in-person or telephone consultation pre-operatively. Over three years, the PAC was also adopted by general surgery, orthopedic surgery, and urology.

METHODS: With IRB approval, we analyzed the electronic medical records of 129 consecutive geriatric neurosurgical patients undergoing operation between January 2017 and January 2020. Inclusion criteria were age 65 years or older and completion of a PAC assessment pre-operatively. Patient demographics, treatment, and medical and neurosurgical outcomes were reviewed retrospectively.

RESULTS: The community hospital PAC evaluated 129 patients aged 65 and older over a three-year period. Geriatric neurosurgical volume doubled between 2017 (25 cases) and 2019 (52 cases). Sixty-nine percent of patients were classified as American Society of Anesthesiologists (ASA) Class III or IV. Mean length of hospital stay was 2.9 days. Intraoperative complication rate was 1.6%. Neurologic deficit rate was 0.8%. Neurosurgical-related 30- and 90-day readmission rates were 3.1% and 4.7%, respectively. Medical-related 30- and 90-day readmission rates were 2.3% and 5.4%, respectively.

CONCLUSION: Community hospitals are typically comprised of a diverse pool of private practice and employed physicians and groups, creating challenges to patient care standardization. In this setting, a PAC triage algorithm may serve to standardize patient flow. In neurosurgical patients, a community hospital PAC supported a doubling of geriatric OR volume and facilitated pre-operative medical optimization of a high-risk population, yielding low medical and neurosurgical readmissions. As academic health systems incorporate community hospitals, implementing PACs should be considered to support patient access and improve outcomes, particularly in vulnerable populations.

172 Surgical Prioritization: The Northwell Neurosurgical Prioritization Initiative

Justin G. Thomas, DO; Shashank V. Gandhi, MD; Timothy G. White, MD; Christian Jocelyn; Teck M. Soo, MD; Mark B. Eisenberg, MD; Michael Schulder, MD; Raj K. Narayan, MD

INTRODUCTION: Beginning in March, 2020, hospitals across the majority of the United States were required to cancel all elective surgery in preparation for a surge of patients with the coronavirus disease of 2019 (COVID-19). A large number of neurosurgical patients with less than emergency conditions had their surgery postponed indefinitely.

METHODS: The Delphi method was used to obtain consensus. Twenty-two neurosurgeons actively practicing in two separate geographic regions of the United States where “black level” COVID-19 surges occurred (New York Metropolitan Area and Detroit, Michigan) participated. A total of 86 neurosurgical case scenarios were categorized into six tiers of priority: emergent or within 24 hours, within 48 hours, within 1 week, within 2 weeks, within one month, or post hospital crisis/more than 4 weeks. Consensus was defined as 75% of participants reaching an agreement. Majority opinion (>50% agreement) was also reported.

RESULTS: 67 of the 86 surgical scenarios (78%) reached a consensus agreement with 85 out of 86 scenarios reaching at least a majority opinion. Only one scenario (central cord syndrome) did not reach any agreement.

CONCLUSION: The NNPI developed in this study can assist neurosurgical departments in prioritizing the timing of surgery, whether it be due to a pandemic, or any other scenario where the normal work flow has been severely disrupted and resources are limited.

173 Idiopathic Normal Pressure Hydrocephalus in the United States: Demographic and Socioeconomic Disparities

Arash Ghaffari Rafi, BS; Rana Mehdizadeh; Shadegh Ghaffari-Rafi; Jose E. Leon-Rojas, MD, MS

INTRODUCTION: With early intervention, up to 80% of idiopathic normal pressure hydrocephalus’s (iNPH) patients may clinically improve, thus there is impetus to understand pathophysiology and sooner identify patients for treatment. By characterizing risk factors and how disease is distributed amongst a population, epidemiology provides an avenue for identifying iNPH’s pathogenesis.

METHODS: To investigate iNPH incidence with respect to sex, age, income, residence, and race/ethnicity, we queried the largest American administrative dataset, the National (Nationwide) Inpatient Sample (NIS), which surveys 20% of United States (US) discharges. Subsequently, median annual incidence (per 100,000 people) and disease trends between 2008–2016 were determined.

RESULTS: Annual national iNPH incidence (with 25th and 75th quartiles) was 2.86 (2.72, 2.93). Males had an incidence of 3.27 (3.11, 3.39), larger (P = .008) than the female incidence of 2.45 (2.41, 2.47). Amongst age groups incidence varied (tau = 30.4, P = .000004) as follows: 1–17 years old group, 0.00 (0.00, 0.00); 18–44 group, 0.064 (0.058, 0.076); 45–64 group, 11.91 (10.99, 12.73); 65–84 group, 2.65 (2.64, 2.67); ≥85 group, 18.81 (16.40, 19.95). Individuals with middle/high income had an incidence of 2.96 (2.77, 3.06), larger (P = .008) than the 2.37 (2.24, 2.53) of low income patients. Depending on whether patients lived in urban, suburban, or rural communities, incidence diverged (tau = 9, P = .01) as follows, respectively: 2.65 (2.43, 2.84); 2.66 (2.56, 2.83); 3.036 (2.96, 3.19). Living in a rural community resulted in a significantly greater incidence, relative to urban (P = .03) or suburban (P = .04). Amongst race/ethnicity (tau = 30.8, P = .000003), incidence for Whites, Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans were as follows, respectively: 3.88 (3.69, 3.93), 1.065 (1.015, 1.14), 0.82 (0.76, 0.85), 0.43 (0.33, 0.52), 0.027 (0.026, 0.12).

CONCLUSION: In the US, iNPH annual incidence (2008–2016) was found to be 2.86 per 100,000 people, with existing disparities between socioeconomic and demographic strata. Disproportionately, incidence was greatest for patients who were White, male, 65 and older, middle/high income, and living in rural communities. In summary, the data emphasizes a healthcare inequality amongst iNPH and provides insight for etiology elucidation.