

Developed in collaboration between



Equitable Impact of Clinical Pharmacists on Oncology Patient Care

Practice interviews and survey results to understand how pharmacists at select medically integrated dispensing (MID) pharmacies help deliver equitable oncology patient care

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Key Findings

Key findings from the surveys and practice interviews are included below:

- Established collaborative drug therapy agreements where possible
- Maximized functionality and utility of clinical workflows to serve individual patient needs
- Ensured that pharmacists clinically check oral cancer treatment choices
- Created open lines of communication between patient/pharmacist and pharmacist/care team

Introduction

Age is the strongest determinant of cancer risk with nearly 60% of new cancer diagnoses being in adults aged 65 years and older in 2019-2020.¹ Among those aged 70 and older, the likelihood of developing cancer stands at one in three for men and one in four for women over their lifetime.² With the population increasingly aging, the healthcare team must be equipped to care for older adult (defined as 65 years of age or older for this project) patients. This population is uniquely susceptible to challenges like multiple comorbidities, polypharmacy, social support challenges and even cognitive issues, all of which can impact treatment decisions.³ Some organizations have created and published formal geriatric assessments to help guide care, but the reality is that these validated tools are only being used consistently by a small (21%) proportion of oncologists, despite the fact that they have been shown to reduce treatment toxicity.⁴ Because the use of geriatric assessments is limited, it is vital to understand how guideline concordant care is appropriately prioritized for older adult patients.

While oncology care for older adults has been in the spotlight since 2007, the role of clinical pharmacists in this space has been largely overlooked. NCODA believes oncology clinical pharmacists play a crucial role in providing quality focused and guideline concordant care to cancer patients of all ages. With this project, NCODA hoped to gauge the oncology practice trends for the management of older adults across Medically Integrated Pharmacies within NCODA's membership and highlight the role clinical pharmacists play in providing equitable oncology care to their patients.

Survey Overview

BACKGROUND

The National Community Oncology Dispensing Association (NCODA), in collaboration with Pfizer Oncology, conducted an online survey of its members (68 respondents) in June 2023 to better understand disparities in oncology care for older adults. The objectives of the survey were to:

- Explore the variability in treatment decisions and adherence to guideline concordant care across oncology practices related to older adult patients
- Understand the impact a clinical pharmacist can have on equitable care in a cancer center
- Use the information to develop a resource for MID pharmacies to learn more about older adults in oncology care and examples of support and decision-making processes across the country

RESULTS

One discovery from this survey was that most practice sites with medically integrated dispensing pharmacies do not have a unique set of processes for treating older adult patients. Additionally, consistent with the literature, most sites are not performing formal geriatric assessments.⁴ To gain a better understanding of this data and how it impacts cancer care, interviews were conducted with three practice sites.

Each practice site has a unique approach to care for all patients, regardless of age. It is widely recognized that some patients are going to need more assistance than others on their cancer care journey; below will highlight how personalized care is being delivered at each respective practice site. Patient age, by itself, turns out to be an unexpectedly small driver of support decisions.

Practice Interviews

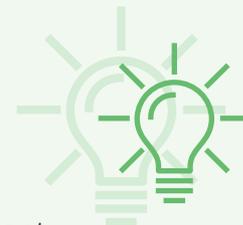
PRACTICE OVERVIEW #1

About Practice #1

- NCI-designated comprehensive cancer clinics
- Specialized providers
- Four pharmacists dedicated to oral cancer treatment management within one of their clinics
- Urban, diverse population

LEARNINGS

- Pharmacist follows patient from start of therapy to completion
- Treatment plans optimize care and give pharmacists the opportunity to customize patient needs that are identified prior to starting therapy
- Pharmacist check points alternate with provider appointments, so patients are in touch at least twice per treatment cycle
- Frequent monitoring and specialized pharmacist allow for guideline concordant treatment



PRACTICE DETAILS

Practice #1 is a multi-site, National Cancer Institute designated comprehensive cancer center, and the first practice interviewed during this project. The patient population at this cancer center is mostly urban, diverse, and many patients are “snowbirds” with a wide age demographic ranging from those in their 20’s and 30’s to those in their upper 80’s and early 90’s. Practice #1 does not see Medicaid patients, but they do see many Medicare patients who possess unique financial challenges as they enter the retirement age. This cancer center is also unique in that they have a lot of communication between other clinics outside the system via telehealth for those that are snowbirds and have other oncologists around the country. In an ideal state, four pharmacists comprise the oral cancer treatment pharmacist team at practice #1. These four pharmacists split responsibilities across the following therapeutic areas:

- Breast and gynecologic clinics
- Genitourinary clinic
- Gastrointestinal clinic and
- All other solid tumors

WORKFLOW & TREATMENT DECISION INVOLVEMENT

Practice #1 does not have a unique process for how to care for older adult patients, nor do they perform formal geriatric assessments. Rather, the oncologist uses performance status assessments to direct care and relies heavily on help from the oral cancer treatment pharmacy team. Each respective pharmacist then walks step by step with the patients from the start of therapy to the end.

To help make this happen, the pharmacist spends their days sitting in clinic near providers, nurses, and other members of the care team to answer all drug-related questions that come their way. Some of their other responsibilities include building and modifying treatment plans, assisting in treatment decisions alongside the oncologists, writing appeals for denied medication, and assisting with obtaining financial assistance for their patients.

One measure practice #1 has added to elevate patient care is through a tool within their clinical workflow called “treatment plans.” Each cancer treatment drug, oral or intravenous, has its very own treatment plan built within the workflow. The first layer of this treatment plan is called “pretreatment tasks.” This is where the pharmacist can assess drug interactions, review the patient’s past medical history, make sure the correct dose of medication is chosen, and more. This is also where orders for any baseline labs are built in, so when the provider signs the orders for the medication, pretreatment orders are automatically released. This way, the pharmacist can follow up to be sure the correct dose is being chosen for the patient based on their clinical characteristics.

- PATIENT ONBOARDING:** Once baseline labs are obtained and a therapy is prescribed, the pharmacist moves on to the next important step of the “pretreatment tasks.” Here they spend time educating the patient on their new therapy and any supportive care that might be prescribed. It is during this initial conversation that they learn so much about each unique patient. **Does the patient have a caregiver they want included in conversations? Do they drive a long way to the clinic and prefer to get labs drawn closer to home?** The pharmacist can gather this information and create unique follow-up tasks specific to each patient’s needs. Another important component of the pharmacist’s initial education session is educating them on how to obtain the medication. They let them know that they don’t have to call around to different pharmacies or their insurance company, as they do that communication on their behalf. Unless there is a need to transfer out a prescription, the majority of patients fill at a specialty pharmacy and the drug is shipped directly to their home. Based on what the pharmacist gathers from initial education with the patient, the pharmacist communicates pertinent information directly to the care team and updates the treatment plan as appropriate. After the education is complete, the pharmacist sends a message to the patient or caregiver. Here the patient, or an approved caregiver, has access to their record, labs, appointments, results, notes, and more. This is also where the pharmacist instructs patients to send them a message when they have started therapy. When they communicate their “Cycle 1 Day 1,” the pharmacist can start their process for ongoing care.
- ONGOING THERAPY MANAGEMENT:** After a patient initiates therapy, the pharmacist checks in two weeks after the Cycle 1 Day 1 for a “Midpoint Evaluation.” Prior to this call, they review mid-cycle lab results to make sure continuing therapy at the same dose is appropriate. During the evaluation, they ask how the patient is tolerating the medication and if they’re having any side effects or concerns. The pharmacist assesses adherence and ensures patients are taking the medication properly. If necessary, they communicate any concerns that arose during this midpoint evaluation to the provider. If everything is status quo, the patient can call and obtain their refill from the specialty pharmacy, and then they come back to have an in-person visit with their provider on Cycle 2 Day 1.

FIGURE: TREATMENT PLANS IN PRACTICE AT PRACTICE #1



- **USING TECHNOLOGY:** Use of the portal system is quite helpful during ongoing care. If patients have family members who would like to stay in the loop with the plans for therapy, they can be added as approved members of the patient's portal system. If a patient has a non-urgent question, that can be sent through the portal. Additionally, patients can use the portal system to send pictures to their pharmacist if they have questions where sending a photo might be helpful.
- **STAGGERED SCHEDULING:** Having the pharmacist's midpoint check offset by clinic visits gives patients at minimum two checkpoints each month. The pharmacist expressed how helpful this schedule is to keep patients on appropriate therapy while also giving them support if concerns arise. Certainly, if a patient needs more frequent checkpoints, the pharmacist can manually add those into a patient's treatment plan. This care is truly personalized.

GUIDELINE CONCORDANT CARE

Because the pharmacist is fully immersed in the breast clinic, they are very familiar with the NCCN guidelines and is up to date on recent literature, too. The pharmacist was quick to point out that they recognize this is a luxury that not all practices have. However, specialization and deep knowledge of treatment guidelines is one reason they can practice at the top of their license. If a provider seeks to prescribe outside the guidelines, the pharmacist can jump in and have face-to-face conversations with the providers to understand their rationale and provide professional recommendations. This multidisciplinary approach allows oncologists at practice #1 to provide guideline concordant care to all appropriate patients because they receive such close monitoring and have open lines of communication with a board-certified pharmacist.

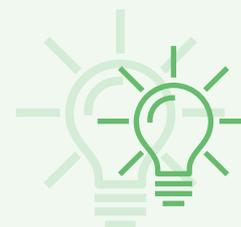
PRACTICE OVERVIEW #2

About Practice #2

- Community care model with generalized providers
- Two pharmacists dedicated to oral cancer therapies
- Mixed rural and urban population

LEARNINGS

- Two pharmacists handling oral cancer treatment: one in the clinic, one at the specialty pharmacy
- Multidisciplinary clinic with generalized providers means the oral cancer treatment pharmacist in clinic is assisting with a wide variety of patients and a wide variety of oral treatments
- The pharmacists rely heavily on the patient treatment dashboard to keep their workflow organized
- Collaborative practice agreements (CPAs)* allow the oral cancer treatment pharmacist to provide guideline-recommended treatment for side effects



*This is just an example of one practice's use of a CPA/CDTA. Requirements for CPAs and CDTAs may vary by state.

PRACTICE DETAILS

A community teaching hospital with multiple facilities that does not currently perform formal geriatric assessments, similar to the majority of the practices surveyed. Pharmacists rotate roles monthly between the clinic and the specialty pharmacy.

WORKFLOW & TREATMENT DECISION INVOLVEMENT

Because the providers in the multidisciplinary clinic are not specialized and do not have disease specific clinics, the pharmacy staff at practice #2 must be intentional to stay involved in treatment discussions and decisions. They must stay in constant communication with each other and providers, with the goal of capturing all patients starting oral cancer treatment so that they can receive appropriate initial education and follow-up. The clinic pharmacists are *truly* the oral cancer treatment "go-to" for all provider, patient, and nurse questions.

Because the pharmacists manage such a wide variety of patients, they rely heavily on their clinical workflows and resources within clinic to serve patient's specific needs. When a patient is initiated on oral oncolytic therapy, they are enrolled in the oncology dashboard. This dashboard has specific components for clinical assessments, refill dates, PA follow up dates, etc., all of which can be personalized by the pharmacist. If a patient is identified during education that might need more support, the pharmacist speaks with the physician directly or electronically to address specific concerns. They can also route a patient's chart to other members of the healthcare team. For example, if a patient starts a medication that needs to be taken on an empty stomach or with a low-fat meal, the pharmacist will loop in nutrition to talk to the patient. If they learn during an education that a patient is unable to afford groceries, they can loop in social work.

Two weeks post start, patients are assessed for toxicity through a phone call. The pharmacist can update and personalize a patient's dashboard as needed here. If another check in is necessary to readdress adherence in the next few weeks, for example, they can manually add a follow up reminder to the patient's dashboard. If therapy is on hold for a toxicity, a dashboard reminder is added to check back and see if a patient can resume. Three months post-start, patients are assessed for efficacy. This includes a full reassessment (medication reconciliation, adherence check, side effect check, etc.) and a deep dive into the patient's chart to see if there is an updated objective measure of disease, like a new scan or repeat labs. The pharmacist always makes sure the provider has read the scans and communicated results to the patient before they complete the reassessment. If all systems go well, the patient can resume therapy and at that point receive yearly assessments. If they have any concerns and use clinical judgment to believe a patient is not suited for yearly check ins, they can again customize the dashboard to check in on that patient more frequently.

The pharmacists at practice #2 have also helped initiate collaborative practice agreements (CPA) that allow them to help individually care for patients experiencing side effects. The CPA they operate under allows them to prescribe guideline recommend prophylaxis and treatment for nausea and vomiting. The pharmacist expressed that patients are so grateful to have a touch point with a pharmacist when they are experiencing nausea and vomiting; this also takes a small load off providers who are managing busy clinic schedules.

FIGURE: ORAL CANCER TREATMENT DECISION WORKFLOW



GUIDELINE CONCORDANT CARE

It would be impossible for the pharmacist to be a part of every treatment decision conversation. When asked how they help ensure providers are prescribing within the guidelines, a few things were noted. Practice #2 utilizes pathways to help providers with treatment selection. The pharmacist is a part of a monthly meeting where pathway updates are reviewed, and an oncology resident provides education on new drug approvals. At these meetings, provider interest in new drug approvals is gauged, and the pharmacist helps identify how many patients might benefit from a new therapy. The pharmacist highlighted that they prioritize their own education to stay up to date too. One pharmacist receives a post from ASCO each evening that they review for new updates in oral anticancer treatment and prioritizes involvement in various pharmacy organizations like NCODA and HOPA.

PHARMACY TECHNICIANS

- Dedicated technician for all oncology refills, prior authorizations and follow up

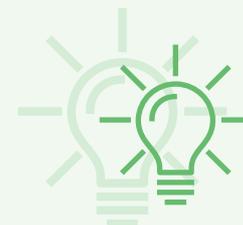
PRACTICE OVERVIEW #3

About Practice #3

- NCI-designated comprehensive cancer center
- Ten clinical practice sites
- Specialized providers with remote oral cancer treatment pharmacists
- Collaborative drug therapy agreement (CDTA)* within the multiple myeloma clinic

LEARNINGS

- Collaborative Drug Therapy Agreement (CDTA) in the multiple myeloma clinic allows oral cancer treatment pharmacists to take burden off physicians
- Tiered system creates follow-up that is customizable to patient-specific needs
- Largely remote operation with opportunity for in-person visits



*This is just an example of one practice's use of a CPA/CDTA. Requirements for CPAs and CDTAs may vary by state.

PRACTICE DETAILS

Practice #3 is an independent, non-profit organization. In the various solid tumor clinics, IV pharmacists sit in the workrooms and verify IV orders, answer drug information questions, and provide education to patients. On the contrary, oral cancer treatment pharmacists at practice #3 largely work remotely and provide unique support to their patients from afar.

WORKFLOW & TREATMENT DECISION INVOLVEMENT

Practice #3 does not have a formal process for screening older adult patients. Rather, they rely heavily on performance status screening, provider judgment, and nurse navigator support to tailor care to a patient's specific needs. In some instances, it is even appropriate to loop in palliative care early on. From a pharmacy perspective, the oral cancer treatment pharmacists at practice #3 utilize collaborative drug therapy agreements (CDTA) in the multiple myeloma (MM) clinic to uniquely manage patients. This clinic is comprised heavily of older adult patients, as the median age of diagnosis of MM is 69 years old.⁵

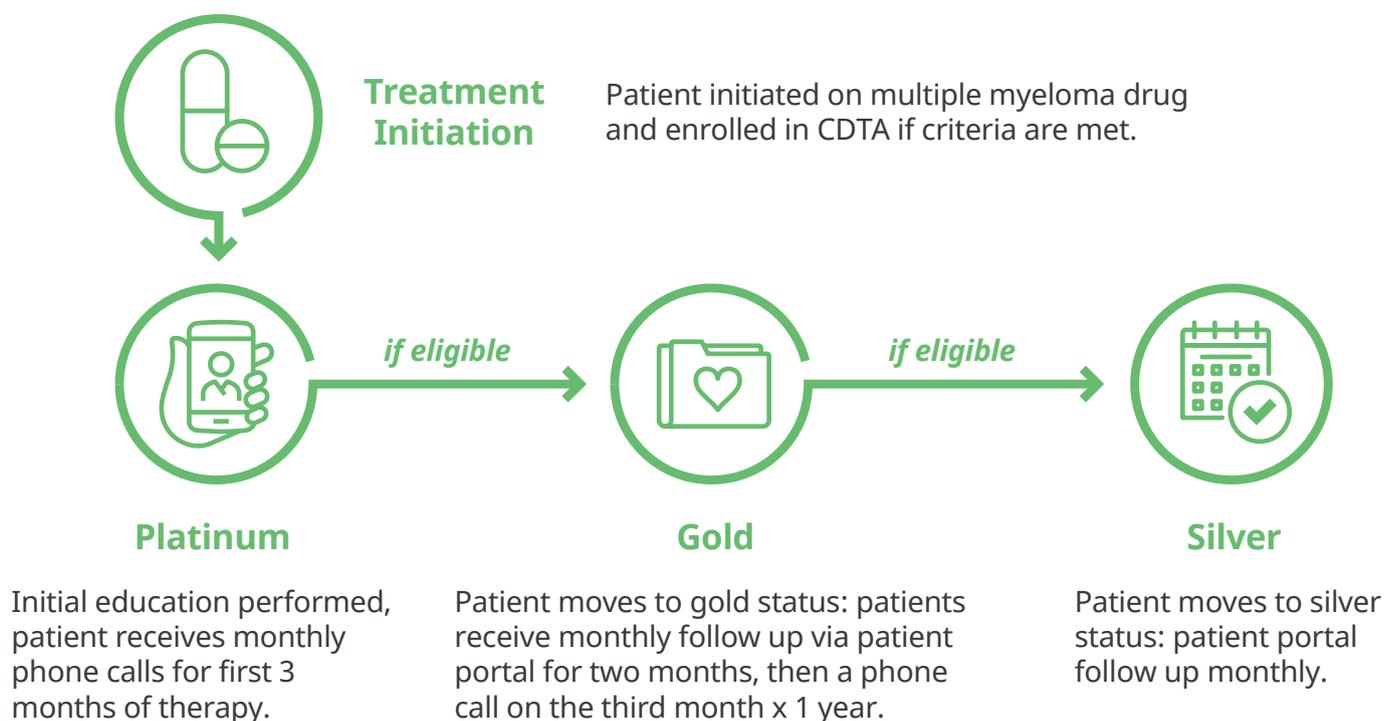
Under the CDTA, oral cancer treatment pharmacists have prescriptive authority authorized by physicians in the MM clinic. When a patient is initiated on one of the participating MM drugs, pharmacists enroll the patient in the CDTA and orient them to the service. Then, patients are stratified to different "tiers" of care: platinum, gold, or silver status. Every new patient in the program starts at platinum status, which means that after initial education and receipt of drug, they receive monthly calls from the pharmacist for the first 3 months of therapy. If after 3 months a patient is stable in terms of side effects, labs, and adherence, they are eligible to be dropped to gold status. In gold status, patients are contacted via their health portal for two months, then on the third month they are contacted via telephone. If a patient remains stable on gold status for a year, then they are eligible to be dropped to silver status, which means they are only contacted unless needs change.

This CDTA allows pharmacists to guide the patient's care based on their individual needs. Within the CDTA, there are specific instructions in place that allow the pharmacist to adjust doses or prescribe supportive care as needed. For example, if a patient is neutropenic or thrombocytopenic, pharmacists can adjust doses; if they're having diarrhea, they can prescribe an antidiarrheal. They explained, "pharmacists are really running the ship, but always looping in their providers."

This program has many benefits, but it also certainly has its limitations. It relies on someone who can speak English, and is willing to take part in the program. However, the pharmacists note that patients frequently express how grateful they are to have a pharmacist touchpoint for their questions, concerns, and overall coordination of care. Not every patient will progress through this program as outlined above; some will need close follow-up for the duration of their care. When a pharmacist has a conversation with a patient who is struggling with side effects, has unstable labs, needs frequent dose adjustments, or has adherence issues, the pharmacist can certainly increase their follow up or change a patient's status back to platinum. Targeted therapies have a max of 6 months of refills before a new prescription is required, and oral anticancer treatment drugs have a maximum of 3 months of refills before a new prescription is required. Though the oral cancer

treatment pharmacists mainly work remotely, they can schedule in-person visits with patients who need extra support. Typically, the pharmacist will try to align these with provider visits.

FIGURE: TIERS OF CARE UNDER CDTA*



GUIDELINE CONCORDANT CARE

When asked how providers are encouraged to prescribe within the guidelines, the pharmacist gave a couple examples. First, they noted their “second attending policy.” If a provider is trying to prescribe outside of guideline recommended treatment algorithms, they must present their treatment plan to a colleague. If that colleague agrees with their management of the patient, they may proceed. Second, they noted that there are caps on refills. This requires a patient to be reassessed frequently for appropriateness of therapy.

PHARMACY TECHNICIANS

- Run referrals for both IV and oral agents
- Run test claim for oral cancer prescription
- Complete prior authorization paperwork and patient assistance if necessary
- Pharmacy Technicians are spread out across the cancer centers and some work remotely as well

Conclusion

Oncology care for older adults is an area of focus for practices, and the practice interviews found that oncology pharmacists can play a vital role in ensuring patients of all ages receive guideline-concordant treatment. The practice interviews found that whether that pharmacist is sitting directly next to a provider in a specialized clinic, the “go-to” for questions in a multidisciplinary clinic, or managing patients remotely within a CDTA*, they can serve as an oral cancer treatment resource to all. Interviews suggested that if practices did not have the resources to fund a full-time clinical pharmacist specific to the oncology clinic, they could still consider leveraging dispensing pharmacists within the same system to help manage oral oncolytic treatments.

In concurrence with the NCODA membership survey, none of the practices interviewed consistently saw geriatric assessments utilized in their respective clinics. The hope is that these assessments are utilized more frequently moving forward, but for now the pharmacists are clinically checking drug therapy to ensure it is congruent with the guidelines and appropriate considering the patient’s individual needs regardless of age. One common theme throughout discussions regarding implementation of a formal geriatric assessment was the lack of resources available to incorporate that step into busy clinic workflows. To address this gap, the importance of utilizing and relying on the electronic workflows was consistently emphasized. Not only does the electronic workflow keep the patient care team on track, but it also often serves as an avenue of communication between patient and pharmacist. Clinical pharmacists can provide integral oversight to the oral oncolytic process to ensure optimal therapeutic outcomes.



Oncology pharmacists had an impact regardless of sub-specialization or location



Gaps existed in implementing geriatric assessments into electronic workflows



Access to the electronic workflows allowed for coordination of care throughout oral oncolytic treatment

RESOURCES THAT EXIST TO IMPROVE CARE FOR OLDER ADULTS:

- Updated 2023 ASCO Geriatric Oncology Guidelines
 - New guidelines published in JCO⁶
- Practical Geriatric Assessment Tool⁷
- ASCO/NCODA Quality Standards⁸

*This is just an example of the practice’s interviewed use of a CPA/CDTA. Requirements for CPAs and CDTAs may vary by state.

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SURVEY RESULTS



Background

Age is the strongest determinant of cancer risk with nearly 60% of new cancer diagnoses being in adults aged 65 years and older in 2019-2020.¹ With this in mind, NCODA, in collaboration with Pfizer Oncology, developed a survey that was shared with its member organizations to better understand standardization of medically integrated dispensing (MID) pharmacy processes and implications for older adults.*

68 respondents who **have medically integrated dispensing pharmacies for oral oncolytics** unless otherwise noted.

Respondents were geographically diverse (rural, suburban, urban, etc.) and included a **mix of pharmacies with and without accreditation.**

>85% of respondents were **pharmacists or pharmacy technicians.**

Pharmacy models varied across respondents with primary models including general **dispensing oncology staff, sub specialized clinical oncology staff and a hybrid rotation between clinical and dispensing staff.** There were also differences in if respondents had **support systems specific to older adults** and if so, what those consisted of. Differences in responses and approaches to support are highlighted in this infographic.

*For this survey, an older adult patient is defined as anyone 65 years of age or older.

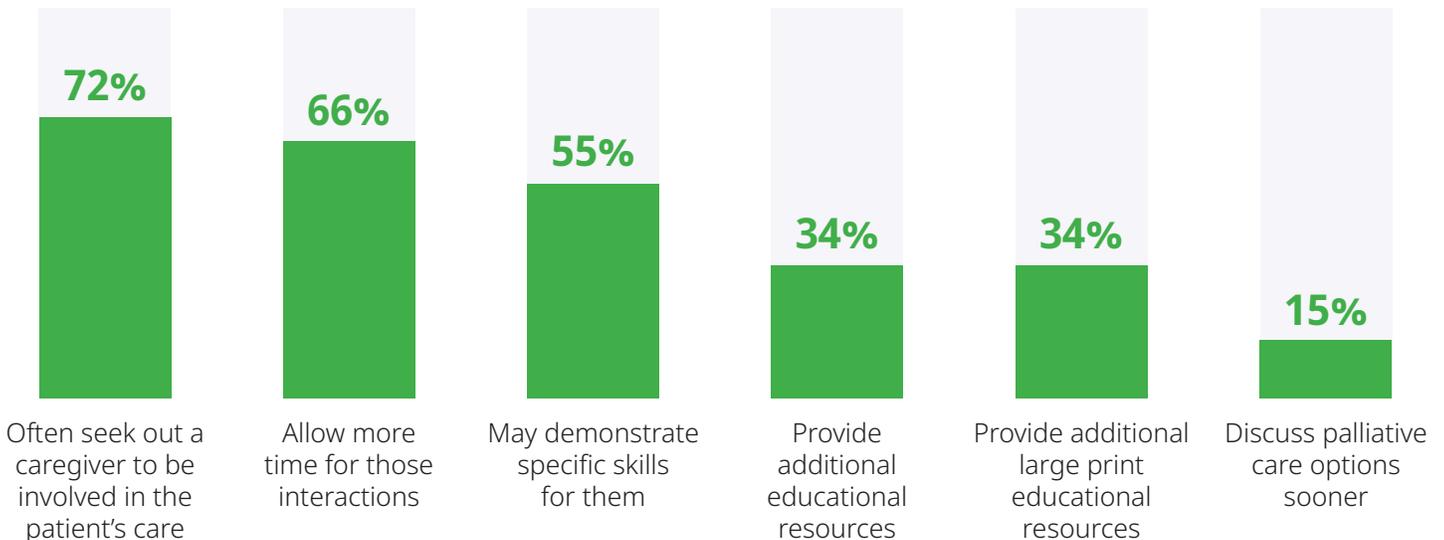
Interaction and decision making for older adults

69% of respondents identified **the way they interact with older adult patients differs** from how they interact with other patients

78% of respondents identified **the older age of patients can impact clinical decisions** regarding treatment options

How interactions differ with older adult patients[†]

(n=47)



[†]Results are based on the 69% of respondents who indicated interactions with older adults differed from other patients.

Therapy Management

(n=47)

32%  of respondents have a unique process for **ongoing therapy management** for older adult patients

Assessments

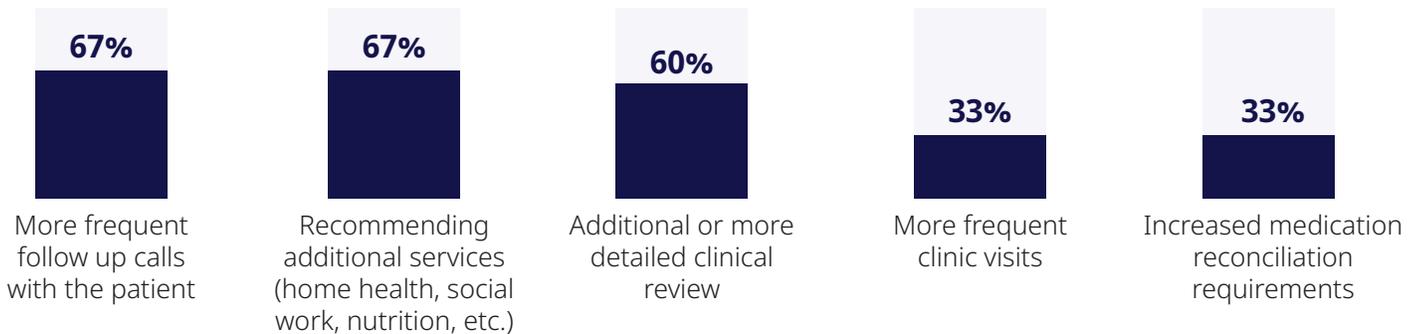
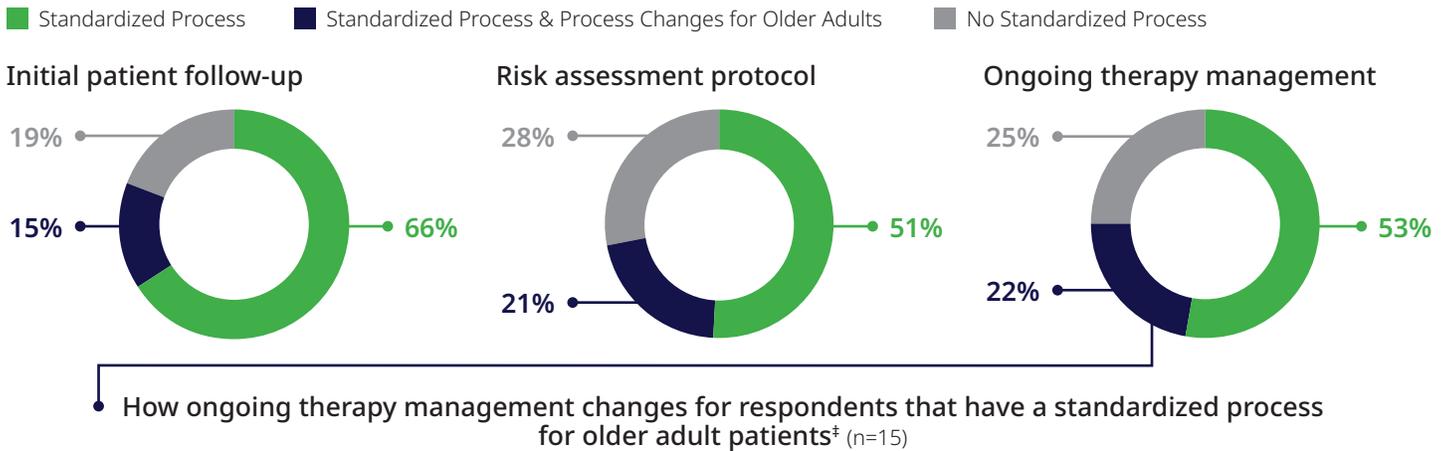
34%  of respondents have **formal assessments** for older adults as part of their standard practice

Training

31%  of respondents require (15%) or offer optional (16%) **specialized training** for older adults

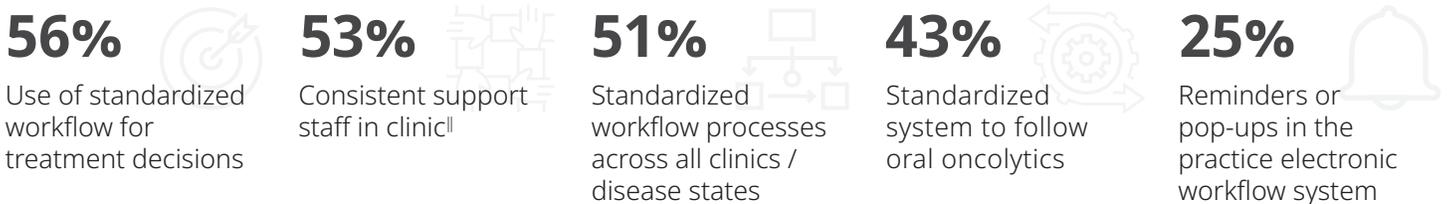
Standardized pharmacy processes

Most respondents did not have standardized processes for older adults, rather patients tended to be identified and supported by standardized processes that were in place for all patients. As a result, this may help address the individual support and need for older adults.



[‡]These results are only for respondents who answered “yes” to the previous question on differences for older adults.

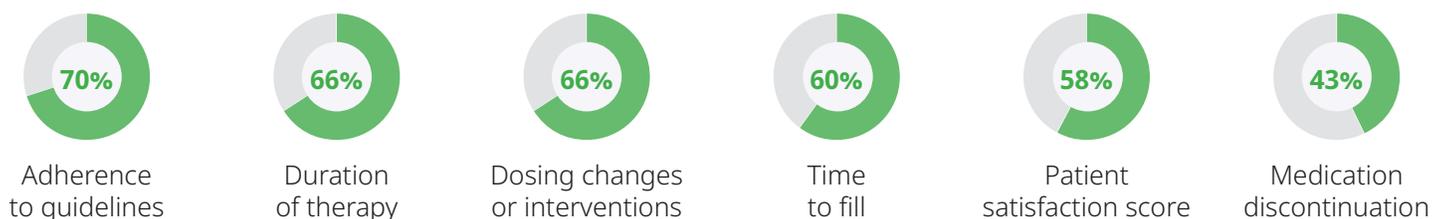
How systems and metrics ensure equitable care across age groups[§]



[§]18% of respondents don't use metrics to help ensure older adult patient care is optimized, while those who do focus on adherence to guidelines, duration of therapy, dosing changes or interventions and time to fill.

^{||}Specialized pharmacists embedded in the clinic, consistent nursing presence, access to a whole team of healthcare professionals for each patient

Metrics most frequently used to help ensure older adult patient care is optimized (n=53)



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