Introduction

Problem/Significance
- CT chemotherapies can cause HF, even in remission (as late as 25 yrs post-cure)
- Continued use of agents r/t efficacy of therapy

Background/Scope of Problem
- AHA & EACVH (2013)
- Recommend monitoring for CT/HF using echocardiogram before & during all CT chemo

Literature Review & Best Practice Recs
- Subclinical changes undetected -> HF, affect tx
- GLS is better early predictor -> as early as 3 months, before pt has signs & symptoms of HF
- May be reversible w/ early detection

Gaps in Practice
- EF still used as standard practice
- No protocols for ordering 2D-STE, GLS interpretation and/or cardiology referral
- Inconsistent plans for monitor/manage of CT

Theory: Rosswurm & Larrabee Model for Translational Framework

Purpose & Aims

Purpose: Educate providers on recommendations for monitoring CT in the setting of chemotherapy & increase consistent use of best practice with ordering 2D-STE echo, interpreting GLS results, and placing cardiology referrals

AIM 1: Improve knowledge of 2D-STE/GLS in monitoring for CT
AIM 2: Improve use of best practice for echo order, results interpretation, cards referral
AIM 3: Increase provider use of recommended orders & referral

Methods

Design: Pre/post-intervention QI project
- 5-item Likert scale post-education evaluation
- Mixed modality, pre/post-intervention self-assessment survey

Site & Sample: Major mid-Atlantic Cancer Center
- 123 providers were contacted
- 4 participated in the confidential post-education evaluation
- 9 participated in the confidential pre/post self-assessment

Analysis
- Data de-identified & stored on secure server
- Descriptive statistics analysis; qualitative analysis for narratives

Sample Demographics

Baseline characteristics of participants (n=9)

<table>
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<tr>
<th>Provider Role, n (%)</th>
<th>MD</th>
<th>APNP</th>
<th>Research RN</th>
<th>BMT Coordinator</th>
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<th>Responsible for monitoring/assessing CT</th>
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<td>Responsible for placing cardiology referrals</td>
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<td>Responsible for postponing/discontinuing treatment</td>
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<td>No</td>
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Results

AIM 1: (n=4)
- Mean for all questions was 2.75 w/ SD=1.26, responses between agree – somewhat agree
- One respondent chose “disagree” for all questions, except efficiency

AIM 2: (n=9)
- NO participants knew how echo’s are performed
- 67% did not feel confident placing the orders
- Only 1 participant used GLS consistently
- 56% did NOT know GLS is the best predictor of CT
- AIM 3: could not be completed d/t project limitations

Conclusion & Future Implications

Discussion: providers are not familiar with GLS, EF standard practice, do not feel confident ordering echo or making cardiology ref
- Limitations: all virtual, sample size too small, educ module too long
- Strengths: highlight gaps in practice, increased awareness

Dissemination: Oncology grand rounds, developed new tool
Research: Submit for publishing to Onc & CV focused pubs
Practice: Standard orderset for monitoring echo/CT for chemo