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**Purpose:** The COVID-19 pandemic forced cancer centres worldwide to consider shortened radiotherapy regimens to minimize the risk of infectious exposure of patients and staff members. The process of obtaining consensus and implementation of new treatment approaches can be more challenging in larger institutions with multiple treatment centres. We describe the implementation of single fraction (SF) lung stereotactic ablative radiotherapy (SABR) in a multi-centre provincial cancer program.

**Materials and Methods:** In a Canadian province with a provincial cancer program, radiotherapy services are distributed across six regional centres. In March 2020, provincial mitigation strategies were developed in the event of severe limitations on radiotherapy access during the COVID-19 pandemic. The provincial lung radiation oncology group identified SF lung SABR as a mitigation measure supported by high quality randomized evidence that could provide comparable outcomes and toxicity to existing fractionated SABR protocols. A working group of radiation oncologists and medical physicists performed a literature review and drafted provincial consensus guidelines and procedures. The guidelines were reviewed by a group of centre representatives as a component of provincial lung radiotherapy mitigation strategic planning. Individual centres were encouraged to implement SF lung SABR as their resources and staffing would allow. Centres were then surveyed about barriers to implementation.

**Results:** On March 24, 2020, a working group was created and consensus guidelines for SF lung SABR were drafted. The final version was approved and distributed by the working group on March 26, 2020. The provincial lung radiotherapy mitigation strategy group adopted the guidelines for implementation on April 1, 2020. Implementation was completed at the first centre on April 27, 2020. Barriers to implementation were identified at the remaining five centres. Two centres located in regions with disproportionately high numbers of positive COVID-19 cases described inadequate staffing as an impediment to implementation. One centre experienced delays due to pre-scheduled commissioning of new treatment techniques. Three centres cited competing priorities as reasons for delay. As of February 2021, two centres had active SF lung SABR programs in place, three centres were in the process of implementation, and one centre had no immediate plans for implementation due to ongoing resource issues.

**Conclusions:** SF lung SABR was introduced in a multi-centre provincial cancer program within weeks of conception through rapid communication during the development of pandemic mitigation strategies for radiotherapy. Although consensus guidelines were adopted quickly, the actual implementation by individual centres was variable due to differences in resource allocation and staffing among the centres. Strong organizational structures and early identification of potential barriers may improve the efficiency of adopting new treatment initiatives in large distributed radiotherapy programs.

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140 BARRIERS TO ACCESS PALLIATIVE RADIOThERAPY FOR PROSTATE Cancer in ontario
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**Purpose:** With improvements in systemic therapy, patients with metastatic malignancies are living longer; however, access to adequate palliative radiotherapy remains an issue. In this study, we aim to describe factors important in access to palliative radiotherapy in patients who received novel Androgen receptor-axis-targeted therapies (ARAT) and died of prostate cancer. The main objective of this investigation was to identify and describe the factors important to receipt of palliative radiation treatment and the barriers to access in patients with prostate cancer in Ontario.

**Materials and Methods:** Population-based administrative databases from Ontario, Canada were used to identify patients 65 years or older with prostate cancer who were eligible for Ontario Drug Benefit 2002-2018 (n=138,976), received continuous androgen deprivation therapy (ADT, n=37,578), and died of prostate cancer-specific death between 2013-2017 (n=3,575). Baseline and treatment characteristics were analyzed for association with receipt of radiotherapy in a two-year observation period prior to death.

**Results:** 48.4% of patients who were included in the study received palliative radiotherapy to bone in the two years preceding death despite 51.3 % presenting with metastasis. Potential barriers to access to radiation treatment in patients with lethal castration-resistant prostate cancer in Ontario include cancer centre consultation, type of oncologist involved, patient distance to cancer centre, or socioeconomic factors, such as income quartile and rurality index. Detailed analysis of the results will be available at the time of presentation.

**Conclusions:** The role of palliative radiotherapy has become increasingly recognized constituting nearly half the courses of radiation therapy delivered in Ontario. However, unimpeded access to radiation therapy continues to be a challenge, as evident from a high proportion of patients dying of prostate cancer in Ontario who never received palliative radiotherapy. We aimed to identify socioeconomic factors that might have accounted for the gap between the actual and optimal rates of receipt of radiotherapy to be able to improve the quality of life of many incurable patients.

141 RADIOTHERAPY DECISION MAKING IN A PANDEMIC: ALBERTA’S EXPERIENCE DURING THE FIRST WAVE OF COVID-19
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**Purpose:** To examine deviations to radiotherapy standard practice in the province of Alberta due to the onset of the COVID-19 pandemic.

**Materials and Methods:** The Canadian partnership for Quality Radiotherapy developed a questionnaire for radiotherapy departments across Canada to track clinical deviations in decision making. The questionnaire is available (www.cpqr.ca) to use and/or adapt for each centre’s needs and captures patient-specific characteristics, COVID-19 status, and deviations to standard care received. In this study, the CPQR questionnaire was completed by the physician at the time of initial radiation oncology consult. It was implemented in Alberta provincially on May 11, 2020 and retrospectively populated to include patient data from March 1, 2020.

**Results:** From March 1, 2020 to July 31, 2020, there were 10,900 recorded COVID-19 positive cases in the province of Alberta. During this time period, 2110 questionnaires were completed, with 162 (7.7%) reporting that standard practice was not followed. Of the 162 reporting non-standard practice, 150 (7.1%) patients had a change to intended timing or dose regimen, and 12 (0.6%) patients did not receive radiotherapy. Among tumour-site groups, breast patients had the largest proportion (30.3%) of deviation from standard practice, followed by hematologic (12.1%), GU (7.2%), gynaecologic (6.3%), lung (4.7%), CNS (3.6%), and GI (1.4%).
To reduce total treatment visits, hypofractionation regimes were introduced: Accelerated partial breast irradiation (APBI) 27Gy in 5 fractions; 40Gy in 15 fractions; Fast forward regime, 26Gy in 5 fractions. The latter was adopted as a standard of care option in June 2020.

Conclusions: The total number of patients that had a deviation from standard practice was minimal. Only breast cancer patient group showed a significant change, facilitated by existing expertise in APBI and hypofractionation.

Materials and Methods: A semi-structured interview-survey was developed to compare provider practice patterns between May 2019 and May 2020. Questions were designed to determine provider-perceived value and impact of virtual visits on clinical interactions with patients. HCP (including physicians, dentists, and nurse practitioners) at a provincial oncology institution were invited to participate. Responses to the interview questions were de-identified and HCP names were replaced with a study code. Quantitative questions were interpreted with descriptive statistics. Qualitative results were analyzed and iteratively coded by multiple reviewers for emerging themes.

Results: Among 531 invited participants, 61 completed the interview-survey and 60 were included in the final analysis. Of those interviewed, 47% were radiation oncologists and 33% were medical oncologists. The remainder of HCP interviewed (n=12) included functional imaging physicians, general practitioners in oncology, hereditary cancer physicians, nurse practitioners, palliative care physicians, psychiatrists, and surgical oncologists. Most oncology providers (87%) desired the continuation of virtual visits as part of their clinical practice so long as barriers to integration were addressed. Barriers identified included limited access to physical resources, such as hardware (70% responses) and quiet spaces (54% responses), insufficient logistic support such as information technology services (84% responses) and operational workflows (46% responses), the absence of guidelines to select patients for this delivery model (38% responses), and concerns regarding HCP liability, security and privacy (30% responses).

Conclusions: Oncology HCP value delivering patient care through virtual means, however, barriers to implementation must be better understood. These data may inform continued use and implementation of virtual care at other Canadian oncology centres.