



Canadian Cancer Society
Société canadienne
du cancer



Canadian Cancer Society & CanCertainty Roundtable on Take-home Cancer Drugs

Hart House, University of Toronto

June 21st, 2016

Discussion Summary

Disclaimer: The contents of this summary do not necessarily reflect the opinions or policy positions of individual attendees or the organizations they represent.

Introduction

On June 21st, 2016, the Canadian Cancer Society – Ontario Division and CanCertainty, a coalition of 35 cancer patient groups, convened the “Roundtable on Take-Home Cancer Drugs”¹. This cross-sectoral meeting included representatives and perspectives from public and private payers, employers, patients, patient groups, pharmaceutical industry, pharmacists and oncologists – each of whom came together to address the current state of access to take-home cancer drugs in Ontario and to begin identifying collaborative opportunities to expand, increase and accelerate that access.

In its composition and purpose, the group also echoed a similar gathering that Cancer Care Ontario (CCO) hosted in May 2014. Entitled, “*Think Tank - Enhancing the Delivery of Take-Home Cancer Therapies in Ontario*,” that event helped inaugurate a loose collaboration dedicated to addressing patients’ needs and proposing tangible solutions for action. In the two years since the “Think Tank,” CCO and its partners – including the Ontario Public Drug Programs (OPDP) – have focused on addressing patient education and navigation, improving the safety of cancer drug prescribing and dispensing, streamlining the Exceptional Access Program (EAP) and exploring the challenge of drug funding sustainability through a Programmatic Review conducted by CCO and the Cancer Quality Council of Ontario.

Despite some important and tangible steps since 2014, one of the core issues identified at the “Think Tank” remains as acute today as it was then: the need to address the discrepancies in access between in-hospital cancer drugs and take-home cancer drugs in terms of the speed of the process, costs to the patient, and quality of care. Exploring how best to bridge this gap was the core question that anchored the Roundtable discussion.

¹ Financial support for the Roundtable was provided by the following companies: AstraZeneca, Eli Lilly, Gilead, Janseen, Merck and Novartis. The Canadian Cancer Society and CanCertainty thank these companies for their support.

Building on the “Think Tank”

The Roundtable referenced and relied on the outputs of the “*Think Tank - Enhancing the Delivery of Take-Home Cancer Therapies in Ontario*”² held in May 2014 – a policy planning and consultation session hosted by Cancer Care Ontario (CCO). The Think Tank’s objective was to explore, in an open and collaborative manner, how to enhance Ontario’s delivery model for take-home cancer medications by examining the following areas for change:

- Quality and safety
- Reimbursement and distribution
- Information management and information technology

Themes identified by Think Tank participants were:

- 1. Patients, providers and administrators want a more integrated system.** Cancer services, including the delivery of outpatient cancer medications, need to be coordinated and integrated across provider locations—whether in the community or hospital—to support seamless, person-centred care. Patients should not have to apply to multiple reimbursement programs to obtain drug coverage and providers should have access to all patient information.
- 2. Patients, providers and administrators want a more responsive system.** Suggestions were repeatedly made to simplify existing policies and procedures to support the efficient delivery of take-home cancer medications. Patients want timely access to services, such as receiving convenient care close to home and easily obtaining drug coverage.
- 3. Patients, providers and administrators want a system that is simpler and more comprehensive.** The delivery of take-home cancer medications should be equivalent in quality to the existing model for hospital-administered drugs.
- 4. Patients, providers and administrators want a single, person-centred system to oversee access and quality of care, regardless of the site of care delivery.** System oversight for take-home cancer medications should be consistent with the one in place for hospital-administered drugs. A single administrator should be tasked with monitoring the accessibility, safety and overall quality of outpatient cancer medication delivery and the cancer system’s performance (including evaluation of public spending and the value of take-home cancer medications).

² Cancer Care Ontario. Think Tank. Enhancing the delivery of take-home cancer therapies in Ontario. Proceedings Report. Toronto: Cancer Care Ontario, December 2014.

Actions since 2014

In December 2014, CCO launched the *Quality Person-Centred Systemic Treatment in Ontario: Provincial Plan 2014-2019*, which sets out a path to improve the safety, quality and accessibility of systemic treatment in Ontario. CCO has taken action in several areas since the Think Tank meeting. Highlights include:

- Improving the safety of take-home cancer drug prescribing
 - Developed pre-printed orders for all regimens containing take-home cancer drugs
 - Initiative to achieve zero handwritten orders for take-home cancer drugs

- Tools for patient education about take-home cancer drugs
 - Trained over 50 front-line providers in health literacy principles and the use of a standardized tool for oral chemotherapy patient education

- Enhancing the skills of community pharmacies to dispense take-home cancer drugs
 - Worked with the Ontario Pharmacists Association to develop an education program for pharmacists
 - Collaboration with the Leslie Dan Faculty of Pharmacy, University of Toronto, and the Canadian Association of Pharmacy in Oncology (CAPHO) to develop an oncology program for pharmacists in all practice settings
 - Checklist for verifying take-home chemotherapy prescriptions
 - Collaboration with the Canadian Association of Provincial Cancer Agencies to develop Safe Handling of Oral Chemotherapy guidelines for community pharmacies
 - Protocol for a toxicity management study in community pharmacies approved by the University of Toronto's Research Ethics Board

- CCO and OPDP are working together to advise the Ministry on enhancements to the Exceptional Access Program (EAP) for take-home cancer drugs
 - Exploring how the EAP application process can be streamlined and made simpler and faster for physicians and patients
 - Collecting information on how physicians currently interface with the EAP process on behalf of their patients
 - Surveying cancer care providers on process and system improvements

- The Cancer Quality Council of Ontario (CQCO) and CCO conducted a Programmatic Review to identify the critical success factors of a sustainable drug funding program
 - A sustainability action plan in development by CCO in partnership with OPDP and other provincial cancer agencies

Presentation Overviews

The Roundtable began with a series of five presentations that reflected the perspectives of patients, public payers, private insurers, oncologists, pharmacists, employers and other health system stakeholders.

1. A Patient Perspective

A cancer patient described her experience in accessing take-home cancer medications prescribed by her oncologist. Her story illustrated the challenges faced by many cancer patients in Ontario and set the stage for discussions about patient-centred care.

The patient's injectable medication was originally given to her in hospital, however, once she was comfortable administering the drug on her own she began taking it at home. At that time her case was adjudicated by the Exceptional Access Program (EAP) and she was granted coverage through the Ontario Drug Benefit Program.

While on the injectable drug, a potentially more effective drug was approved for marketing in Canada and her oncologist recommended that she switch to this drug. The new drug came with a \$5,000 per month price tag, which the patient was expected to pay upfront and be reimbursed later. She could not afford this amount and so worked with her local pharmacist who agreed to be paid directly by the insurance company.

Paperwork was sent to the patient by mail (original documents were required), then on to the pharmacy, back to the patient and to the insurance company, leading to a delay of two weeks. Only then did the pharmacy tell her that they couldn't get the medication in the dosage needed, so she was forced to find a pharmacy willing to stock the drug (the closest was located an hour's drive away) and to repeat the entire process with the second pharmacy.

The side effects of the new medication became unbearable so her oncologist requested that the previous drug be reinstated. This required two attempts to contact EAP for approval. The net result was that the patient was without any medication for four months.

The patient's oncologist now wants to change her treatment to something potentially more effective, but she is afraid to do it. The process has been a very time-consuming and labour-intensive ordeal that has been frustrating for all involved.

2. The Public Payer Perspective

Both CCO and OPDP shared their perspectives on the core programs – including the Trillium Drug Program (an income-tested program which covers Ontarians under age 65 who have high drug expenditures relative to their income), Ontario Drug Benefits (ODB) and the New Drug Funding Program (which pays for cancer drugs administered in hospitals). Together, under all 6 OPDP programs, almost 3 million Ontarians receive some degree of coverage from Ontario's public drug programs.

Key mandate commitments of the OPDP are aligned with the needs of patients and the health system:

- Continuing the pursuit of affordable drug access for patients in partnership with federal, provincial and territorial colleagues.
- Enabling a coordinated process for approving new and expensive drugs to minimize the wait for Ontarians who need lifesaving medications.
- Pursuing changes to deliver more efficient and coordinated care to patients.
- Accelerating the adoption of new health technologies and innovations that demonstrate value and contribute to a more productive and sustainable health care system.

Challenges of rapidly growing expenditures

The dramatic growth in investment by the Ministry in take-home and intravenous cancer drugs reflects impressive new medications and the government's willingness to invest because of their clear benefits. Yet, spending on drugs to treat cancer is far outstripping available funds. OPDP's budget is growing at 3% a year, greater than that of the overall health system budget that is less than 2%.

Growth in spending is driven both by the increasing number of cancer patients and the relatively high cost of treatment compared to other categories of drugs. The number of ODB recipients on cancer drugs is growing at more than 5% a year and the number of Trillium Drug Program recipients receiving cancer drugs has grown 15% over 5 years. Of its \$730 million cancer drug expenditure, OPDP spent \$375M in Fiscal Year 2015/16 on take-home cancer drugs, compared to \$269 million in 2013/14.

Other examples of cost drivers include an aging population: the number of seniors is projected to more than double over the next 25 years. As well, cost-shifting from the private sector is increasing, as insurers respond to rising expenses by reducing their plans' payouts (for example, capping the amounts paid), which drives patients to seek coverage from the Trillium Drug Program. Another cost driver is pharmacy fees, increases in which averaged 8.8% a year over the past three years.

Ontario's legacy drug programs do not meet the demands of these new realities. Programs have become so complex for providers and patients that clinical teams now require a specialized role in the form of hospital-based Oncology Drug Access Navigators. Navigation and appropriate prescribing are concerns the OPDP is working on.

System sustainability

Sustainability and value are central discussions in Ontario and around the world. While public payers are grateful for robust pipelines, they are challenged to incorporate these new therapies and make the system affordable. Greater expectations to fund all new drugs are not realistic given an aging and growing population. Also, more patients are now surviving cancer and many need continuing treatment. The reality is that enabling additional budgets for cancer drugs will require trade-offs of programs and services elsewhere within the health system budget; such an approach would require broader public input.

The issue is also one of fairness. Public payers need to protect the system for multiple generations. The current Minister of Health and Long-Term Care is looking at pharmacare in general and is open to doing things differently in Ontario. The Minister has made a commitment to the *Patients First* action plan and proposed legislation. Also, the Ministry has announced consultations later in 2016 for a 'Patients First Public Drug Plan'.

CCO has estimated the annual costs of full public coverage of take-home cancer drugs at an incremental \$250-300 million (excluding pharmacy fees and markups), an amount that is unrealistic for the public payer to absorb. Costs currently borne by private plans are estimated at nearly \$200 million, however the data, including out-of-pocket expenses by patients, are unavailable to develop a more accurate and reliable estimate.

3. A Private Insurer Perspective

Private payers include private insurers, employers and patients who pay out-of-pocket costs. Although private and public drug insurance have co-existed for decades, the role private payers in the oncology area was relatively small until the expansion of oral cancer medications approximately 10 years ago. Today, private insurers spend as much as public payers on prescription drugs.

Private payers need to be at the policy-making table. Solutions to creating a patient-centred system of take-home cancer drug access are not all the responsibility of the government; private payers have a significant interest in maintaining their share of coverage for take-home cancer drugs and are willing to work together with government to create something new and better to what we have in place today.

A lot of issues are common to both public and private payers:

- Oncology has the most robust pipeline and the largest costs, which is why it is a focus
- Patient experiences. Patients have all kinds of worries; drug access is an 'ordeal' for them. How can we take this off the table and put in place a navigation system to ensure patients can access all required drugs in a coordinated, timely and efficient way?
- Plan sustainability and patient affordability.

Unique aspects of private insurance include:

- The private sector is very diverse – 24 insurers, 120,000 plan sponsors, and over 20 million plan members – reflecting a lot of different needs, attitudes and perspectives
- Insurers and employers (i.e., plan sponsors) have different roles and perspectives. Insurers have a fiduciary responsibility to employers and must reflect their clients' interests, however employers' views are sometimes different from those of insurance companies
- Employers spend very little time thinking about health benefits, let alone drugs, except at renewal time when plan costs increase and adjustments in coverage need to be made
- Private health benefits are voluntary and can be changed or withdrawn at any time

- Small employers, which are the economic drivers of our country, are the most vulnerable and are approaching the limits of their ability to pay; 95% of employers have fewer than 50 employees and only half of these have a drug plan
- There is not much private payer research on which to base policy decisions (for example, it is unknown how much spending on take-home cancer drugs is private (either insured or out-of-pocket) versus public)

An integrated approach would address long-standing issues such as who is the first payer. It is consistent with the 2016-17 provincial budget that announced that by 2019, a “redesigned drug program would effectively coordinate with individuals’ private insurance benefits and increase equitable access to medications.” (p. 186). Private payers want to be part of shaping policy and to benefit from price negotiations by the public sector. We are all part of the same system – taxpayers, insurers, employers, patients – that creates opportunity for an integrated, multi-payer solution.

4. An Oncologist’s Perspective

The introduction of many new cancer drugs over the past few years has meant that patients are now living longer, especially when medications are given sequentially. However, the introduction of new cancer drugs that are taken at home rather than in hospital has also exposed gaps in the system of access.

In the past, when all cancer medications were administered in a hospital or cancer clinic, these problems did not exist because the drug was on formulary and the health system paid the costs directly. With the advent of take-home cancer drugs, a multi-silo problem was created. At the root of the issue is a lack of equity in the processes used to access take-home and hospital-administered cancer drugs, in terms of the speed of the process and cost to the patient. It is important that oncologists are able to access new therapies quickly for their patients and for governments not to impose barriers to proven approaches to treatment.

Speed of access is essential for cancer patients – it can be a life-or-death matter. Access to cancer drugs through the EAP and Trillium drug programs takes too long for the estimated 20% of cancer patients who need those medications immediately. Private insurance has a faster approval process and plays a very important role. Time-to-listing – the delay between the drug receiving its approval, or Notice of Compliance (NOC), from Health Canada and its listing on the drug program formulary, or list of approved drugs – is typically one year for public drug programs but it is much shorter for private plans. This is also an equity concern. Another related issue is the complexity of the EAP application process, which leads to delays and adds burden to an oncologists’ time. In addition, forms for patients to apply for coverage by the Trillium Drug Program are too complex and difficult to complete, even for well-informed people and with the help of a patient navigator.

Solutions to these problems must address the equity issue by making access to take-home cancer drugs as accessible as those administered in hospitals. The fact that the oncology clinical team now includes an Oncology Drug Access Navigator suggests that the system has become far too complex. Approaches must involve simplifying our multi-silo system. Other issues related to take-home cancer drugs include patient adherence to their prescribed treatment regimen, and the prevention and management of drug interactions.

The computerized physician order entry system (CPOE) OPIS (CCO's Oncology Patient Information System) works very effectively in hospitals for intravenous therapies and all other cancer drugs administered there. This system allows oncologists to enter information about the patient and their prescribed drugs and then links to CCO's eClaims service that adjudicates the request based on the patient's eligibility and whether the drug has been authorized for the specific indication, or use. Expanding the use of this system to include take-home cancer drugs would greatly simplify the process of requesting drugs that have been approved for inclusion on the drug program's formulary, and dramatically improve patient safety.

5. A Pharmacist's Perspective

Several aspects of oncologists' experiences also apply to pharmacists. Patients cannot start their cancer treatment due to process delays in public coverage (by both EAP and Trillium processes) or because of Special Authorization processes in private coverage. Pharmacists routinely ask whether the patient has private insurance and this drives whether or not the medication can be dispensed that day. The cost of a take-home cancer drug can be as high as \$15,000 a month, which is beyond the disposable income of almost all patients, and requiring that they pay this amount upfront is unreasonable. The best-case scenario is having private coverage, no deductible or co-pay, and on-line adjudication.

Pharmacists working in cancer centres could not function without Oncology Drug Access Navigators. Completing and sending forms back and forth is very time-consuming and the paperwork involved requires considerable effort for a patient already under stress.

The payer system is complex and there are a lot of vested interests, from manufacturers to insurers, distributors and hospitals. Pharmacists want to spend their time doing tasks that use their training, such as medication reconciliation, counseling patients, following up and toxicity management; they need to devote their time to being part of the care team.

Regarding the safety concerns of take-home cancer drugs, the Canadian Association of Oncology in Pharmacy (CAPHO) is involved in initiatives by CCO and the Canadian Association of Provincial Cancer Agencies (CAPCA) to address the safe handling of oral cancer drugs by community pharmacists. Further work is needed to ensure patient safety, monitoring and optimal follow up and care.

Issues and Obstacles

Reflecting on the day's presentations and drawing on their own experiences and expertise, the Roundtable attendees identified several key issues which need to be addressed in order to create a patient-centred system that supports faster and more efficient access to take-home cancer drugs.

Issue: Lack of Equity for Patients

There is a lack of equity between the systems of access to take-home cancer drugs and hospital-administered cancer drugs, in terms of the speed of the process, costs to the patient, and quality of care. There is no direct cost to the patient if the drug is administered in a hospital setting (i.e. intravenous) and is publicly funded. The patient can start the same day if needed, under the supervision of their oncology-specific care team. However, there is a cost if the drug is taken at home (i.e. oral or self-injectable). The funding approval process can take weeks, and the medication may be dispensed by a community pharmacy that has no experience dispensing cancer drugs and does not provide the patient with any counseling about how to take the drug. This inequity exists for arbitrary historical reasons that no longer apply. We need to put history aside; it has led to a broken model for cancer patients today.

Issue: Lack of Consistency in Process

Ontario already has an excellent foundation for intravenous cancer drugs managed through CCO – why not keep it and organize/coordinate programs, using other provincial models to inform changes? Some cancer centres are already using OPIS for prescribing take-home cancer drugs for internal record keeping. As a potential short-term measure, can they not simply fax that form for adjudication by EAP? Or move beyond fax machines entirely and shift to scanning documents and sending them via email while respecting appropriate confidentiality and privacy requirements? The current process creates inconsistencies, can cause delays, is time consuming and does not leverage newer technology tools.

Issue: Lack of Quality and Consistency of Care

A number of attendees argued that the current system all too often fails to put patients at its centre. Although some promising commitments and reforms are materializing – such as *The Patient First Act* – a number of the specific concerns expressed by participants regarding the present system merit closer examination:

a) *Complex and bureaucratic system*

- For oncologists: Adjudicating take-home cancer drugs through EAP includes complicated forms, and back-and-forth communications between the oncologist and the EAP office. Many requests are denied initially, only to be approved following subsequent submissions

- For patients: Registration forms for the Trillium Drug Program are too complex and difficult to complete, and are extremely difficult for patients for whom English is a second language. Multiple lines of communication by mail between the patient, private insurer, pharmacy and EAP leads to delays of weeks, and often months, during which the patient has no access to necessary cancer treatment
- From an employer perspective, some employees don't have computers. They may also lack health literacy or have little interest in understanding their benefits and the system
- The role of Oncology Drug Access Navigators has been established to work within this complex system, but not all cancer patients have access to a Drug Navigator

b) *Effect on patient stress and financial burden*

- The complex process of enrolling for the Trillium Drug Program creates problems for patients who are already shocked, stressed and scared from having received their cancer diagnosis
- Deductibles and co-pays create a financial burden on cancer patients who may need time away from work (either on reduced-income disability benefits or unpaid).
- The financial implications of a cancer diagnosis on patients are not just about the drug costs, but also include parking, travel, and ancillary costs. Research on the full financial burden of cancer across seven provinces is ongoing with results expected in two years
- Patients shouldn't have to fight the government when they're sick
- When industry gets calls for compassionate use of a drug, patients are terrified that their employer will know they have cancer when they learn that it's their employer's decision whether to fund their drug

c) *Negative impact on quality of care and health outcomes*

- Whether a patient has private drug coverage is one of the factors that can influence the choice of treatment, the format of treatment (intravenous or oral), and how quickly a drug can be dispensed
- Patients' experience of EAP/Trillium processes is that the combined, sometimes necessary sequential processes can lead to delays of months before the treatment can begin

d) *Impact on health care resources*

- The patient navigators and clinicians in attendance suggested that navigating drug access obstacles occupies more and more of their time – and that of their colleagues

Issue: Safety Concerns with Dispensing Take-Home Cancer Drugs

Safe, high quality dispensing of take-home cancer medications includes toxicity management, patient education about safe handling of the medication, counseling about adherence to the treatment regimen, and management/monitoring of drug interactions.

A review of ODB records showed that 87.5% of claims for cancer drugs were filled at community pharmacies. Roundtable participants expressed many concerns about the safety of dispensing take-home cancer drugs by community pharmacies. It takes a critical volume for the pharmacy to be competent about cancer drugs, and when that experience is lacking, inadequate care can occur.³ This may include dispensing errors, inaccurate advice, and insufficient provision of information or follow up. Significant errors at the community pharmacy level were described by a number of attendees, including the wrong dose given and the wrong drug given. One specific example shared was that of a patient who mistakenly took all of their cancer medication at once due to miscommunication with their community pharmacist.

Training and expertise are issues: pharmacies need to employ a sufficient number of staff who are knowledgeable about all cancer drugs and have a system in place to get updated information. Patient education on safety issues surrounding these toxic chemotherapy agents must include practical precautions, such as double-gloving and disposal.

Issue: Rising out-of-pocket costs

Not all cancer patients have insurance coverage for take-home cancer drugs. Fewer still have complete coverage (100%). Many patients with private insurance or Trillium coverage cannot afford co-pays or deductibles of \$2,000 and more.

Although the extent of the problem of out-of-pocket expenses is unknown, health care practitioners attending the meeting noted that the issue is both all-too common and very important, especially since high out-of-pocket expenses can impact patient adherence to treatment regimens. Beyond the impact on health outcomes, rising out-of-pocket costs are believed to result in economic consequences of importance to patients, employers and governments, such as disability, productivity, absenteeism and presenteeism.

³ As CCO and the Canadian Association of Provincial Cancer Agencies (CAPCA) note: "Clinical verification of OACD [Oral Anti Cancer Drugs] in community pharmacy settings is challenged by factors including the lack of access to patient medical records and/or to the healthcare team, lack of expertise and training related to cancer treatment, and low dispensing volumes. As such, where possible, it is recommended that OACD prescriptions be reviewed by a pharmacist with experience and training in cancer treatment." SOURCE: *Recommendations for the Safe Handling of Oral Anti-Cancer Drugs in Community Pharmacy: A Pan Canadian Consensus Guideline* (Draft Version, July 2016), Canadian Association of Provincial Cancer Agencies & Cancer Care Ontario, p. 6.

Issue: Lack of Integration with Private Insurance

Private insurers are responding to employer concerns about rising drug costs by changing their plans (for example, capping amounts paid or removing expensive categories of drugs), which shifts more costs on to governments. With high cost drugs – including oncology medications – a public policy approach is needed that includes private insurance and projects how the private sector will react.

Specific issues raised by private insurers were:

- Instances where coordinating with the Trillium Drug Program has been less effective than they would like
- Manufacturers have stepped in to cover the gaps in public and private insurance coverage through compassionate use programs but often these are variable, geared-to-income programs that require patients to disclose income tax information to a third party

Issue: Employer Challenges

Employer issues include:

- A lack of understanding of how the system works – including who pays for what drugs, and when. Employers have varying levels of in-house expertise and working knowledge of the medical system broadly, and how cancer is diagnosed and treated more specifically.
- Depending on the benefit plan selected – and the nature of the relationship with their insurer – different employers may have very different perspectives on managing costs.
- HR practitioners operating within smaller organizations are likely to be responsible for a more diversified portfolio of programs beyond health insurance. In these instances, it can be difficult to find an adequate amount of time to fully understand the impact of take-home cancer drugs on employer costs.

Issue: Rising Costs, Affordability and Sustainability

Growth in the costs of cancer drugs and other specialized medications is far outstripping the rate of budget increases. Increasing the cancer drug budgets is not an option for public payers and opportunity costs mean that funding one drug is, *de facto*, a decision to not fund another. The public (not just patients) needs to provide input into how we invest our resources within the health care budget. While the effectiveness of new cancer drugs is improving, rising absolute and relative costs are concerning to payers and patients.

Opportunities and Solutions

Attendees agreed that the current inequity in access that exists between take-home and in-hospital cancer drugs must be addressed – and that creating a more patient-centred system is essential. Many of the principles proposed at the Roundtable echoed those that emerged from the 2014 “Think Tank” – the system should be integrated, responsive, simple, comprehensive, and benefit from a single administrator. Attendees added four additional complementary principles, to this foundational list:

- **Sustainable.** Focusing on the best quality of care for the patient, not just on funding of cancer drugs
- **Timely.** Providing the patient with the best quality treatment in the best setting in a timely matter
- **Supportive.** Moving all processes for reimbursement away from the patient to administrators/navigators
- **Integrated.** Accepting and acknowledging that issues and solutions are multifaceted – and that private insurers and public payers each have a role to play in filling current coverage gaps

Attendees also spoke at length about what such a “patient-centred” system actually looks like, with a number of themes mentioned by multiple discussants:

- The patient is in the center and the complexities of background processes are made invisible to the patient at the cancer centre
- The patient receives the drug and is educated about the drug in a timely and appropriate fashion. The patient leaves the cancer centre with the cancer medication and safety information in hand
- Dispensing of the first prescription is handled by an oncology-trained pharmacist at the cancer centre who can provide patient counseling, education, and organize appropriate monitoring for toxicities and follow-up questions
- Payment for the drug, from all payers, is organized in the background, without involvement of the patient
- For the oncologist, an on-line computerized physician order entry (CPOE) system, such as OPIS, links the drug request to automatic claims adjudication (based on pre-programmed authorization criteria such as are already in place for intravenous drugs)
- For the navigator, reimbursement is coordinated from both public and private insurers and manufacturers (including compassionate drug programs)
- Patients prescribed oncology medications outside of the cancer centre (e.g., urology patients) access their medication from an oncology-trained pharmacist

Guided by this set of potential principles and focused on creating the more integrated, better-coordinated and higher-impact system outlined above, the attendees turned their attention to potential opportunities for meaningful system change:

Potential Solution: Pharmacy Reform

Participants discussed the need for pharmacy reform in Ontario that would potentially limit dispensing of take-home cancer drugs to oncology-trained pharmacists only. A number of attendees expressed their support for this policy shift, given the work underway by CCO, business considerations, literature citing patient safety concerns, and community pharmacists' discomfort with dispensing cancer medications.

Participants discussed three models for dispensing take-home cancer drugs:

1. Community Pharmacies

Community pharmacies offer the benefit of convenience to patients. Filling a prescription at a pharmacy close to home supports existing patient/pharmacist relationships and is often more practical for the patient, especially when they are unwell and/or live at a distance from the cancer centre. The downside of this approach are safety concerns inherent in having community pharmacists prescribe toxic drugs that require in-depth knowledge, experience in handling, willingness to stock, and a commitment to provide initial patient education and follow-up.

2. Specialty Pharmacies

Specialty pharmacies are another option increasingly used by private insurers and manufacturers, and some attendees noted that private insurer surveys suggest most patients have had a broadly positive experience with specialty pharmacies, where available.

3. Cancer Centre Pharmacies

A third option is to dispense all cancer drugs through the cancer centre. Hospital-based pharmacies have access to the care team and medical records; communications are easier for problem solving within the centre but can be difficult with outside pharmacies. Hospital pharmacists benefit from access to "local" records, discuss the patient with the team, monitor drug interactions and are alert to changes in patients. Counseling on the use of take-home cancer drugs is routine. Given these advantages – and excluding the cost component of in-hospital human resources – it's not surprising that a survey by a cancer patient organization found that the vast majority of patients prefer to fill their first prescription at the cancer centre.⁴

An audit of pre-chemotherapy medications showed there was also a retention issue: patients forget to go to their pharmacy to fill the prescription even when they had seen their oncologist the day before. One cancer centre has decided to open a retail pharmacy in its building and encourages patients to get their first prescription filled there.

⁴ Strategic Directions Survey on behalf of CanCertainty Coalition of 1,420 people from Ontario, Nova Scotia, Newfoundland, New Brunswick and PEI conducted between February 4th and 11th, 2016. Results are considered to be accurate within +3.0%, 19 times out of 20.

Concerns were expressed, however, that a cancer centre-only dispensing model is oversimplified. Patients go to their local pharmacies for other medications and there is a high probability that drug interactions will go undetected because there is no communication between their local pharmacy and cancer centre pharmacy.

Hybrid pharmacy model recommended

A number of attendees favoured a hybrid dispensing model, including cancer centres and a network of oncology-trained pharmacists. Patient group participants agreed that no cancer patient should have their cancer medication dispensed by someone who has not received specific training in oncology. Other provinces and private insurers who have used hybrid models have had generally positive results. As with all models, they are imperfect but offer learnings.

The advantages of a hybrid model include:

- Allows for same-day dispensing of first dose (at cancer centre)
- Offers patients the choice of where they would like their subsequent cancer medications dispensed
- Improves quality of care for patients in rural communities
- Community pharmacists can choose whether or not to opt in
- Safety and quality concerns with community pharmacies are mitigated by mandatory training, service standards and performance audits
- Formal connections with the cancer centre will improve quality of care through sharing patient records, ongoing communications with care team, and access to updated drug information
- Potential cost savings by negotiating reduced dispensing fees and markups
- Builds on work already underway by CCO and OPDP

Building a pharmacy reform solution needs to involve all players, including public and private payers, cancer centres, community pharmacies, and patients.

Potential Solution: Funding Reform

There was a strong sentiment among many attendees that they see the value, necessity and utility of a hybrid system of funding cancer drugs that combines the legitimate roles of both payer groups. The next step is to work on coordinating and organizing it.

Several models of systems of finance exist in Canada and internationally. Germany, the Netherlands and Québec have social insurance models which have ground rules that make costs predictable to the patient and the insurer. For example, in Québec everyone must have either private or public insurance and private insurers must offer at least the same level of coverage as the public plan. Participants noted that there are issues with these examples and all parties (public and private insurers, patients) need to be engaged if one of these models is entertained for Ontario.

The costs of adopting a model which places all costs for take-home cancer drugs on the public payer were discussed. Public payers estimated the incremental costs to government of a single-payer option

to be \$250-300 million. However, opinions were divided on the level of incremental cost and the potential benefits, especially when offsets and savings to the health care system for health problems avoided are factored in. The incremental costs to each sector of a hybrid public/private system have not yet been calculated.

Clarity is needed around who are the first and second payers and the role of pharmaceutical companies in bridging coverage, providing co-pay assistance, and providing medications on an affordable and compassionate basis.

Potential Solution: Risk Management

Considerations include managing the risk is that employers will cut back their drug coverage plans if a public plan is available. The “all or nothing” approach considered by New Brunswick was suggested as being worth further review: private insurers would have to offer drug coverage if they provide any health benefits at all (for example, if they offer vision coverage they must also offer drug coverage, which must at minimum match the provincial formulary and criteria).

Potential Solution: Reducing Waste and Inefficiencies

Cost savings or avoidance could result from eliminating unnecessary costs and duplication of efforts. Higher quality of care may also result in savings by avoiding costs of downstream complications.

Suggestions from participants include:

- EAP Reform
 - Streamlining the EAP adjudication process to reduce the need to rely on oncologists throughout every stage of consultation – and in so doing reduce some of the attendant costs
- Physician reform
 - Explore whether Ministry auditing of oncologist prescribing could uncover the minority of physicians with room to improve their practices. This might save costly and potentially dangerous delays that result when all oncologists have to meet administrative rules that are necessary for only a few
- Pharmacy reform
 - Better training for community pharmacists to help avoid or reduce the downstream costs caused by adverse drug interactions
 - Eliminating or reducing dispensing fees and markups where service is not provided by a community pharmacy; leverage negotiating power by combining public and private payers’ drug purchase volumes
 - Using preferred provider networks to dispense take-home cancer drugs

- Care team re-alignment
 - Streamlining and automating the drug access system would allow time currently spent by drug navigators, oncologists, hospital pharmacists and nurses to be freed up to spend on higher value tasks.

Next Steps

The Roundtable closed with a wide-ranging discussion on potential next steps that would allow attendees to harness the momentum of the day and identify opportunities for additional collaboration. The following specific ideas were among the opportunities for collaboration that emerged from the day's discussion:

1. Developing a more coordinated and equitable funding model to more clearly describe how the system *should* work
2. Convene public payer and private insurer representatives to explore opportunities to better coordinate benefits between CCO, OPDP and private insurers – perhaps including (but not limited to) (i) approval criteria for take-home cancer drugs; (ii) a common drug request form; and (iii) building in patient consent for background navigation/data sharing/coordination of benefits
3. Accurately describing – and measuring – the scope of the issues impacting and undermining the present system
4. More information is needed on the OPDP/CCO information technology solution presently in development – also required is an exploration of potential to scale or expand the role of OPIS
5. Explore the feasibility of hematology/oncology pilot program for EAP requests using the CCO system for IV drugs.
6. Leveraging the upcoming Health Accord to increase awareness, engagement and potentially funding required to close the access gap

There was widespread agreement among the attendees that solving the inequity impacting cancer drug access in Ontario would require the efforts and engagement of every voice in the room – and many more. The Canadian Cancer Society and CanCertainty are committed to building on the momentum of the discussion and to working closely with the participants and a broad range of stakeholders to effect the change so clearly required.

Appendix 1 List of Attendees

Name	Title	Company/Organization
Robert Bick	Co-Founder	CanCertainty Coalition
Alan Birch	Drug Navigator	Oncology Drug Access Navigators of Ontario
Julie Blouin	Senior Clinical Pharmacy Consultant, Pharmaceutical Benefits	Sun Life Financial
Chris Bonnett	Principal Consultant	H3 Consulting
Alayna Brown	Program Specialist, Provincial Drug Reimbursement Programs	Cancer Care Ontario
Flay Charbonneau	Sponsor Representative	Canadian Association of Pharmacy in Oncology
Vivian Choy	Pharmacy Manager	Princess Margaret Hospital Outpatient Pharmacy
Sal Cimino	Director, Pharmacy Services	Green Shield
Sharon Dennis	Patient Representative	Canadian Cancer Society, Ontario Division
Joanne Di Nardo	Senior Manager, Public Issues	Canadian Cancer Society, Ontario Division
Elaine Fok	Manager, Total Rewards	Superior Propane
Stephen Frank	Vice President, Policy Development & Health	Canadian Life and Health Insurance Association
Steve Gallant	Managing Partner	Accucam Machining
Daniela Gallo-Hershberg	Assistant Professor	Leslie Dan Faculty of Pharmacy, University of Toronto
Scott Gavura	Director, Provincial Drug Reimbursement Programs	Cancer Care Ontario
Rob Godin	Director, Oncology Market Access	Astra Zeneca
Kelly Gorman	Senior Manager, Public Issues	Canadian Cancer Society, Ontario Division
Karina Lee	Manager, Drug Submissions Group	Ministry of Health and Long-Term Care
Christopher Longo	Co-Lead, Health Technology Assessment Research Program	Canadian Centre for Applied Research in Cancer Control
Dr. Janet MacEachern	Medical Oncologist	Grand River Regional Cancer Centre
Kim MacFarlane	Director Product Development, Group Benefits Product	Manulife Financial
Deborah Maskens	Co-Founder	CanCertainty Coalition

Suzanne McGurn	Assistant Deputy Minister & Executive Officer, Ontario Drug Benefit Program	Ministry of Health and Long-Term Care
Gabriel Miller	Director, Public Issues	Canadian Cancer Society
Rohini Naipaul	Senior Pharmacist, Provincial Drug Reimbursement Programs	Cancer Care Ontario
Stephen Petersen	Lead, Special Projects, Evidence Development & Standards	Health Quality Ontario
Ruth Pritchard	Health Policy & Reimbursement	Novartis
Angela Rocchi	Principal	Athena Research
Dr. Sandeep Sehdev	Medical Oncologist	William Osler Health Centre
Yvonne Ta	Drug Navigator	Oncology Drug Access Navigators of Ontario
Sara Trotta	Senior Coordinator, Public Issues	Canadian Cancer Society, Ontario Division
Susan Turner	President	Turner & Associates
Kathy Vu	Clinical Lead, Safety Initiatives, Systemic Treatment	Cancer Care Ontario
Ross Wallace	Principal	Santis Health
Margaret Wong	Operations Manager, Exceptional Access Program, Ontario Drug Benefits Program	Ministry of Health and Long-Term Care