publication. ***Results:*** The study included 1109 patients (median age 72, 50% female). Real-world duration of therapy was median 5.0 months (95% Confidence Interval [CI]: 4.2-5.7). Median overall survival was 13.8 months (95% CI: 11.8-16.2) over the full study period. The sensitivity analysis excluding patients with missing PDL1 status found median overall survival of 14.9 months (95% CI: 12.5-17.6). The shorter time horizon (October 2016 to June 2018) estimated median overall survival of 13.1 months (95% CI: 10.8-NR). ***Conclusions:*** In this case, EHR-derived data offered longer follow-up time (max 49 months) than the trial follow-up (max 22 months) used for extrapolation. This cohort had a median overall survival of 13.8 months while the trial (n=154) estimated 30.0 months and a similar Medicare claims analysis (n=3079) estimated 11.4 months. Real-world median age was 7-9 years older than the trial. Our study demonstrates that EHRs can be a source of mature data on specific cohorts of interest with potential to contextualize trial evidence and inform HTA-decision making.

P15
TRANSCATHETER VERSUS SURGICAL AORTIC VALVE REPLACEMENT: A REAL-WORLD COMPARISON OF CLINICAL OUTCOMES BASED ON A GERMAN CLAIMS DATASET

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Objectives: This study aimed to describe clinical outcomes after transcatheter aortic valve implantation (TAVI) and surgical aortic valve implantation (SAVR). ***Methods:*** This study consisted of a retrospective analysis of German health insurance claims data from 01/01/2013-30/06/2019. Continuously insured adults with either TAVI (OPS 5-35a.0) or SAVR (OPS 5-351.0) between 01/01/2014 and 30/06/2018, who had aortic valve stenosis (ICD-10 I35.0, I35.2) were included. Patients with previous TAVI or SAVR were excluded. Both cohorts were described with regards to their baseline characteristics (one-year baseline) and the incidence rate (IR) of events during the follow-up period for death, transient ischemic attack (TIA), stroke, major bleeding event, periprocedural complications, and myocardial infarction (MI). ***Results:*** Overall, 2,932 TAVI and 826 SAVR patients were identified. Compared to SAVR patients, TAVI patients were on average older (81.75 years vs. 69.18 years), more often female (56.92% vs. 42.37%), more comorbid (CCI 5.86 vs. 3.82; CHA2DS2-VASc-Score 3.17 vs. 2.47), and they had a higher probability of previous TIAs (3.07% vs. 1.33%), strokes (8.29% vs. 4.00%), and MIs (10.57% vs. 3.87%). 3.07%/1.21% of TAVI/SAVR patients died during the index hospitalization. Outcomes were observed during a follow-up period of 2.43 years (TAVI) / 3.02 years (SAVR). The following IR have been observed for TAVI/SAVR: death (0.17 vs. 0.04; $p<0.001$), TIA (0.00 vs. 0.01, $p=0.046$), stroke (0.03 vs. 0.01, $p<0.001$), major bleeding event (0.08 vs. 0.04, $p<0.001$), periprocedural complications during index hospital stay (1.87 vs. 1.13, $p<0.001$), and MIs (0.02 vs. 0.00; $p<0.01$). ***Conclusions:*** TAVI has become the new standard of care in recent years and has replaced the classic aortic valve replacement, specifically in more fragile patients. The above results confirm that TAVI procedures are widely used in clinical practice, and that in line with current guidelines, physicians assess which patients should receive a TAVI or a SAVR procedure.

P16
RECENT ESTIMATES OF SURVIVAL IN PATIENTS WITH ADVANCED NON-SMALL CELL LUNG CANCER (NSCLC) IN THE US (2010-2020)

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Objectives: Despite availability of new treatments, the prognosis of lung cancer remains poor. This study aims to provide recent estimates of survival in patients with advanced non-small cell lung cancer (NSCLC) in the US. ***Methods:*** The survival of patients with advanced NSCLC was estimated using two US databases together covering 2010–2020. The study included patients with stage III or IV NSCLC diagnosed between 2010–2016 in the Surveillance, Epidemiology, and End Results Program (SEER) database, and patients with stage IIIB, IIIC or IV NSCLC, diagnosed between 2017–2020, without known oncogenic driver mutations who had completed ≥4 cycles of 1L treatment (restricted to platinum-based combinations, immuno-oncology monotherapy, or ipilimumab/nivolumab) in the Flatiron Health database, a US Oncology Electronic Medical Record database. Overall survival (OS) was defined as time from diagnosis of stage III or IV NSCLC to death or to date of last confirmed activity. ***Results:*** A total of 49,298 and 133,395 patients with stage III and IV diagnosis respectively were identified in SEER. The 1-, 3- and 5-year OS for patients with Stage III disease were 55.1%, 26.3% and 17.5%, and for stage IV disease were 25.8%, 7.4% and 4.0%, respectively. The Flatiron database had 1,045 patients with stage IIIB, 130 patients with stage IIIC and 3,210 patients with stage IV disease at diagnosis. The 1- and 3-year OS for stage IIIB/IIIC disease were 72.5% and 36.4%, and for patients with stage IV disease were 65.9% and 24.6%, respectively. ***Conclusions:*** Despite differences in study population characteristics between the two databases, the study shows that mortality in patients with advanced NSCLC remains high, underscoring the need for continued efforts to identify novel treatments and synergetic treatment combinations to improve patient outcomes.

Evaluating Individuals and Patients Preferences: Discrete Choice Experiments and Beyond

P17
PREFERENCE OF RHEUMATOID ARTHRITIS PATIENTS FOR TAPERING BIOLOGICS: A DISCRETE CHOICE EXPERIMENT

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Objectives: Tapering of biologics is a safe and feasible approach in the long-term management of rheumatoid arthritis (RA) patients who are in remission. However, the appeal of tapering strategies needs to be balanced against the risks of disrupting patients' disease control. The aim of this study was to measure the preferences of RA patients and their risk-benefit trade-offs in relation to biologic tapering. ***Methods:*** A web-based discrete choice experiment (DCE) was employed. Seven attributes (identified via focus groups and a systematic review) of varying levels describing three hypothetical choice were presented: frequency of treatment, chances of known adverse effects, chances of regaining disease control and healthcare service-related features. DCE data were analysed using mixed logit model to estimate the preference weights for key treatment features and to quantify trade-offs between the attributes. ***Results:*** A total of 142 complete responses were analysed. Mean age was 60.3 years with an average disease duration of 20.8 years Frequency of biologic treatment was the most important attribute, followed by the chance of flare upon tapering. Time to see the rheumatology team after a flare was ranked the least important among the seven attributes. On average, participants were willing to accept between 25.3% to 50.2% increase in chance of disease flare in exchange for reducing the frequency of biologic treatment, chance of serious infection and chance of skin cancer. ***Conclusions:*** This study provides evidence that RA patients' preference for tapering biologics are most influenced by the frequency of treatment and chance of flare. For these attributes, they are willing to accept a greater chance of flare in exchange for treatment benefits in the form of a reduction in biologic dosing and potential risk of serious infection and skin cancer associated with long-term biologic use. These findings have implications for clinical practice and policy making about tapering.

P18
PATIENT PREFERENCES FOR ATTRIBUTES OF A MULTI-CANCER EARLY DETECTION TEST: A DISCRETE CHOICE EXPERIMENT (DCE) QUANTITATIVE PILOT STUDY

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Objectives: Early cancer detection and intervention can significantly improve patient outcomes and reduce mortality rates. Evidence shows that emerging blood-based multi-cancer early detection (MCED) tests can detect a variety of cancer types across stages and provide a predicted cancer signal origin with high specificity. However, little is known about patients' preferences for MCED tests. This study aimed to quantify preferences for attributes of blood-based MCED tests among the US general population aged 50-80 years. ***Methods:*** A DCE consisting of five attributes (true positives, false negatives, false positives, likelihood of the cancer type unknown [e.g., inaccurate cancer signal origin], and number of cancers tested for) was administered online to US general population members to elicit preferences to quantitatively pilot test the DCE. Data were analyzed using an error-component multinomial logit model and relative attribute importance (RAI) was obtained. ***Results:*** Participants (N=303) were 62.0% male (n=188), mean age 68.2 years (SD=6.4). RAI indicated that the rank order of attribute importance was false negatives (35.7%), true positives (27.6%), false positives (17.3%), number of cancers tested for (16.8%), and cancer type unknown (2.7%). Attributes related to improved test accuracy were important and participants strongly preferred screenings that tested for more cancer types (all $p < 0.05$). Preferences were non-significant for the likelihood of cancer type unknown attribute levels. Overall, 71.9% of participants reported that they would prefer to receive the MCED test in addition to their currently recommended cancer screenings. ***Conclusions:*** Participants' preferences were strongly driven by the desire for a screening test with fewer false negatives and more true positives, with these 2 attributes comprising 63.3% of the RAI. False positive results and number of types of cancer tested for also impacted preferences but were of lower importance. The majority of participants preferred adding a MCED test to supplement current cancer screenings.

P19
ASSESSING HETEROGENEITY IN MAR: METHODS AND MODELS BEYOND DCE

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Objectives: Discrete choice experiments (DCEs) are robust stated-preference methods frequently used to estimate maximum acceptable risk (MAR) as a secondary outcome. However, DCEs provide sample-level estimates and explaining preference heterogeneity for MARs based on participant characteristics can be difficult. The study objective was to compare the capability of a DCE and a probabilistic threshold technique (PTT) to identify preference heterogeneity among MARs for preventive rheumatoid arthritis (RA) treatment. ***Methods:*** Participants from 3 countries (United Kingdom (UK), Germany, and Romania, n = 2959) completed a DCE and PTT in random order. Participants made choices between treatments that reduced chance of developing RA but increased chance of three risks (mild and serious side effects, serious infection). For the PTT, interval regressions estimated MARs that accounted for age, education, numeracy, literacy, and RA family history. For the DCE, random parameters logit (RPL) models were used to calculate MARs for subgroups in which heterogeneity was identified in the PTT. ***Results:*** The PTT identified preference heterogeneity for numeracy, literacy, and family history. Regarding these characteristics, the PTT identified statistically significantly different MARs ($p<0.05$) for at least one risk in at least two countries. The DCE identified preference heterogeneity for the chance of serious infection between UK participants with low vs. high numeracy ($p<0.05$). Using the DCE, no statistically different MARs were identified for other combinations of participant characteristics, risks, or countries. ***Conclusions:*** The PTT identified preference heterogeneity in MARs for more participant characteristics by directly incorporating participant characteristics in the regression model. When attempting to estimate MARs, PTT may partially overcome challenges with stratified DCE models, particularly if analyses such as latent class analysis are not feasible or desirable. Further research is needed to confirm the findings in this case studies and to explore which method most accurately identify true underlying preference heterogeneity are needed.

P20
EVALUATING PREFERENCES AND THE EFFECT OF ALTRUISM ON COVID-19 VACCINE DECISIONS: A DISCRETE CHOICE EXPERIMENT

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Objectives: To elucidate how Americans value COVID-19 vaccine characteristics, and determine whether their willingness to vaccinate is altered by the framing of the vaccination decision as altruistic or not. ***Methods:*** We conducted a discrete choice experiment (DCE) with Amazon MTurk participants randomized into a control group with standard DCE questions, versus a treatment group with questions framed altruistically. The survey consisted of demographic questions, an altruism index, and a DCE of 12 choice tasks with 3 profiles (Vaccine A, Vaccine B, and No Vaccination). Vaccine attributes included number of doses, efficacy in preventing infection, risk of severe disease, severe side effect type, risk of severe side effect, and subsidy. We estimated preference weights using multinomial logit models, controlling for framing, sex, age, political party, health status, race/ethnicity, and altruism score. ***Results:*** Sample included 2,014 respondents (control with no framing, n=1,037; altruism framing, n=977). Respondents preferred COVID-19 vaccines with allergic reactions vs neurological disorder as side effects (OR: 1.32; $P<0.01$), higher efficacy (OR: 1.03; $P < 0.01$), higher subsidies (OR: 1.00; $P < 0.01$), lower risk of side effects (OR: 0.99; $P < 0.01$), and lower risk of severe disease (OR: 0.99; $P < 0.01$). Preferences for single- vs double-dose formulations did not significantly differ ($P > 0.01$). Respondents with higher baseline altruism scores were more likely to prefer vaccination compared to those with lower altruism scores (RR: 1.83; $P < 0.01$). However, framing neither significantly affected preferences for vaccination nor modified the effect of baseline altruism on these preferences for vaccination. ***Conclusions:*** Preferences were strongest for vaccines with less severe side effects, suggesting that innovators should prioritize COVID-19 vaccines with these characteristics. More altruistic individuals were more likely to vaccinate, but framing did not modulate vaccination decisions, implying its limited nudging effects for vaccination.

Impact of the COVID-19 Pandemic: Healthcare Utilisation and Outcomes

P21
SOCIAL DISTANCING AND TRENDS IN INFLUENZA HOSPITALIZATION DURING THE COVID-19 OUTBREAK: A DIFFERENCE-IN-DIFFERENCE ANALYSIS OF GERMAN CLAIMS DATA

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Objectives: As COVID-19 spread worldwide, indicators of influenza activity in the Northern Hemisphere began to decline by mid-to-late February. In Germany, federal lockdown measures were introduced to contain the outbreak on 22/03/2020 (week 12). We used claims data from AOK PLUS, a regional sickness fund covering around half the population in Saxony and Thuringia (6.2 million inhabitants), to examine the trend of influenza hospitalizations in 2020 compared to 2019. ***Methods:*** Using data from 01/01/2019 to 31/05/2020 (weeks 1-22), influenza hospitalizations were identified using ICD-10-GM codes J10-J11. We estimated changes in the number of influenza hospitalizations using a "difference-in-differences" model including variables for age group (<18, 18-44, 45-64, 65-79, 80+), gender, week, year, and outbreak status (interaction variable between year 2020 and week 12 or later). Adjusted incidence rate ratios (aIRRs) were estimated using Poisson regression with heteroskedasticity-robust standard errors. ***Results:*** During weeks 1-22, we observed 5,174 influenza hospitalizations in 2019 and 2020. Influenza hospitalizations in 2020 showed similar trends until week 12 and then showed a relative decline compared to 2019. The average number of influenza hospitalizations per week during weeks 12-22 significantly decreased in 2020 compared to 2019 (1.6 vs. 5.2; aIRR: 0.45; 95% CI: 0.34-0.59; $p<0.001$). When stratified by age group, all groups except age 18-44 had a similar decrease in average influenza hospitalizations per week in 2020 compared to 2019, with large relative declines in patients age 80+ (2.2 vs. 5.8; aIRR: 0.36; 95% CI: 0.28-0.46; $p<0.001$) and children <18 (1.8 vs. 8.0; aIRR: 0.38; 95% CI 0.32-0.46; $p<0.001$). ***Conclusions:*** The number of influenza hospitalizations saw a relative faster decline in 2020 compared to 2019 after the introduction of federal lockdown measures in Germany, possibly due to the effectiveness of non-pharmaceutical interventions like social distancing and the use of facemasks.

P22
COVID-19 PANDEMIC IMPACTS VOLUME OF EVALUATION & MANAGEMENT (E&M) TELEHEALTH VISITS WITHIN COMMUNITY ONCOLOGY PRACTICES

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Objectives: The USA declared the COVID-19 pandemic a national emergency on 03/13/20. On 03/17/20, CMS expanded telehealth rules, allowing Medicare to cover telehealth visits like regular visits. This study aims to analyze the utilization of Evaluation & Management (E&M) telehealth options in community oncology pre and post pandemic. ***Methods:*** Deidentified patient visits data were obtained from iKnowMed electronic health records between 01/01/18 to 05/24/2021 from 20 US Oncology practices. A combination of patient MRN and date was used as an identifier to report number of visits for all measures. Patient visits with modifiers –GT, –95, and –GQ were classified as telehealth visits. Visit dates without modifiers were defined as non-telehealth (in-office) visits. E&M visits were defined based on standard CPT codes. ***Results:*** A total of 5,914,125 unique E&M patient visits were analyzed during the study period. Between Jan-2018 and Mar-2020 (pre-COVID-19), E&M visits rose from 30,000/week to 36,000/week (20%). Fewer than 0.01% of these visits were telehealth. By April 12, 2020, overall E&M visits had dropped 35%, but the telehealth visits had risen to 16%. Since then, the overall E&M visit count remained approximately 5% lower as compared to the pre-COVID-19 trend, and telehealth visits averaged approximately 6% thereafter. Corresponding to the 2nd wave, in Dec-2020 the telehealth proportion rose again to 10%. As of 05/23/2021, telehealth E&M visits represented approximately 5% of the total E&M visits within US Oncology practices. ***Conclusions:*** This study provides a timeline of how COVID-19 has impacted E&M visits and telehealth utilization among community oncology practices. The pandemic has led to an increase in E&M telehealth visits that may remain post pandemic. Continued research is necessary to monitor telehealth utilization and its impact on the quality of care, provider finances, and future of community oncology considering rising vaccination rates, CDC guidance, and public sentiment.

P23
CHANGE IN HEALTHCARE UTILISATION AND INPATIENT MORTALITY IN PATIENTS HOSPITALISED WITH HEART FAILURE DURING THE CORONAVIRUS PANDEMIC IN ENGLAND: A RETROSPECTIVE CROSS-SECTIONAL STUDY UTILISING HES

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Objectives: This study quantifies change in healthcare utilisation and inpatient mortality of all adult patients hospitalised with Heart Failure in England during three coronavirus national lockdowns compared to the same time period in the previous year. ***Methods:*** A retrospective cross-sectional study using the Hospital Episode Statistics (HES) database was conducted. All adults admitted to an English hospital with a primary diagnosis of I110 Hypertensive heart disease with (congestive) heart failure, I255 Ischaemic cardiomyopathy, I420 Dilated cardiomyopathy, I429 Cardiomyopathy unspecified, I500 Congestive heart failure, I501 Left ventricular failure and I509 Heart failure unspecified between 1st March 2019 and 28th February 2021 were included. Admissions, bed days and inpatient deaths of patients admitted between 1st March 2020 and 28th February 2021 (during pandemic) was compared with patients admitted between 1st March 2019 and 29th February 2020 (prior to pandemic).