AYA HL patients. **Results:** A total of 9 publications meeting search criteria were identified. Late effects including cardiac disease, hypothyroidism, xerostomia, dental decay, and infertility primary affected AYA HL survivors, highlighting the importance of quick identification and proper management. In addition, survivorship care includes managing psychosocial needs resulting from prior cancer care. **Conclusion:** AYA cancer survivorship was identified as a major gap in knowledge with the emergence of AYA Oncology. Often underscored is the imperative role an AP plays in managing these patients and their associated late effects. At many institutions, APs lead survivorship programs, however, lack of consensus on survivorship guidelines exist, further limiting care in the AYA HL population. Following the Children's Oncology Group Long-Term Follow-Up Guidelines for Survivors of Childhood, Adolescent and Young Adult Cancers provides APs structured guidelines allowing APs to quickly identify, ameliorate, and manage serious toxicities thereby improving patient's health and quality of life. **Implications:** APs have the unique ability to follow and manage AYA HL survivorship patients. Their role in providing comprehensive care cannot be overstated. Patient education, laboratory and imaging studies, interpretation, management, psychosocial needs assessment and care coordination provide comprehensive survivorship care and must be addressed. Conversations focusing on the risk of infertility and identifying unique psychosocial needs are of paramount importance. Incorporating other team members, such as a mental health provider (social worker, vocational counselor, psychologist, psychiatrist), reproductive endocrinologist, further improves AYA HL survivor's care thereby improving quality of life.

JL1243C: The emotional journey of patients and caregivers with genetic testing in mCRPC

Erin M. Pierce,[1] MSN, APRN, FNP-C, Ruhee Jain,[2] MPH, MBA, Rob Seebold,[3] BSc, Jonathan Weiser,[3] MPPA, Andrea Stevens,[2] PhD, Neerav Monga,[2] MSc, Katherine B. Bevans,[2] PhD, Matthew J. Pagano,[3] MS, Katie Pascoe,[2] PhD; [1]Center for Innovative Cancer Therapies Program at Oschner Health, [2]Johnson & Johnson Innovative Medicine, [3]buzback

Background: A metastatic castration-resistant prostate cancer (mCRPC) diagnosis significantly

impacts the physical and psychological well-being of both patients and caregivers. Patients often have questions and feelings about their diagnoses and require additional support from healthcare professionals (HCPs) to make informed decisions. For example, patients who have mCRPC with DNA damage repair alterations, such as homologous recombination repair alterations including BRCA mutations, may not realize these alterations can significantly shorten life expectancy and they may be eligible for targeted treatment with poly(ADP-ribose) polymerase (PARP) inhibitors. To better understand the attitudes, emotions, and experiences of patients with mCRPC and caregivers, a survey was conducted assessing their experiences with treatments, as well as perceptions of and openness to genetic testing. **Methods:** We explored the emotional journey of patients with mCRPC (≥21-year–old males with a mCRPC diagnosis for ≥3 months) and caregivers using an in-depth, non-interventional, cross-sectional, quantitative-qualitative survey. The study included 380 participants (221 patients and 159 caregivers) from 7 countries, all of whom completed an online survey between February 17, 2022, and March 9, 2022. De-identified qualitative data were coded into themes and analyzed. **Results:** Results show that progression to mCRPC elicited mixed emotions among patients—some remained optimistic and actively sought treatment solutions, while others were emotionally burdened with feelings of loneliness, isolation, and helplessness. Most patients were aware of and open to genetic and biomarker testing hoping to find a cure or improved treatment options. Statements from patients such as, "I would do everything possible to get cured," and "It gives me the possibility of acquiring new ways of treating it and living longer" reflected this optimism. Additionally, 5% of patients expressed a desire to better understand their disease and its hereditary implications. One patient said, "I want to know why I have cancer and if this genetic mutation will affect my offspring." Patients wanted more information before making decisions about genetic testing but were hesitant to discuss their concerns and feelings (eg, anxiety and confusion) with HCPs. For example, over one-third of patients considered, but did not ask about, side effects and risks of testing and its impact on survival. And, almost one-third of patients had, but did not express, negative thoughts about testing (eg, being afraid and feeling overburdened by additional tests). **Conclusions:** Patients with mCRPC experienced a range of emotions during their disease course, particularly when making decisions about genetic testing. HCPs can help enhance patients' experiences by providing additional relevant medical information, guidance regarding how genetic testing will impact treatment choices and family, and emotional support to manage their feelings throughout care. **Implications:** HCPs play an important role in treating patients with mCRPC. Enhanced communication between the patient-caregiver dyad and HCPs, and consideration of patients' emotional concerns, is needed to understand feelings, emotions, and knowledge levels surrounding their disease and treatment options. This insight is essential to enhancing patients' experiences and quality of life, and necessary to support patients make informed decisions about treatment options, including the benefits of genetic testing.

JL1244C: The Role of an Advanced Practitioner in a Novel Therapeutics Clinic

Shannon Perkins, NP; The Cleveland Clinic

Background: With the increasing number of oncologic experimental therapies, our large academic cancer institute created a Novel Therapies Clinic (NCT), dedicated to therapies in phase 1/2 clinical trials. These trials are logistically demanding for both the research team and the patients. The need for an advanced practitioner to both provide clinical care and coordinate the clinic's operations and processes was identified. **Problems Encountered:** Workflows were inefficient. Major examples included: (a) Out of state patients were screen failing at their visit for reasons that could have been identified before they traveled. (b) The mechanism for tissue prescreening was disorganized. (c) Excessive time was taken for patient eligibility screening, hindering patient access. New procedures: Many trials required procedures, such as intralesional injections and skin punch biopsies. Continuity in clinic: With a daily rotating physician staffing the clinic, there was disjointed continuity of care and access of information. **Results:** The NTC brought on a ad-

vanced practitioner (AP) to act as a point person for clinical care and processes. Clinical processes improved: (a) We determined that all out of state patients needed to be screened by an AP or physician to determine eligibility for consultation. (b) The clinic research coordinators were taught to identify the most recent biopsy and procure that tissue for screening first, with additional tissue only tested as needed. (c) Templates were created for each clinical trial for prescreen eligibility and are completed by a pharmacist and an AP. New procedures: The AP was trained and certified to perform skin punch biopsies and intralesional injections. Continuality in clinic: The AP is in the NTC with the rotating physician, providing visit to visit continuity. **Conclusion:** Starting a new clinic dedicated to phase 1 clinical trials required creating multiple clinical and administrative processes. There was also a need for a dedicated clinician for continuity of care. A full-time AP acted as a point person to fulfill these needs to allow for growth of a research clinic's volume. **Future Projects:** The establishment of a dedicated novel therapeutics clinic has doubled the number of phase 1 clinical trials at our institution. Further efforts are aimed to increase the efficiency of enrolling patients by using informational technology. A dashboard is being created that draws data from standard note templates to track patients through their engagement, from screening to enrollment and on trial treatment.

JL1245C: Understanding the Research Self-Efficacy of Oncology Advanced Practice Providers in the Hawaii Minority/ Underserved (M/U) NCI Community Oncology Research Program (NCORP)

Jodi Hinderleider,[1] BSNc, Christa Braun-Inglis,[1] DNP, APRN, FNP-BC, AOCNP®, Yosuke Kawai,[1] PhD, Kathryn E. Weaver,[2] PhD, MPH; [1]University of Hawaii Cancer Center, [2]Wake Forest University School of Medicine

Background: The oncology Advanced practice provider (APP) role in clinical research is expanding. However, it is known that most APPs do not have any formal research training or background which can limit their potential in the research space. From 2021-2023, an APP mentorship project was implemented within the Hawaii Minority Underserved NCI Community Oncology Research Program (HI MU NCORP). This program's primary aim was to increase minority accrual for supportive care trials within the NCORP. The success of this mentorship project has led to a development of a national concept through the Wake Forrest NCORP Research Base. The primary outcome for the national concept is APP Research Self Efficacy (APP RSE), with accrual metrics and NCORP engagement being evaluated as secondary outcomes. The primary focus of this pilot project was to measure current APP RSE among APPs in Hawaii, while validating an APP RSE tool in a larger population. **Methods:** The APP RSE survey tool was developed based on two prior validated tools measuring clinical research attitudes, beliefs, and roles among APP and medical student RSE. The 51-item survey, of which 22 items specifically focused on RSE, was sent to 27 APPs (NP, PA and CNS) in Hawaii via an electronic survey platform. The remaining items inquired about the APP's background and NCORP engagement. Descriptive parameters of participant characteristics and the Mann Whitney U test were used to test differences in the RSE between those who did (n = 4) and did not (n = 13) participate in the mentorship project. **Results:** 17 APPs anonymously completed the survey with a response rate of 63%. Of the 17 APPs, 76% were masters prepared, 18% DNP, and 6% PhD. The average years of experience was 6-10, ranging from 1 to > 15, with visits ranging from 25 to > 75. Mentorship project participants were more likely to report high confidence for 6 out of the 22 survey questions (extremely/very confident vs. slightly/ not at all confident, $p < 0.05$). The additional 16 responses showed a similar association between participation in the mentorship project and reporting higher RSE. Higher APP RSE also correlated with APPs serving as enrolling and site primary investigators on supportive care trials, active sub-investigators on treatment trials, and participants on research committees within HI MU NCORP. **Conclusion:** We explored the impact of APP research mentorship on APP RSE among Oncology APPs in [State] in this study. APPs' involvement in research activities and participating in a research mentorship project was associated with higher RSE, however, the sample is limited. **Recommendations:** Cancer programs looking to increase involvement of APPs in clinical research

should consider a mentorship model to maximize APP contributions in this space. In addition, with the tool validation, it can now be utilized to measure APP RSE across practice models.

JL1246C: Uptake of Radiation Oncology Advanced Practice Provider Program and Impact on Urgent Care Center Encounters Among Patients With Head and Neck Cancers Treated With Curative Intent Radiation Therapy

Yingzhi Wu,[1] MSN, NP-C, Edward Christopher Dee,[1] MD, Sarin Kitpanit,[2,3] MD, Anna Lee,[4] MD, MPH, Nancy Lee,[1] MD, FASTRO; [1]Memorial Sloan Kettering Cancer Center, [2]King Chulalongkorn Memorial Hospital, [3]Thai Red Cross Society, [4]University of Texas MD Anderson Cancer Center

Objectives: Radiation therapy (RT) is a major treatment modality for head and neck cancers (HNCs). However, curative intent RT is associated with substantial acute toxicities for patients with HNCs, leading to Urgent Care Center (UCC) encounters during and after treatment. Advanced Practice Providers (APPs), who can independently provide symptom management, are integral to the care of patients with HNCs. This study evaluated uptake of APP integration in a head and neck radiation oncology service and the association with UCC encounters. **Methods:** Medical records of patients with HNCs treated with curative intent RT from July 1, 2016, to June 30, 2017, July 1, 2018 to June 30, 2019, and July 1, 2021 to June 30, 2022 at an academic cancer center by one head and neck radiation oncologist were reviewed. The first time period was without APP integration. One APP was integrated into the service during the second time period, with two APPs during the third time period, who independently managed patients after treatment completion through full recovery. Encounters at UCC of this center from RT start to 8 weeks after RT conclusion were recorded. Baseline characteristics and clinical variables such as sex, disease site, disease stage, RT regimen, RT alone or concurrent with chemotherapy, ECOG prior to RT, and body mass index prior to RT were collected. Uptake of APP integration and UCC encounters after RT conclusion were compared over 3 time periods. The mean number of post RT UCC encounter per patient was compared between patients without APP follow- up and patients with APP follow- up after RT conclusion. **Results:** Over 3 time periods, 138 patients with HNCs were treated with curative intent RT by one radiation oncologist, with 55 from July 1, 2016, to June 30, 2017, 54 from July 1, 2018 to June 30, 2019, and 29 from July 1, 2021 to June 30, 2022. In the first time period, no APP follow- up was provided after RT conclusion. In the second time period, 85.2% of patients were followed up by APP after RT conclusion; in the third time period, 96.6% patients saw an APP after RT conclusion. In the overall cohort, 61 (44.2%) patients had at least one UCC encounter from RT start to 8 weeks after RT conclusion. Only 34 (24.6%) patients had at least one UCC encounter after RT conclusion and this may have declined over the time, with 14 (25.5%) patients, 15 (25.9%) patients, and 6 (20.7%) patients across chronological time periods. The mean number of post RT UCC encounters per patient may have also trended downward over time, with 0.4, 0.31, and 0.24 respectively. Of note, among 74 patients followed by APP after RT conclusion, only 6 (8.1%) patients had UCC encounter while being followed by APP; and the mean number of post RT UCC encounter per patient was 0.29. However, the mean number of post RT UCC encounter per patient was 0.375 among 64 patients who were not followed by APP after RT conclusion. **Conclusion:** APPs in head and neck radiation oncology provide close follow-up to patients after RT until full recovery. Our data has suggested that APP integration had a nominal association with post RT UCC encounters. Future work should explore predictors of UCC encounter and determine the high-risk timeframe to help individualize post RT APP follow-up to mitigate UCC encounters among patients with HNCs treated with curative intent radiation therapy.

JL1247C: Utilization of Oncology Advanced Practice Providers in Transitional Care Management Visits

Shreya Jain, PA-C, Jake Canavan, MHA, Rachel Carroll, MSN, FNP-BC, AOCNP®, Ellen Ronnen; MD Astera Cancer Care

Background: Transitional Care Management (TCM) involves coordinating patient care after discharge from a hospitalization or other inpatient stay. During this transition period, patients are managing new diagnoses, medication changes, or disease progression. To qualify for a TCM

visit, several criteria must be met, including contacting the patient within two business days post-discharge, scheduling a follow-up visit within 7 to 14 days, managing medication reconciliation, reviewing hospitalization records and discharge information, following up on pending diagnostics, coordinating care, and making appropriate referrals. The TCM period is vital for ensuring smooth transition to the outpatient setting and for preventing hospital readmission. However, factors such as physician availability, staffing shortages, and patient education may delay a patient's access to this appointment. Initially, TCM appointments were primarily scheduled with the physicians at our practice. Our goal was to incorporate advanced practice providers (APPs) to provide these services under physician supervision, thereby increasing the percentage of eligible patients scheduled for TCM appointments. **Methods:** To increase TCM appointment availability and provide patients with timely follow-up after hospital discharge, APPs were educated on TCM criteria and necessary documentation. APP schedules were opened to accommodate these appointments. As part of the implementation process, we instructed staff to schedule visits with APPs while the attending hematologist/oncologist was present in the office. This approach facilitated a seamless transition of care to the outpatient setting, with the APPs assuming responsibilities such as reviewing hospital records, explaining treatment plans, reconciling medications, and coordinating care under physician supervision. **Results:** From September to December 2022, 52.07% (377 of 724) of eligible TCM patients were scheduled and seen within the appropriate timeframe. Following APP integration for TCM appointments in 2023, scheduling rates improved as follows: 62.09% from May to June (190 of 306 eligible patients), 62.25% from July to September (348 of 559 eligible patients), and 56.43% from October to December (329 of 583 eligible patients). There were scheduling staff shortages from January to March 2024 and only 37.14% of patients were scheduled (273 of 735). With the return of appropriate staffing from April to June 2024, scheduling increased to 61.32% (287 of 468 eligible patients). **Conclusion:** Adding TCM appointments to APPs' schedules provided quicker appointment options post-hospitalization. However, adequate support staffing remains a significant barrier to ensuring timely scheduling of all eligible patients within the required two-business-day timeframe, as evidenced by the lower scheduling percentage from January to March 2024. Additional barriers include difficulty contacting patients, hospital readmissions before appointments, patient no-shows, lack of patient education, and inadequate follow-up after discharge from subacute rehab facilities. To address some of these challenges, our practice created a dedicated TCM scheduler role to call patients after discharge and streamlines workflows during biweekly meetings. Inpatient oncology APPs educate patients and caregivers on the importance of follow-up appointments and verify patients' preferred contact details in the EMR prior to discharge, ensuring they can be reached by the scheduling team. We continue to improve processes to further increase the percentage of eligible TCM patients scheduled with providers.

JL1248C: Weekend Infusion Services for Oncology Patients Save Inpatient Days and Emergency Department Visits

Marie I. Carrera,[1] CRNP, Suzanne McGettigan,[2] MSN, CRNP, AOCN®, Colleen Kucharczuk,[1] DNP, CRNP, Lindsey Joan Zinck,[3] PhD, RN, OCN®, NEA-BC, Caitlin M. O'Neill,[1] DNP, RN, OCN®, NEA-BC, Alfred Garfall,[4] MD, Andrew Matthews,[1] MD, Erin Lightheart,[1] MBA, CSSBB, PMP; [1]Hospital of University of Pennsylvania, [2]Abramson Cancer Center, [3]Penn Medicine, [4]University of Pennsylvania

Background: Health care systems are charged with providing the right care, in the right place, at the right time. It is a priority to reduce the amount of time patients spend dealing with their cancer, a concept known as time toxicity. A multidisciplinary workgroup called the Inpatient-Outpatient Transitions Committee sought to address this imperative. The Oncology Evaluation Center (OEC) is an Advanced Practice Provider (APP) led service which opened in 2016 to provide same day symptom management for oncology patients, operating Monday through Friday. The committee's priority was to expand OEC services to a 7-day a week model. This abstract describes this intervention and its outcomes. **Methods:** The committee used a lean six sigma methodology with plan-do-study-act cycles. Before the intervention, retrospective chart reviews and voice of the customer surveys to patients

and providers were performed to assess opportunities for earlier hospital discharge and reduction of Emergency Department (ED) usage. Throughout the intervention, data was collected through chart review to analyze the real impact on inpatient days and ED visits saved. Observed to expected (O/E) length of stay (LOS) was monitored through a validated hospital dashboard. The committee met weekly to discuss and iteratively refine the intervention. **Intervention:** The intervention was the expansion of OEC services to a 7-day a week model, 8 hours per day, starting March 2024. Weekend staffing included two APPs, three registered nurses (RNs), two certified nursing assistants (CNAs), and one pharmacist. Services included transfusion, chemotherapy administration, symptom management evaluation, and supportive care. **Results:** In 18 weekends, there were 351 weekend patient visits, of which 69% were scheduled and 31% were unplanned. Most patients (92%) were discharged home following their visit, the remainder being either directly admitted to the hospital or referred to the ED. The expansion saved 213 inpatient days by allowing earlier discharge from the hospital. Also, the intervention prevented 167 ED visits, which amounts to an estimated 501 additional inpatient days saved based on the conservative assumption that 33% of oncology patients who present to the ED are admitted. Due to capacity constraints, 13 patients were turned away. O/E length of stay was reduced from 1.10 (Apr 2023 – Mar 2024) to 0.96 (Apr-May 2024). No meaningful changes were observed in 30-day unplanned readmission rates and mortality O/E, which were balancing measures. **Conclusion/Future Direction:** This intervention can serve any of the over 5000 patients admitted to this hospital, reducing time toxicity and allowing them more time at home, in their jobs, and with the people they love. The project also improves capacity management and patient throughput. The reductions we have achieved in ED utilization and inpatient bed-days mean better access to ED and inpatient facilities for all patients whenever they truly need them. Based on the early successes of this model, weekend services will be extended to 12-hours per day in July 2024. Future development will include 24-hour OEC services, 7 days a week, by February 2025 to adapt delivery systems to the needs of patients and clinicians.

JL1249C: Workload Index: A Simple, Translatable, and Actionable Tool to Optimize AP Resourcing

Joanne Lang,[1] ARNP, Catherine Patterson,[1] Pc-C, Maclin Johnson,[1] PA-C, Jessica E. Fugate,[1] PA-C, Hannah McLaurin,[1] BS, Christine Yennaco,[1] PA-C, MPH, MCHS, Jeannine Sanford,[1] ARNP, OCN®, Gabrielle A. Zecha,[2] PA-C, MHA; [1]Fred Hutchinson Cancer Center, [2]HPMG

Background: Oncology Advanced Practitioners (APs) are often primary providers for high acuity patients, managing complex medical issues, providing emotional support, and coordinating care. Tracking inpatient census or outpatient clinic slot utilization fails to capture much of this important work. The workload index (WLI) is a simple tool created to bridge this gap and better account for the non-billable care performed by APs. It was originally implemented to address acute staffing needs (Verdugo, Clark 2021) but has been a valuable tool for operational and strategic planning across our organization. **Method:** The Hematopoietic Stem Cell Transplant/Immunotherapy (HSCT/IMTX) inpatient teams at a large academic center began tracking daily WLI in 2020. Each day, APs submitted a WLI score for each patient based on an objective scale including points for medical complexity and care coordination. The data was compiled and analyzed by AP leadership. **Results:** The WLI demonstrated the inpatient HSCT/IMTX team was consistently under resourced. Workload data was used to justify additional staffing and approval of a new inpatient team, promoting patient safety and preventing AP burnout by illustrating the value of accounting for complexity versus census alone. Given the initial success of this tool, the WLI was further implemented among other teams at our center. The inpatient Hematology/Oncology AP service utilizes two WLI values: end-of-day and anticipated next-day workload. The anticipated next-day value enables surge staffing to be driven by either census or high acuity and facilitates redistribution of patients to balance workload. The end-of-day WLI retrospectively illustrates the appropriateness of daily staffing, providing valuable feedback on the efficacy of our predictive staffing system and highlighting changes in staffing needs over time through trend analysis. The Acute Clinical Evaluation and Infusion Service APs provide urgent services and episodic care across several

sites. This team adopted the WLI to evaluate and support necessary staffing changes to account for variable and unpredictable patient care needs. WLI points are given for: assessments, medication/transfusion reactions, rapid responses, procedures, triages, and teaching. As the service expands to meet patient access demands, the WLI has been used for longitudinal staffing predictions to support operational and strategic goals. The outpatient HSCT/IMTX clinic tracks WLI weekly, capturing billable and non-billable activities, including complex medical and psychosocial care, patient communications, order entry, and clinical vacancies coverage. This team modified the WLI to include a subjective scale which helps provide real-time resources to APs and balance panels. The goal is to equate a WLI score that is both representative and predictive of the amount of work on a clinical team. **Conclusions:** The applications of the WLI are broad, including use in supporting daily and longitudinal staffing needs as well as for operational and strategic planning. It has improved morale by helping APs demonstrate productivity not captured by usual methods. The WLI has been translatable and successfully implemented across AP service lines. It is versatile and can be modified to meet the unique needs of different departments. Next steps might include application of the WLI at other centers to further validate the tool.