lymphoma lesions or combination therapy is selected to cover the heterogeneous susceptibility to chemotherapy regimens.

INNV-30. USE OF MULTIDISCIPLINARY TEAMS AND MULTIMEDIA APPROACHES TO DEVELOP AND DISSEMINATE SYMPTOM AND DISEASE EDUCATIONAL MATERIALS FOR RARE CENTRAL NERVOUS SYSTEM (CNS) TUMOR PATIENTS

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BACKGROUND: Primary CNS tumors represent less than 2% of all cancers, with the majority of patients receiving care outside of specialty centers. Patients are highly symptomatic while trying to navigate care for their rare disease and evidence-based tumor and symptom education is limited. Our primary objective was to create and disseminate patient-centered content utilizing multidisciplinary teams and health communication to improve access to content. METHODS: The multidisciplinary team of neuro-oncology scientists and health care providers developed content from evidence-based sources. The team partnered with communication specialists to ensure health literacy and established outreach strategies for use on social media, e-newsletters, and web- and app-based programs. Web analytic tools assessed outreach and efficacy. RESULTS: Educational content for 12 rare tumors and 6 self-care topics was created using evidence-based sources and multidisciplinary team review. Content was published on the National Cancer Institute Comprehensive Oncology Network Evaluating Rare CNS Tumors (NCI-CONNECT) website and disseminated via multimedia platforms, including e-newsletters and social media (private Facebook group and Twitter). Since launching the website in September 2018, visits have increased 2,384%. The content was also shared directly to 6,156 newsletter subscribers, 4,897 Twitter followers with greater than 1 million impressions per year, 407 Facebook members, 9 non-profit advocacy partners, and thousands of attendees at more than 10 patient-focused neuro-oncology events. This outreach approach is now being replicated for symptom management content on the NCI-CONNECT website and a symptom tracking and self-care mobile application launching in 2021. CONCLUSIONS: By marrying patient-centered health communication, education, and outreach, our team successfully created highly sought content that reflects the unique needs of CNS tumor patients and their families. This material can educate neuro-oncology patients on their specific tumor, promote self-care, facilitate symptom management, and empower families to advocate for their unique needs, reaching outside traditional health care systems.

INNV-31. NEURO-ONCOLOGY OUTPATIENT SATISFACTION IS MAINTAINED IN THE ERA OF COVID-19 TELEMEDICINE

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INTRODUCTION: The use of telemedicine increased during the COVID-19 pandemic. However, the impact on patient satisfaction in the Neuro-oncology population is unknown. This quality improvement project compares outpatient satisfaction before and during the COVID-19 pandemic as well as in-person versus telemedicine platforms during the pandemic. METHODS: We performed an IRB-exempt retrospective analysis of aggregate de-identified outpatient satisfaction scores among Neuro-oncology patients seen at The Preston Robert Tisch Brain Tumor Center (PRTBTC) at Duke University. The Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) is a survey developed and distributed by Press Ganey Associates, and is the most widely used outpatient satisfaction survey in the United States. We compared pre-COVID-19 CG-CAHPS scores from patients who received in-person care at the PRBTC between April 2019 and March 2020 to COVID-19 pandemic CG-CAHPS scores (i.e. those who received either telemedicine or in-person care at the PRTBTC) from April 2020 to March 2021. RESULTS: Approximately 1448 surveys were completed for both in-person and telemedicine visits. During the pandemic, 48.6% of surveys represented telemedicine, with monthly variations from 84.6% (April 2020) to 21.4% (March 2021). Patient satisfaction scores pre-COVID-19 were similar to those during the pandemic: overall provider rating from 0-10 (9.28 v 9.36), knowledge of medical history (96.9% v 95.4%), listens carefully (96.6% v 96.9%), shows respect (97.2% v 98.1%), and time spent (93.2% v 95.5%). During the COVID-19 pandemic, in-person and telemedicine demonstrate similar levels of satisfaction: overall provider rating from 0-10 (9.29 v 9.48), knowledge of medical history (94.9% v 96.1%), listens carefully (95.4% v 99.0%), shows respect (97.5% v 99.0%), and time spent (94.7% v 96.7%). CONCLUSION: Outpatient satisfaction prior to and during the COVID-19 pandemic was similar. Patients reported similar satisfaction between in-person and telemedicine platforms. We support the ongoing use of telemedicine for outpatient Neuro-oncology.

INNV-32. ACCESS TO SPECIALTY RADIATION CARE FOR PATIENTS WITH RESECTABLE BRAIN TUMORS

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INTRODUCTION: Many patients with brain tumors face challenges with access to care. For rural patients, prolonged travel times may limit access to appropriate radiotherapy. Radiation centers (RCs) offering specialized brain radiotherapy, e.g., stereotactic radiosurgery (SRS), are geographically limited. Brain brachytherapy at the time of resection offers an option for such patients, but technical challenges have limited the adoption. To address the limitations of traditional brachytherapy, a device with Cs-131 seeds embedded in a bioresorbable collagen tile (GammaTile (GT), GT Medical Technologies, Tempe, AZ) was developed. The device is FDA-cleared for permanent implantation at the time of resection for all recurrent intracranial tumors and newly diagnosed malignant intracranial neoplasms. To investigate if wider availability of this treatment could possibly lower the geographic barrier to access to care, we mapped the US population against existing RCs with brain tumor expertise and neurosurgery centers (NSCs) performing craniotomies. METHODS: We analyzed 2018 CMS claims data using CPT codes for single- and multi-fraction SRS to identify RCs with brain tumor treatment expertise and mapped these against the population. Using similar methodology, using CPT codes for craniotomies, we identified NSCs, as any facility performing craniotomies is potentially eligible to implant the device. RESULTS: 135 RCs used CPT codes for SRS. 193-, 119-, 82-, and 52-million Americans lived >30-, >60-, >90-, and >120-minutes from one of these centers, respectively. 530 NSCs preform craniotomies, including ≥ 1 in every state, a 4-fold increase over the number of RCs offering SRS. CONCLUSIONS: For many patients, substantial travel distances limit access to RCs with brain tumor treatment expertise. In contrast, the 530 craniotomy-performing NSCs have far greater geographic dispersion. The option of undergoing brain radiation with GT implantation at the time of brain tumor craniotomy brings treatment closer to millions, ensures compliance, and reduces additional travel for follow-up radiation treatment.

INNV-33. THE IMPACT OF COVID-19 ON NEURO-ONCOLOGY CLINICAL TRIALS DURING WAVE 1 AND WAVE 2 AT A FRONTLINE DETROIT HEALTH CARE SYSTEM

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In the wake of the Coronavirus disease outbreak (COVID-19), clinical trial operations were significantly impacted following the shutdown of elective healthcare services and even emergency operations. When the pandemic hit Detroit, Michigan in March 2020, the Hermelin Brain Tumor Center (HBTC) at Henry Ford Health System was consumed in COVID-19 emergency care which affected patient enrollment, conduct of trial activities, therapeutic treatment, deviation from protocol requirements, and sponsor-study site contact. The first Metro-Detroit COVID-19 case was confirmed March 10th 2020. At that time there were 18 active brain tumor clinical trials (phase 1 - phase 3) providing anti-cancer therapies. Trial modifications included decentralized operations to buildings with clinic and radiology access away from inpatient COVID-19 care, utilization of telemedicine for non-essential visits, shipping of investigational products to patient home, and in some cases utilization of local results in place of central histopathological confirmation. By April 2020, trials were ranked based on availability of alternative therapies and subject safety in 4 tiers that correlated with subject benefit and impact on care. Trials were given a prioritization level to commence enrollment with priority given to trials where no standard of care exists. Of the HBTC trials, one was graded Tier 1 and most were graded Tier 2. All patients already enrolled continued on study. As restrictions eased, trials were opened in a sequential manner. Changes that were made during the first wave of the pandemic helped to minimize its effect on clinical trial operation and enrollment during the second wave in Fall 2020. Thus, leading toward a decrease in trial deviations and increased enrollment during the 2nd wave. The changes made during the first wave helped to safely continue enrollment and treatment during the second wave and will have a longstanding impact on how clinical trials will be conducted in the future.