**Meeting Report**

# Tenth Canadian Cancer Treatment Hackathon

**November 21, 2025**

**Toronto, CANADA**

# Table of Contents

## Thank you to Our Sponsors

## Executive Summary

The Tenth Canadian Cancer Treatment Hackathon, held virtually on November 21, 2025, focused on exploring the potential to scale Ontario's Accelerated Access Pilot (FAST) nationally to improve timely and equitable access to cancer treatments across Canada. Despite incremental improvements, Canadian patients continue to experience lengthy delays in accessing new therapies, averaging 598 days from Health Canada approval to first provincial listing in 2024. Ontario's FAST pilot, targeting high-priority drugs approved through Project Orbis, seeks to reduce these delays by allowing public listing immediately after a positive health technology assessment (HTA) recommendation while pricing negotiations proceed in parallel—a model expected to accelerate patient access by up to nine months. Hackathon #10 aimed to identify strategies, governance models, and evaluation frameworks for adapting the FAST pilot program nationally while ensuring equity, political support, and policy sustainability.

Organized by Colorectal Cancer Canada and moderated by Bill Dempster (3Sixty Public Affairs), the event included pre-recorded panel discussion (introducing Ontario's FAST pilot and innovative access) and breakout group discussion, which focused on four key themes: Accountability & Collaboration, Political Acceptability, Policy Sustainability, and Evaluation Metrics. Participants included stakeholders from industry, patient organizations, federal and provincial governments, HTA agencies, and research organizations. The breakout discussions allowed participants to explore cross-cutting challenges, share perspectives, and propose actionable solutions for national scaling.

**Major Findings:**

*Accountability & Collaboration:*

- FAST ensures public availability of therapies in Ontario, supporting some aspects of equity, but does not directly address disparities in take-home drugs or access for rural and marginalized populations.
- Reliance on Project Orbis drugs may inadvertently introduce inequities; expansion beyond these drugs should consider patient values and preferences.
- Variability in provincial systems, manufacturer prioritization, and operational capacity across jurisdictions present barriers to equitable national adoption.

- Early and meaningful patient and clinician engagement, as well as transparency in drug listings, are key to building trust and improving access.
- Coordinated integration with other accelerated pathways and pan-Canadian Pharmaceutical Alliance (pCPA) processes can enhance national alignment and implementation efficiency.

*Political Acceptability:*

- Engagement with federal, provincial, and territorial stakeholders is essential, leveraging existing political leadership and aligning the pilot with broader health system priorities.
- Early involvement of patient organizations and clinicians strengthens the case for national adoption and reinforces accountability.
- Potential risks, including manufacturer leverage, interprovincial disparities, public perception, and geopolitical factors, must be mitigated through transparent communication, policy alignment, and commitment to timely drug listing.
- Federal leadership, cost-sharing mechanisms, and intergovernmental collaboration can facilitate broader support for scaling the pilot.

*Policy Sustainability:*

- Governance structures should include multi-stakeholder representation, transparent metrics, and accountability mechanisms to track performance across regulatory, HTA, and funding timelines.
- Scalability requires modular implementation adaptable to provincial infrastructure, resource constraints, and operational capacities, with potential federal support for smaller jurisdictions.
- Risk-sharing arrangements and continuity-of-care clauses help ensure sustainability while safeguarding patient access if negotiations fail.
- Incremental expansion beyond Project Orbis drugs is feasible, with structured review and stakeholder engagement to broaden eligibility over time.

*Evaluation and Performance Measurement:*

- Metrics should capture time-to-access reductions, patient impact, and healthcare system outcomes, with SMART targets and rolling evaluations to inform continuous improvement.

- Comparative benchmarks include historical timelines, interprovincial differences, and international standards.
- Evaluation should prioritize patient-centered outcomes, qualitative clinician feedback, and financial implications to guide scaling, refinement, or discontinuation of the pilot program.
- Data transparency, cross-jurisdictional learning, and integration with existing pathways are essential for evidence-informed decision-making.

**Recommendations:**

1. Expand FAST beyond Project Orbis drugs to include a broader range of high-priority therapies, incorporating patient values and clinical input.
2. Establish multi-stakeholder governance structures with clear accountability, transparent metrics, and federal-provincial coordination to support national adoption.
3. Engage early with policymakers, clinicians, patient groups, and industry to secure political buy-in and align the pilot with broader health system priorities.
4. Implement standardized evaluation frameworks with SMART metrics, rolling assessments, and interprovincial and international comparators to inform continuous improvement.
5. Develop modular, adaptable implementation approaches to address provincial capacity differences and operational constraints while ensuring equity in patient access.
6. Leverage existing accelerated access pathways, such as pCPA's Early Negotiation Pathway (ENP), to streamline regulatory, HTA, and reimbursement processes and enhance national coordination.

Hackathon #10 highlighted that scaling Ontario's FAST pilot nationally is feasible but requires coordinated governance, clear accountability, transparent metrics, inclusive stakeholder engagement, and careful policy design. By addressing political, operational, and evaluative considerations, Canada can achieve faster, fairer, and more equitable access to innovative cancer therapies for patients across all provinces and territories.

# 1.0 Introduction

## 1.1 Background

Canadian patients continue to face long and uneven waits to access newly approved cancer treatments through public drug plans. While timelines have improved in recent years, the path from Health Canada approval to publicly funded access remains lengthy and variable across provinces and territories. Delays are driven by the cumulative time required for sequential processes including regulatory approval, health technology assessment (HTA), pan-Canadian price negotiations, and jurisdiction-specific funding decisions and implementation. The result is a system in which the speed of access can depend heavily on where a patient lives, creating persistent interprovincial inequities in timely access to life-saving therapies.

Against this backdrop, Ontario announced a three-year accelerated access pilot, Funding Accelerated for Specific Treatments (FAST), intended to reduce delays for a defined subset of high-priority oncology medicines. FAST is designed to provide publicly funded access immediately after a positive final HTA recommendation, while pan-Canadian Pharmaceutical Alliance (pCPA) negotiations proceed in parallel. A key feature of the pilot is Ontario's commitment to fund eligible treatments prior to the conclusion of national price negotiations, with a later financial reconciliation mechanism once a final negotiated price is reached. The policy is intended to bridge the gap between clinical value recognition through HTA and the completion of pricing processes, thereby accelerating access for patients without abandoning pan-Canadian negotiation structures.

FAST applies to oncology medicines reviewed through Project Orbis, an international regulatory collaboration intended to expedite reviews of clinically significant therapies addressing high unmet need. By focusing on Project Orbis products, Ontario's pilot begins with a narrow and operationally manageable scope, while raising broader questions about how accelerated access approaches could be expanded over time to include additional categories of cancer therapies and, potentially, other innovative medicines. Ontario's FAST pilot also emerged alongside other recent efforts intended to accelerate elements of the drug access pathway, including pCPA's Early Negotiation Process (ENP) and updates to the Targeted Negotiation Process (TNP). These pathways aim to shorten negotiation timelines but do not provide early patient access. FAST therefore represents a distinct approach: it seeks to accelerate access by initiating funding earlier, rather than solely accelerating the negotiation phase.

### 1.2 Purpose

The tenth Canadian Cancer Treatment Hackathon was convened to examine Ontario's FAST pilot and explore whether and how an accelerated access model of this kind could be scaled and adapted nationally. Building on the cumulative learning of the Hackathon series, Hackathon 10 focused on identifying success factors, implementation requirements, and policy considerations that would support broader adoption across provinces and territories, while safeguarding equity and sustainability.

The session also aimed to clarify how FAST interacts with existing pan-Canadian structures and to surface design questions that will materially influence whether the pilot can be sustained, expanded, and translated to other jurisdictions. These questions include governance and oversight needs, risk management and reconciliation approaches, implementation readiness across diverse health system models, and evaluation methods that can credibly demonstrate value to governments, clinicians, patients, and the public.

### 1.3 Thematic Areas

Hackathon 10 discussions were organized around four themes, each framed by guiding questions circulated in advance:

1. **Equity**
    - To what extent does the Ontario pilot improve timely and consistent access within Ontario?
    - What gaps remain (e.g., marginalized populations, rural/remote communities, differences in coverage models)?
    - What barriers would arise in extending the model to other provinces and territories, and how can patient and clinician input support equitable implementation?
2. **Political Acceptability**
    - How can federal, provincial, and territorial stakeholders be engaged to support broader adoption?
    - What policy levers and advocacy strategies could enable expansion?
    - What conflicts or concerns could undermine political support, and how might they be mitigated while aligning with broader health system priorities?
3. **Policy Sustainability**

- What governance and oversight structures are required for long-term sustainability and scalable implementation?
- What mechanisms could ensure consistency across jurisdictions with different capacities and health system models?
- How might FAST be designed to adapt over time, including potential expansion beyond Project Orbis “high-priority” cancer drugs?

4. **Evaluation**
    - What metrics should be used to assess whether FAST shortens time to patient access (including end-to-end timelines and meaningful patient-centred outcomes)?
    - What baseline comparators and benchmarks are needed to measure impact (e.g., historical oncology timelines, non-FAST submissions, and other accelerated pathways)?
    - How should implementation be evaluated to identify bottlenecks, best practices, and areas for improvement, and how can evaluation results inform decisions to scale, refine, or discontinue elements of FAST?

# 2.0 Pre Panel Discussion

### 2.1 Pre Panel Discussion 1: Exploring Ontario's FAST Pilot Program and Related Accelerated Pathways

**Panel focus:** Ontario's FAST pilot as an early access model for select oncology medicines, and how it relates to newer pCPA initiatives intended to accelerate negotiation.

**Moderator:** Bill Dempster, 3Sixty Public Affairs

**Panelists:**

- Allison Wills, Partner, 20Sense
- Douglas Clark, Principal Consultant, Agathon Consulting
- Michael Dietrich, Vice President, Market Access and Policy, Innovative Medicines Canada

**Purpose and context**

The first pre watch discussion was positioned as preparation for Hackathon 10, with the moderator reiterating the hackathon series' goal of collapsing time to patient access for life saving medicines, particularly in cancer. The panel framed Ontario's FAST announcement, and related initiatives announced shortly afterward, as timely developments to examine, while noting that many elements remained a work in progress.

**What Ontario's FAST pilot is intended to do**

Michael Dietrich described FAST, Funding Accelerated for Specific Treatments, as a pilot intended to change the sequencing of Canada's access pathway. He stated that Canada's process can take roughly two years after breakthrough regulatory milestones, and that FAST aims to move the access point earlier so patients are not waiting while negotiations and related steps proceed.

Key design features discussed included:

- FAST is limited to a narrow subset of products, specifically Project Orbis oncology medicines.
- Ontario would provide access following a health technology assessment recommendation from Canada's drug agency.

- Negotiations would continue through the pan Canadian Pharmaceutical Alliance, and Ontario's cost would be retroactively reconciled to the pan Canadian negotiated price once negotiations conclude.

The approach was characterized as an attempt to deliver earlier access while keeping pan Canadian negotiations as the mechanism that ultimately determines the price Ontario pays.

**What remains unclear and why it matters**

A major theme of the discussion was that FAST has been announced as a concept, but key operational and financial details have not been publicly clarified. Panelists repeatedly returned to the point that these details will determine whether FAST speeds access or unintentionally creates new complexity.

Areas of uncertainty highlighted included:

- Whether interim provision occurs at list price and how reconciliation is handled in practice.
- What happens if pan Canadian negotiations conclude without an agreement.
- What arrangements, if any, are required up front between Ontario and manufacturers to manage the no agreement scenario.

Panelists discussed FAST as operating on a list price basis during the interim period, with retroactive reconciliation to the pan Canadian negotiated price once negotiations conclude. The discussion also noted that a contingency approach would be needed for how reconciliation would work if negotiations do not succeed, and that those specifics were not in the public domain. The moderator noted that early thinking in the system has included concepts such as paying a fraction up front and reconciling later, illustrating that implementation mechanics are still being worked through. Panelists emphasized that pricing is central to the model. They cautioned that if FAST requires additional negotiation steps, it could risk duplicating elements of the existing process rather than reducing delay.

**Comparison to Germany and the importance of a workable interim pricing concept**

The panel explored comparisons to Germany's approach as a reference point, while also noting that Ontario's model is not identical. Germany's system was discussed as an example of a structured framework that allows earlier access while a later price is determined. The Ontario approach, as described by Michael, differs because it is explicitly designed to preserve the pCPA

as the price setting mechanism and to retroactively align Ontario's net cost with the pCPA negotiated result. Doug emphasized that for FAST to work at scale, Canada would need a commonly understood method for setting an interim price and managing risk, and that clarity on this issue is necessary before meaningful national replication can be assessed.

**Relationship to pCPA initiatives: ENP and updated TNP**

The discussion then turned to the Early Negotiation Process and the updated Targeted Negotiation Process. Panelists distinguished these as negotiation accelerators rather than early access mechanisms. ENP was described as still being in consultation at the time of recording and as an approach intended to start negotiations earlier in the HTA cycle. Panelists also raised concerns that constrained negotiation structures may be difficult to apply to complex oncology products. At the same time, panelists noted that clearer process communication was encouraging, while questioning whether narrow eligibility and small volumes would translate into meaningful access improvements for patients.

**Broader pressures shaping the policy environment**

The panel closed by situating FAST and the pCPA initiatives within a broader international context. Michael noted significant uncertainty and concern about global pricing dynamics, including the potential implications of most favored nation style pricing approaches in the United States and increased focus on net price comparisons. Panelists suggested that this external environment could affect launch strategies and pricing decisions, adding urgency and uncertainty to domestic reform efforts.

**Key takeaways for Hackathon 10**

Panelists agreed that FAST, ENP, and updated TNP collectively signal momentum toward faster access and modernization, but that outcomes will depend on implementation details, coordination across institutions, and the ability to evaluate early cases. The discussion reinforced the hackathon's focus on examining FAST as an access accelerator, understanding how it interacts with national negotiation reforms, and identifying what practical conditions are necessary for scalability without introducing new layers of complexity.

### 2.2 Pre Panel Discussion 2: FAST, ENP, and the Practical Conditions for Faster Access

**Panel focus:** Ontario's FAST pilot as a funding accelerator, emerging pCPA accelerated negotiation pathways, and the real-world risks that could determine whether these initiatives produce a net improvement for patients

**Moderator:** Bill Dempster, 3Sixty Public Affairs

**Panelists:**

- Andrea Masters, Strategic Access and Pricing Director, Hoffmann-La Roche Canada
- Bob (Robert) Bick, Health Policy Consultant; Board Member, Kidney Cancer Canada; Co-Lead, CanCertainty Coalition
- Dr. David Stewart, Professor of Medicine, University of Ottawa; Medical Oncologist, The Ottawa Hospital

**Purpose and context**

The moderator framed the discussion around the long time to funded access in Canada, noting that it can take two years or more between Health Canada approval and funded access to new cancer therapies. He reiterated that the hackathon series was created to cut time to access by half and positioned Hackathon 10 as an opportunity to examine initiatives now being proposed or piloted by governments and the pan Canadian Pharmaceutical Alliance.

**Ontario FAST as a funding accelerator**

Andrea Masters described FAST as a three-year Ontario pilot focused on Project Orbis oncology products. FAST is designed to start funded access at the point of a final HTA recommendation, rather than waiting for completion of pCPA negotiations and downstream listing steps. The panel discussed FAST as an attempt to move the access start point forward in the pathway, with the potential to reduce waiting time by six to nine months, and in some cases more, depending on the drug and negotiation timelines. At a high level, the model was described as providing coverage at final recommendation, then reconciling the final economics once negotiation concludes. The panel also noted that FAST is limited in scope, both because it is restricted to Orbis products and because it operates as a pilot for a small number of therapies each year.

**Risk, delisting, and what happens if negotiations fail**

A central theme was that FAST's impact depends on how financial and access risks are managed when negotiations do not reach a successful conclusion. Andrea highlighted the core policy tension: earlier access is attractive, but uncertainty about failure scenarios creates hesitation for both payers and manufacturers.

Concerns raised included:

- What price is paid during the interim period and how reconciliation is handled in practice.
- Whether provinces would be prepared to delist or stop new starts if a negotiation fails.
- Whether manufacturers could face expectations to carry patients for long periods in a no deal scenario, and how that risk influences participation decisions.

Bob and Dave emphasized that these questions matter most because they directly affect patient access. Bob framed the evaluation challenge as measuring whether the model produces a net positive for access over time, not just faster starts for a limited number of drugs.

**pCPA ENP and updated TNP as negotiation accelerators**

The panel then discussed the pCPA's Early Negotiation Process and updated Targeted Negotiation Process. Andrea drew a clear distinction between the Ontario model and the pCPA initiatives:

- FAST is about earlier funding, because it starts coverage at final HTA recommendation.
- ENP and TNP are about earlier negotiation, because they begin or streamline negotiation activity, but do not commit provinces to fund.

Andrea also differentiated ENP and TNP by the types of products they are expected to handle. ENP is intended to begin earlier in the HTA cycle and aims to conclude around the time of the final recommendation. TNP was more suited to less complex files, where there is an established price reference and a more standardized negotiation is feasible. A key concern was that applying a rigid two offer structure to complex oncology products could create fast no outcomes. Andrea cautioned that speed cannot be the primary objective if it increases the risk of early breakdown and lost access.

**An example of misclassification risk: Lorlatinib**

Bob provided a case example that illustrated how misclassification and limited consultation can derail access. He described how the pCPA placed lorlatinib into the targeted negotiation process on the assumption it was a non-complex, “me too” product. Clinicians and patient advocates viewed it as best in class with meaningful benefits, including efficacy for brain metastases. When the manufacturer disputed the file being handled through that pathway, the negotiation was cancelled, and patient groups and partners had to push for a return to the standard process so negotiations could resume.

Bob used this example to argue for improved transparency and stronger external consultation, particularly with expert clinicians, when deciding which pathway a product enters.

**Clinical urgency and the cost of delay**

Dr. Stewart emphasized that access delays have measurable clinical consequences. He noted that cancer patients cannot wait for long pilots and narrow programs to slowly scale, particularly in settings like metastatic lung cancer where delays translate into preventable deaths. He also stressed that Orbis focus alone is too narrow, given the number of unfunded therapies that matter to patients and clinicians today. Dr. Stewart also raised a structural concern: relying on Orbis and alignment with the United States could be risky if US regulatory approaches change. He argued that Canada should explore more direct alignment with other regulators and adopt mechanisms that reduce duplication and delay, including earlier access models used in parts of Europe.

**Fragmentation, coordination, and system wide improvement**

The panel observed that Canada is now seeing multiple accelerated initiatives emerge in parallel: FAST in Ontario, newer pCPA accelerated pathways, and other provincial signals of competitive or responsive action. Panelists warned that without coordination, this patchwork approach risks creating confusion, inconsistent incentives, and uneven patient outcomes. Bob argued that Ontario could support broader learning by creating an observation layer for FAST, similar to how earlier oncology review pilots enabled other provinces to participate through active observation before joining formally. This was framed as a practical step to reduce apprehension in other jurisdictions and build confidence through real world experience, without requiring immediate full adoption. At the same time, Bob raised a separate performance issue: Ontario can accelerate a limited number of drugs through FAST but could also unlock substantial benefit by improving routine implementation timelines for all negotiated products. The panel used Quebec as a contrast

case, noting that faster post negotiation implementation can generate large system wide gains even without an early access pilot.

**Value, incentives, and manufacturer engagement**

Dr. Stewart also challenged the underlying valuation assumptions that can shape negotiation outcomes. He argued that outdated thresholds and narrow metrics can produce unrealistic price expectations, which can contribute to negotiation failure or discourage companies from prioritizing Canada. He emphasized the importance of valuing not only overall survival, but also broader health system and societal benefits such as reduced hospital use, productivity, and keeping people well enough to remain active in daily life. Bob added that system performance is not solely the responsibility of public agencies. He pointed to manufacturer choices that can also create delay, including uneven participation in initiatives intended to compress timelines, such as earlier submission alignment.

**Key takeaways for Hackathon 10**

The panel closed with a shared focus on outcomes: whether these initiatives lead to a net improvement in access for patients. Across the discussion, FAST was treated as a promising sequencing change, ENP and TNP as negotiation reforms that may help reduce delay in some cases, and fragmentation as a risk that must be actively managed.

Priorities identified for the hackathon discussion included:

- Clear, transparent rules for accelerated access and negotiation pathways, including failure scenarios.
- Consultation mechanisms that reduce misclassification risk, particularly for oncology innovations.
- Better coordination across provinces and within pan Canadian institutions so pilots do not become isolated experiments.
- Evaluation approaches that measure real patient impact, not only procedural speed.

# 3.0 Breakout Group Discussions

## 3.1 Breakout Group 1: Accountability and Collaboration

Breakout Group 1 focused on accountability and collaboration, with particular attention to how Ontario's FAST pilot affects equitable and consistent access to cancer treatments, what gaps remain for underserved populations, and what challenges must be addressed to support broader adoption across provinces and territories. Participants emphasized that while FAST represents a significant shift toward earlier public access, its equity implications are complex and context dependent.

### Equity Implications of the FAST Pilot

Participants agreed that FAST advances a baseline dimension of equity by enabling earlier public funding of selected cancer therapies following a positive HTA recommendation. Earlier public availability can reduce reliance on private insurance, compassionate access programs, or out of pocket payment for some patients in Ontario. This was viewed as a meaningful improvement within the current system. At the same time, the group stressed that FAST is not designed as an equity focused policy. Its primary objective is to accelerate access, not to systematically address disparities across populations or regions. As a result, faster funding decisions do not automatically translate into equitable access for all patients.

Within Ontario, participants highlighted longstanding differences between hospital administered cancer drugs and take-home oral therapies. FAST does not resolve these structural coverage gaps, particularly for patients who are not eligible for public coverage of oral cancer medicines. As a result, faster access for some therapies may coexist with persistent inequities for others, depending on drug type and funding mechanism. At a national level, participants noted that FAST may temporarily worsen interprovincial inequities by favouring patients in Ontario relative to those in other provinces and territories. Some participants viewed this as an unavoidable short-term effect of a provincial pilot, while others suggested it could create constructive pressure on other jurisdictions and pan Canadian bodies to accelerate their own processes. Whether this dynamic ultimately improves equity was seen as dependent on the speed and willingness with which lessons from FAST are shared and adopted elsewhere.

### Scope, Transparency, and Selection of Therapies

A recurring concern was the limited scope of FAST, which currently applies only to oncology medicines reviewed through Project Orbis. While participants recognized the operational rationale for starting with a small subset of high priority drugs, they cautioned that prioritizing Orbis products could be inherently inequitable if it excludes therapies that patients value but that fall outside this regulatory pathway.

Participants emphasized the need for safeguards to ensure that decisions about which therapies are included reflect patient valued outcomes and unmet needs, rather than being driven solely by regulatory process. The lack of transparency around how therapies will be selected for FAST, and which therapeutic areas may be prioritized, was identified as a limitation of the pilot. Participants noted, a pilot cannot improve equity or consistency across the entire system. Without clear selection criteria and public reporting, it is inevitable that some disease areas, patient groups, or treatment needs will be left out during the pilot period.

Several participants underscored the importance of publicly accessible, comparative information on which cancer medicines are funded in which jurisdictions. Existing patient led resources that compare coverage across provinces were cited as valuable, but participants noted the absence of a comprehensive, system wide approach that would allow patients, clinicians, and policymakers to clearly identify where inequities persist.

**Structural and System Level Drivers of Inequity**

Beyond program design, the group identified broader system level factors that shape access and equity outcomes. Participants highlighted substantial variation across provinces and territories due to differences in health system models, including cancer agency-based systems versus mixed or ministry led models. Differences in diagnostic and testing capacity, operational readiness, and administrative resources further contribute to uneven access.

Participants also noted that manufacturers may need to prioritize engagement and implementation in larger provinces with higher patient volumes, which can contribute to slower uptake in smaller jurisdictions. In some cases, jurisdictions may delay listing because there are few or no eligible patients at a given time, reducing perceived urgency and further contributing to variability. The group also raised the possibility of interprovincial medical tourism, whereby patients might seek access in Ontario to therapies not yet available in their home province. While largely speculative, this was identified as a potential equity issue that could emerge as FAST is implemented.

**Barriers to Expansion Across Provinces and Territories**

Political will was identified as a central enabler of FAST in Ontario. Participants noted a clear link between political leadership, recognition of the life sciences sector as an economic driver, and the willingness to fund accelerated access through mechanisms such as Treasury Board allocations. This level of political direction and fiscal flexibility may not exist uniformly across provinces and territories, creating a major barrier to national scaling.

Operational and fiscal constraints were also emphasized. Some jurisdictions, particularly those with cancer agency models, require all implementation elements such as clinical criteria, diagnostics, staffing, and infrastructure to be in place before access is activated. This approach can lengthen timelines and make accelerated access more difficult to operationalize. Administrative burden on clinicians and health systems, especially for complex therapies, was also cited as a concern.

A major challenge discussed was the risk associated with negotiations that do not conclude successfully. Participants noted that the possibility of delisting, or of denying future access if an agreement cannot be reached, poses political and practical risks for provinces and territories. This risk was seen as a significant deterrent to participation in accelerated access models. Differences in provincial discretion and ministerial authority further complicate efforts to establish consistent, pan Canadian approaches.

**Role of Patient and Clinician Input**

Participants emphasized that patient and clinician engagement already plays a critical role upstream through the HTA process, which occurs before FAST is triggered. However, they suggested that additional opportunities for engagement should be built into the pilot itself. Participants proposed that patients, clinicians, and health system leaders should have a formal opportunity to provide feedback after an initial period of implementation, such as one year. This feedback could inform decisions about expanding the scope of FAST, adjusting processes, and ensuring that drug programs have sufficient capacity to manage accelerated volumes.

The group also highlighted the importance of transparency around which products are being funded through FAST and when they become available. Clear communication and integration with Cancer Care Ontario and hospital systems were viewed as essential to ensuring that funding decisions translate into real world access. Earlier and more consistent involvement of patients

and clinicians was seen as critical to maintaining trust and aligning accelerated access with patient needs.

**Interaction With Other Accelerated Access Pathways**

Finally, participants situated FAST within a broader policy environment that includes pCPA initiatives such as the Early Negotiation Process and the Targeted Negotiation Process. They emphasized the urgency of improving access in light of global pricing pressures and international policy developments, including most favored nation considerations in the United States. Participants noted that Canada's ability to adopt and deploy innovative medicines affects not only patient outcomes, but also the country's role in the global life sciences ecosystem. If Canada remains a site for clinical trials but does not adopt resulting therapies in a timely manner, its attractiveness as a research and innovation partner may erode. Stronger collaboration across accelerated access pathways, supported by formal forums for coordination, was viewed as essential to improving both timeliness and equity of access across Canada.

**Summary**

Breakout Group 1 concluded that FAST can improve baseline access for some patients but does not on its own resolve entrenched equity challenges within or across jurisdictions. Achieving more equitable access to cancer treatments will require greater transparency, deliberate attention to system level differences, sustained patient and clinician engagement, and coordinated national efforts that extend beyond a single provincial pilot.

### 3.2 Breakout Group 2: Political Acceptability

Breakout Group 2 examined the political acceptability of Ontario's FAST pilot and the conditions under which it could gain broader support across federal, provincial, and territorial governments. Discussions focused on how governments might be engaged to support national expansion, what political risks or conflicts could undermine support, and how FAST could be aligned with existing priorities and accelerated access pathways without destabilizing the broader system.

#### Engaging Federal, Provincial, and Territorial Stakeholders

Participants emphasized that political acceptability depends first on demonstrating credibility and feasibility. Several noted that FAST is still very new, and that many governments may be reluctant to consider expansion until there is clearer evidence that the pilot is functioning as intended in Ontario. In this context, early signals of success, clarity about operational details, and credible evaluation plans were seen as essential to sustaining political interest beyond Ontario. Ontario's experience was widely viewed as being driven by strong political leadership from the highest levels of government. Participants highlighted that FAST benefited from a clear political mandate, which enabled rapid alignment across ministries and access to funding mechanisms outside traditional drug program budgets. This type of leadership was seen as a key differentiator, and one that may not be easily replicated in all jurisdictions.

Some participants suggested that Ontario could play a convening or demonstration role, allowing other provinces and territories to observe the pilot in practice and learn from its implementation. Rather than immediate replication, a period of structured observation and information sharing was viewed as a more politically realistic pathway toward broader adoption. Participants also emphasized that patient advocacy and industry engagement would be critical to maintaining political momentum. While governments may gain reputational benefit from announcing accelerated access initiatives, sustained accountability would require continued pressure from patient organizations and other stakeholders to ensure that promised benefits are realized and maintained over time.

#### Political Risks, Conflicts, and Mitigation Strategies

A central concern raised was the perception that FAST could shift bargaining leverage toward manufacturers. Some participants noted that early funded access could be viewed by governments as weakening negotiating positions, particularly if there is public or political pressure to maintain access once patients have begun treatment. Others cautioned that these concerns

may be overstated, especially if robust risk sharing mechanisms are in place and clearly understood. Uncertainty around how financial risk is shared during the interim access period was identified as a potential political vulnerability. Participants agreed that clearer articulation of how interim pricing, reconciliation, and responsibility for costs are handled would be important for building confidence among governments and treasuries. Without this clarity, political leaders may be hesitant to support expansion, particularly in smaller jurisdictions with limited fiscal flexibility.

International policy dynamics were also raised as a complicating factor. Participants discussed the potential implications of most favored nation pricing initiatives in the United States and broader geopolitical pressures on drug pricing. Anchoring accelerated access pathways too closely to international regulatory processes, such as those involving the US Food and Drug Administration, was seen by some as politically sensitive. Others suggested that stronger emphasis on domestic frameworks, such as Health Canada priority review processes, could help mitigate these concerns.

Another political risk discussed was the possibility of negative public attention if negotiations fail and access cannot be sustained for future patients. The prospect of delisting or denying access after a period of early funding was viewed as politically challenging, particularly for cancer therapies. This risk was seen as a major reason why some governments may hesitate to participate in accelerated access models without strong safeguards and clear communication strategies.

**Alignment With Existing Priorities and Pathways**

Participants emphasized that FAST should be understood as complementary to, rather than competitive with, existing pan Canadian processes. In particular, alignment with pCPA initiatives such as the Early Negotiation Process and the Targeted Negotiation Process was seen as essential for political acceptability. FAST was described as addressing access acceleration, while ENP and TNP focus on negotiation efficiency. Maintaining this distinction was viewed as important to avoid perceptions of system fragmentation or duplication.

Several participants noted that political acceptability would be enhanced if FAST is clearly framed as supporting broader health system and economic priorities. The link between timely access to innovative medicines, patient outcomes, and the strength of the life sciences sector was repeatedly emphasized. Participants argued that governments are more likely to support

accelerated access models when they are positioned as contributing to economic competitiveness, research attractiveness, and long-term system sustainability, rather than as isolated drug funding initiatives.

At the federal level, participants discussed whether there may be a role for coordination or support, particularly in relation to interim funding challenges faced by smaller provinces and territories. While no consensus emerged, the idea that federal involvement could improve political feasibility for less resourced jurisdictions was raised as a potential avenue for future exploration.

**Tailoring FAST to Jurisdictional Contexts**

The group acknowledged that political acceptability will ultimately depend on whether FAST can be adapted to the realities of different provinces and territories. Jurisdictions vary widely in governance structures, fiscal capacity, and health system organization, and a uniform model may not be feasible. Participants suggested that flexibility in how accelerated access is implemented, combined with shared principles and transparent evaluation, could make adoption more politically palatable. Importantly, participants cautioned against waiting for a perfect model before acting. From a patient perspective, delays associated with prolonged policy design were seen as unacceptable given the stakes involved. Several participants emphasized that political leaders must balance risk management with the urgent need to improve access for patients facing life threatening illness.

**Summary**

Breakout Group 2 concluded that political acceptability of FAST depends on clear evidence of early success, transparency around risk sharing and costs, and strong alignment with existing pan Canadian processes. Sustained political support will require continued engagement from patient organizations and industry, careful management of perceived risks, and framing accelerated access as both a health and economic priority. While expansion beyond Ontario may take time, participants agreed that FAST has the potential to influence national policy discussions if lessons are communicated clearly and adapted to diverse jurisdictional contexts.

### 3.3 Breakout Group 3: Policy Sustainability

Breakout Group 3 examined the conditions required to support the expansion and long-term sustainability of Ontario's FAST pilot. Discussions focused on governance and oversight, mechanisms to ensure consistency and scalability across provinces and territories, and how FAST could evolve beyond its initial focus on high priority cancer drugs reviewed through Project Orbis. Participants emphasized that sustainability depends on credibility with public payers, operational feasibility across jurisdictions, and trust among all stakeholders.

**Governance and Oversight for Long Term Sustainability**

Participants agreed that clear, credible metrics are central to sustaining FAST over time and supporting its adoption beyond Ontario. Metrics that demonstrate value in terms that resonate with public payers were viewed as a critical policy lever. These measures must be transparent and understandable to a broad audience, including patients, clinicians, and the public, rather than remaining internal or technical.

Beyond traditional process metrics, participants emphasized the importance of patient centric and impact focused indicators. Examples discussed included measures related to patient outcomes, such as lives saved or avoided disease progression, alongside economic evidence that demonstrates broader system value. These indicators were seen not only as tools for evaluation, but also as mechanisms to justify expansion of the FAST drug list and to inform future phases of the pilot. The group highlighted the importance of establishing transparent milestones that can be adjusted as lessons are learned. Rather than waiting until the end of the three year pilot period, participants supported interim assessments, such as at twelve months, to determine whether FAST is meeting its objectives and whether scope adjustments are warranted.

Governance structures were seen as equally important. Participants emphasized that sustainable oversight should include meaningful partnership and representation from key stakeholders, including manufacturers, public payers, clinicians, and patient groups. While equal decision making authority may not be feasible in all cases, participants stressed the importance of shared voice and structured engagement to build trust and legitimacy. A recurring challenge was identifying an appropriate body to establish accountability for tracking performance across the full access pathway, from regulatory approval to public listing and patient access. Participants noted that, in the current system, no single organization clearly owns end to end accountability. While

the pan Canadian Pharmaceutical Alliance could potentially track certain metrics, such as time from notice of compliance to listing, and Canada's Drug Agency could theoretically play a coordinating role, participants expressed uncertainty about whether either organization is currently structured or mandated to assume this responsibility.

**Risk Sharing, Negotiation Dynamics, and Continuity of Care**

Participants discussed how policy sustainability is closely tied to how financial and clinical risks are managed. Some stakeholders referenced publicly discussed continuity of care clauses associated with FAST, under which manufacturers may be responsible for funding ongoing treatment for patients if negotiations fail. While continuity of care was viewed as essential for patients already receiving therapy, participants noted that such provisions increase financial risk for manufacturers and may affect negotiation dynamics. Potential mitigation approaches were discussed, including shared risk models in which manufacturers and drug plans jointly bear interim costs, or the use of an agreed interim price if final negotiations are unsuccessful. Participants emphasized that whatever approach is adopted, all parties must clearly understand the risks associated with non-agreement and how those risks are allocated. Without this clarity, sustainability and willingness to participate could be undermined.

Some participants questioned whether expanding existing pCPA processes, such as the Early Negotiation Process, might be a more politically or operationally feasible step for some provinces than adopting FAST directly. This reinforced the need to consider how FAST interacts with other accelerated access pathways and whether elements of these models could converge over time.
Transparency was also raised as a sustainability issue, particularly with respect to when cancer centres are able to deliver FAST funded therapies. Participants noted that access is only realized when therapies are implemented at the site level, and that visibility into implementation readiness across centres would strengthen accountability and trust.

**Mechanisms for Consistent and Scalable Implementation**

Participants agreed that scalability depends on openness and willingness among provinces and territories to learn from Ontario's experience, including both successes and challenges. While there is clear interest across jurisdictions in accelerating access, there is also hesitation driven by uncertainty about financial exposure, implementation burden, and political risk. Collaboration among provinces and territories was seen as essential to establishing a scalable approach. Participants pointed to previous examples, such as the implementation of CAR T therapies, where

jurisdictions came together to share information, align processes, and coordinate access. These experiences were viewed as instructive for FAST. The pCPA was repeatedly identified as a natural forum for facilitating dialogue, sharing best practices, and supporting coordination across jurisdictions. Participants suggested that pCPA could play a convening role between Ontario, other drug plans, and system partners to clarify how FAST aligns with existing accelerated pathways and to explore whether different models should eventually merge or remain distinct. Some participants noted that for pCPA to effectively support this role, closer connection to drug plans and greater attention to system readiness and implementation realities may be required.

A structural limitation highlighted by the group is that, under the current system, provinces and territories have no obligation to list therapies following a successful negotiation. Participants suggested that greater consistency and scalability may require mechanisms that create clearer expectations or commitments to list, while still respecting jurisdictional authority. To accommodate variation across jurisdictions, participants supported the idea of a modular FAST blueprint that provinces and territories could adapt to their own systems. Smaller jurisdictions, in particular, may lack the resources or fiscal flexibility to implement accelerated access independently. In this context, some participants raised the possibility that federal leadership or funding support may be required to enable consistent access nationwide, especially if equitable outcomes are a shared policy goal. Implementation challenges were also discussed, including disparities in biomarker testing access and diagnostic capacity, which could limit the ability of some jurisdictions to operationalize FAST even if funding is available.

**Expanding Beyond Project Orbis**

Participants generally agreed that starting with Project Orbis drugs was a practical way to operationalize change, given their high unmet need and accelerated regulatory status. However, they stressed that long term sustainability depends on the ability to broaden the scope of FAST beyond this narrow subset. Maintaining pressure for regular review and evaluation was seen as essential. Participants strongly supported expanding the eligible drug list incrementally, without waiting for the end of the three-year pilot. A step wise approach was discussed, including the potential inclusion of Health Canada priority review drugs, which represent a meaningful proportion of new therapies and could serve as an intermediate expansion beyond Project Orbis. The group emphasized that genuine engagement from all stakeholders is required to support such expansion. Over time, several participants expressed the view that accelerated access at the time of a positive HTA recommendation should become the norm for cancer therapies, rather

than an exception limited to specific pathways. Risk sharing between payers and manufacturers was again highlighted as a necessary condition for expansion. Participants discussed the need for agreed processes to manage situations where negotiations do not conclude successfully, including the possibility of arbitration or predefined fallback mechanisms. While views differed on feasibility, there was consensus that clarity and predictability are critical.

**Data, Accountability, and Continuous Improvement**

Participants emphasized that robust data collection and performance monitoring are foundational to policy sustainability. Data strategies should align with broader government priorities and clearly demonstrate how FAST benefits patients. Measures that show improvements in patient outcomes, not just faster processes, were viewed as particularly important for maintaining political and public support. Lessons from other accelerated pathways, including time limited recommendations and temporary access programs, were seen as valuable inputs for continuous improvement. Participants emphasized the importance of learning from both successes and shortcomings of these models to refine FAST over time. Several participants suggested that public reporting mechanisms, such as a report card that highlights when treatments become available across jurisdictions, could reinforce accountability and transparency. Such tools were seen as supporting trust among stakeholders and providing practical insight into whether accelerated access is translating into real world benefits.

**Summary**

Breakout Group 3 concluded that the long-term sustainability of FAST depends on credible metrics, transparent governance, and adaptable implementation models that reflect the realities of different provinces and territories. Sustaining and scaling the pilot will require shared accountability, thoughtful risk sharing, strong coordination through pan Canadian forums, and a clear pathway to expand beyond Project Orbis. Continuous evaluation, aligned data strategies, and visible patient benefit were identified as essential to maintaining trust and ensuring that accelerated access can be sustained and extended over time.

### 3.4 Breakout Group 4: Evaluation and Performance Measurement

Breakout Group 4 focused on how the FAST pilot should be evaluated to determine whether it meaningfully accelerates patient access to cancer therapies, how implementation bottlenecks can be identified and addressed, and how evaluation results should inform decisions about scaling, refining, or discontinuing elements of the program. Participants emphasized that evaluation must go beyond funding timelines to capture real world access, patient impact, and system sustainability.

**Defining Core Metrics for Success**

Participants agreed that the primary measure of success for FAST is whether patients gain access to publicly funded cancer therapies faster than they would under the traditional pathway. Reducing the overall time from regulatory approval through HTA and funding was viewed as the central objective, and any measurable shortening of this timeline should be considered a meaningful success. However, the group stressed that funding decisions alone are insufficient as an outcome measure. Evaluation must also capture how quickly therapies are implemented and used within the health system. Participants raised concerns about potential “postal code” effects, where access may vary by cancer centre or region even after funding is in place. As a result, metrics should distinguish between funding approval and real-world availability and use.

Participants also emphasized the importance of measuring the number of patients affected. This includes assessing how many patients receive earlier access because of FAST and whether the program is targeting the therapies with the greatest potential patient impact. Because implementation and uptake vary by product, participants noted that some metrics will need to be tailored on a per drug basis rather than applied uniformly. Qualitative input from clinicians was identified as an important complement to quantitative measures. Checking in with physicians about changes in practice, patient experience, and perceived value of earlier access was seen as critical to understanding whether FAST is delivering meaningful benefits.

Several participants supported the use of clear, time bound targets, such as SMART style metrics. Examples discussed included the proportion of eligible medicines funded within defined timeframes and comparisons against historical benchmarks. Ontario’s stated objective of reducing time to access by up to a full year compared with traditional processes was cited as an explicit target that could anchor evaluation efforts.

**Financial and System Impact Measures**

Participants emphasized that financial impact must be a core component of evaluation, noting that while patient stories are influential, government decision making ultimately depends on cost and sustainability. Measuring interim drug costs per patient and comparing them with final negotiated prices was seen as important for understanding fiscal exposure and value. Beyond drug costs, participants discussed the need to examine broader system impacts associated with faster treatment. Potential measures included changes in emergency department visits, quality of life outcomes, real world evidence on treatment effectiveness, time on disability benefits, and time away from work. While participants acknowledged challenges in capturing some of these data within a three year pilot, they emphasized the importance of identifying feasible proxies that reflect patient and system benefit. The group also discussed the relevance of international benchmarks. Measures that position Canada relative to peer countries, such as OECD based comparisons, were seen as potentially persuasive for governments, even if their direct linkage to patient outcomes is indirect.

**Comparative Evaluation and Benchmarks**

Participants strongly supported the use of comparative evaluation to assess FAST's impact. Ontario's role as the sole jurisdiction piloting FAST was viewed as creating a natural comparison group, enabling interprovincial comparisons of timelines and outcomes. Participants described this as a "golden opportunity" to examine differences in quality of life or access outcomes between Ontario and other provinces, potentially through surveys or shared research initiatives. Several baseline comparators were proposed. These included historical timelines for Project Orbis drugs that followed the traditional pathway in Ontario, comparisons with non-FAST oncology submissions, and interprovincial comparisons of time to funding and access. Participants also emphasized the value of international benchmarking to assess whether FAST moves Canada closer to global standards for timely access. The group noted that benchmarking should not be limited to Canadian accelerated pathways. Given that FAST builds on Project Orbis, participants supported examining accelerated access models in other countries to provide broader context and identify best practices.

**Examining Implementation Processes and Bottlenecks**

Participants emphasized the importance of systematically examining FAST implementation processes to identify bottlenecks and areas for improvement. While FAST is intended to be complementary to existing pathways, starting funding at the time of a final recommendation introduces new coordination challenges. Timing risks were discussed, including changes that may

occur during the HTA process, such as reconsideration requests or adjustments to clinical criteria. Participants noted that some jurisdictions manage implementation more efficiently by addressing operational requirements earlier in the process. Saskatchewan and Quebec were cited as examples where earlier attention to implementation readiness can shorten timelines. One proposed solution was to initiate implementation planning earlier, even while recognizing that final recommendations may change. Participants acknowledged the trade-off between efficiency and certainty but emphasized that waiting until all decisions are finalized can unnecessarily extend delays.

**Baseline Comparators and Rolling Evaluation**

Participants outlined three complementary approaches to establishing baselines for evaluation. The first involves comparing FAST products with similar Project Orbis therapies that previously went through the traditional pathway. The second uses interprovincial comparisons to assess whether FAST meaningfully accelerates access relative to other jurisdictions. The third considers international comparisons to evaluate whether FAST improves Canada's relative performance globally. Participants also stressed the importance of conducting evaluations on a rolling, per product basis rather than waiting until all ten to twelve anticipated FAST products have completed the pathway. Rolling evaluation was seen to identify issues earlier, enable course correction, and avoid missing opportunities to improve patient access during the pilot period.

**Incorporating Patient Perspectives**

Participants emphasized that patient perspectives must be embedded in evaluation design from the outset. Patient leaders should be involved in selecting metrics, interpreting results, and shaping how findings are communicated. Outcomes that matter most to patients and caregivers, such as quality of life, functional status, and time to treatment, should be prioritized alongside system level measures. Participants also noted that evaluation should consider whether FAST influences whether medicines come to Canada at all. Access acceleration was viewed not only as a patient benefit, but also as a factor in maintaining Canada's attractiveness for innovation and clinical research.

**Using Evaluation to Inform Policy Decisions**

Finally, participants discussed how evaluation results should inform decisions about scaling, refining, or discontinuing elements of FAST. Scaling too quickly was seen as potentially undermining negotiation leverage and value for money, while overly cautious scaling could delay

patient benefit. Evaluation was therefore viewed as a critical tool for balancing access, value, and sustainability. Participants concluded that transparent, credible evaluation will be essential to determining whether FAST should be expanded beyond Ontario, broadened to include additional therapies, or adapted in response to observed challenges. Robust performance measurement was seen as foundational to sustaining trust among governments, patients, clinicians, and manufacturers.

**Summary**

Breakout Group 4 concluded that effective evaluation of FAST requires a comprehensive approach that measures time to access, real world implementation, patient impact, and financial sustainability. Comparative benchmarking, rolling evaluation, and integration of patient perspectives were identified as essential components. By using evaluation results to guide iterative improvement, FAST has the potential to inform broader system reform while ensuring that accelerated access delivers meaningful and sustainable benefits for patients.

## 4.0 Conclusion

Hackathon 10 underscored both the promise and the urgency of rethinking how Canada provides timely access to high value cancer therapies. Ontario's FAST pilot was widely recognized as a meaningful and concrete shift in how the drug access system operates, moving from sequential decision making toward earlier, patient focused access while national negotiations continue. Participants consistently acknowledged that this represents a fundamental change in the way the system does business, even if many operational and policy details are still evolving.

Across all discussions, a central theme was urgency. Participants repeatedly emphasized that delays in access are not abstract policy problems but real, time sensitive issues for patients and families. The context of global pricing pressures, international policy shifts such as most favored nation proposals, and increasing competition for life sciences investment reinforces the need for Canada to act decisively. Faster access is not only about compassion and equity, but also about maintaining Canada's role in clinical research, innovation, and the broader life sciences ecosystem.

At the same time, the hackathon made clear that speed alone is not enough. Participants stressed the importance of clearly defining value, including what outcomes matter most to patients, what constitutes value for public payers, and how these perspectives can be aligned. FAST was seen as an access accelerator rather than a comprehensive equity solution, highlighting the need for deliberate attention to system level disparities, transparency, and national coordination if equity is to improve rather than worsen in the interim.

Evaluation emerged as a critical enabler of sustainability. There was strong consensus that FAST should be assessed dynamically and continuously, rather than relying solely on infrequent or end of pilot reviews. Drug by drug evaluation, comparative benchmarking across provinces and internationally, and early identification of bottlenecks were viewed as essential to ensuring that the pilot evolves in real time and remains responsive to patient needs. Participants emphasized that evaluation must extend beyond funding decisions to include real world implementation, patient outcomes, and system impact.

Collaboration was another unifying theme. Participants highlighted the importance of strong forums for dialogue among provinces and territories, national bodies, patient organizations, clinicians, and industry. The pan Canadian Pharmaceutical Alliance was repeatedly identified as

a critical convening mechanism, though participants also noted that its current structure may need to evolve to better support accelerated access and system readiness. Lessons from other collaborative efforts, such as CAR T implementation and international accelerated pathways, reinforced the value of shared learning and coordinated action.

Finally, the discussions reinforced that FAST should be viewed as a starting point rather than an endpoint. While beginning with Project Orbis drugs was seen as practical, participants expressed concern about the narrow scope and emphasized the need to expand eligibility incrementally, including consideration of priority review therapies. Waiting until the end of a multiyear pilot to broaden scope was widely viewed as inconsistent with the urgency facing cancer patients.

In closing, Hackathon 10 affirmed that meaningful change is possible when political leadership, patient advocacy, and system wide collaboration align. The FAST pilot is not perfect, nor is it complete, but it represents tangible progress driven by sustained advocacy and collective problem solving. Participants agreed that Canada does not have the luxury of waiting. Continued experimentation, transparent evaluation, and shared commitment across jurisdictions will be essential to building a faster, fairer, and more resilient cancer drug access system for patients across the country.

## 5.0. Post-Event Survey Report

**Overview**

A post event survey was distributed to participants following Hackathon 10 to gather feedback on understanding of Ontario's FAST pilot, perceptions of its potential impact, priorities for improvement and national scaling, preferred evaluation metrics, and recommended actions to translate hackathon findings into real world impact. Eight participants completed the survey, representing a mix of perspectives across the cancer drug access ecosystem.

**1. Participant Roles**

Respondents primarily identified as industry leaders, with additional representation from clinicians and a patient group representative:

- 62.5% identified as **industry leaders** (5 of 8)
- 25.0% identified as **clinicians** (2 of 8)
- 12.5% identified as **patient group representatives** (1 of 8)
- 0% identified as HTA leaders, academics, researchers, consultants, policy experts, or government officials

**2. Understanding of Ontario's FAST Pilot**

When asked whether the Hackathon improved their understanding of Ontario's FAST pilot program:

- 75.0% responded **Yes** (6 of 8)
- 25.0% responded **No** (2 of 8)

**3. Expectations for FAST Reducing Time to Patient Access**

When asked whether Ontario's FAST pilot will be successful in reducing time to patient access for high priority cancer drugs:

- 50.0% responded **Yes** (4 of 8)
- 37.5% responded **Unsure** (3 of 8)
- 0% responded No
- 12.5% selected **Other**, specifying "Yes, but limited in scope"

Overall, responses suggest cautious optimism, with uncertainty driven largely by perceived limits in scope and remaining implementation unknowns.

**4. One Change to Improve FAST**

Seven respondents provided an open text answer on what they would change about FAST. Responses were highly consistent and centered on removing or expanding scope limitations, particularly the restriction to Project Orbis drugs and caps on the number of files:

- Remove the arbitrary cap on number of files or drugs per year
- Expand beyond Project Orbis to include all cancer medicines, or at minimum all drugs meeting high unmet need
- Expand eligibility to fast tracked or Priority Review drugs (including those granted Priority Review at Health Canada)

**5. Most Significant Barrier to Scaling FAST Nationally**

Respondents identified a mix of political, structural, financial, and process barriers. Key themes included:

- Inertia and slow system change (noted by multiple respondents)
- FAST being provincially generated rather than led through a pan Canadian mechanism such as pCPA
- Differences in provincial processes and the need for tailored solutions by province, including budget flexibility constraints in smaller provinces
- Political will and acceptance from other provinces and territories given concurrent pCPA initiatives
- Budget impact uncertainty and concerns about manufacturer influence or pressure to adopt therapies quickly without fiscal readiness
- Uncertainty around what happens if negotiations do not reach agreement, plus the need to discuss implementation considerations earlier

**6. Metrics to Evaluate FAST Success**

Respondents selected multiple metrics, indicating interest in both speed and real world impact. The most frequently selected metrics were:

- 87.5%: Time saved from positive CDA recommendation to public funding (7 of 8)
- 75.0%: Number of drugs or products approved under FAST (6 of 8)
- 75.0%: Comparison with non FAST provinces or other accelerated access pathways (6 of 8)
- 62.5%: Number of patients accessing FAST drugs (5 of 8)

- 50.0%: Percentage of cancer drugs funded within target timelines (4 of 8)
- 37.5%: Patient reported outcomes such as lives saved or quality of life (3 of 8)
- 37.5%: Economic impact such as interim costs per patient and long-term system costs (3 of 8)
- 37.5%: Qualitative measures such as whether the right drugs are being included and patient experience (3 of 8)

Two respondents selected “Other” and specified:

- Time to patient from Health Canada submission to patient access
- Percentage of eligible cancer drugs funded within target timelines

**7. Actions to Translate Hackathon Findings into Real World Impact**

Respondents prioritized advocacy-oriented outputs alongside more formal written products:

- 75.0%: Launch an advocacy campaign about drug access challenges and opportunities (6 of 8)
- 62.5%: Develop a manuscript or research paper for publication (5 of 8)
- 62.5%: Develop policy briefs tailored to key stakeholder groups (5 of 8)
- 62.5%: Continue presenting hackathon results at national and international conferences (5 of 8)
- 37.5%: Develop a white paper (3 of 8)
- 25.0%: Develop infographics (2 of 8)
- 25.0%: Establish a task force or coalition focused on access (2 of 8)
- 25.0%: Develop a “What We Learned” webinar series (2 of 8)
- 12.5%: Develop a hackathon webinar series on emerging topics (1 of 8)
- 0%: Work with CDA to develop patient input tools (0 of 8)

One “Other” response recommended using results in lobby days and direct advocacy events with elected officials, with an actionable ask and identified political champions

**8. Additional Comments**

Three respondents provided additional comments:

- One noted that selecting many metrics and actions made prioritization difficult because many options were strong
- One suggested that, given growing traction, the series could benefit from choosing a single key objective such as implementing FAST in two to three more provinces and focusing energy there

- One offered general positive feedback (“Great work!”)

**Conclusion**

Survey responses indicate that Hackathon 10 improved understanding of FAST for most respondents, and that participants are cautiously optimistic about FAST’s ability to reduce time to patient access, while recognizing limitations in scope and uncertainty in implementation details. The strongest improvement priority was broadening eligibility beyond Project Orbis and removing arbitrary caps on the number of therapies. The most cited barriers to national scaling were inertia, differences in provincial systems and budgets, political will, and unresolved questions about negotiation failure scenarios. Participants supported a balanced evaluation approach that measures time saved and uptake, while also tracking patient impact and comparisons across jurisdictions. For translating findings into impact, respondents most strongly favored advocacy campaigns, policy briefs, published research, and continued dissemination through conferences, with some support for white papers and coalition building.

## Appendix 1: Hackathon #10 Agenda

| Time | Agenda item | Lead |
|---|---|---|
| 1:00 – 1:15 pm | • Opening remarks<br>Celebrating 10 Hackathons | |
| 1:15 – 1:25 pm | • Roundtable introductions<br>• What has changed since Hackathon 1?<br>• Review glossary of accelerated access initiatives<br>• Review format for breakout groups | Bill Dempster |
| 1:25 – 2:25 pm | Breakout groups<br>• 30 min. – theme 1<br>• 10 min. – theme 2<br>• 10 min. – theme 3<br>• 10 min. – theme 4 | All |
| 2:25 – 2:30 pm | Break | |
| 2:30 – 3:20 pm | Group presentations to the plenary | All |
| 3:20 – 3:30 pm | Closing remarks and next steps | Barry Stein |

## Appendix 2: List of experts and representatives on the pre-recorded panel

Panel#1 Exploring Ontario's FAST pilot program: Reimagining the Path Forward - Enabling National Implementation

To explore how Ontario's Funding Accelerated for Specific Treatment (FAST) pilot program can be expanded and adapted across provinces and territories to improve timely and equitable access to cancer drugs in Canada. This includes examining the enabling policies, infrastructure, and advocacy steps required to scale the model nationally, building on insights from previous hackathons and related initiatives such as Project Orbis. The session will identify implementation barriers, opportunities, and evidence-based strategies to support broader adoption of accelerated access approaches across Canada.

**Panelist:** Allison Wills, Doug Clark, and Michael Dietrich

Panel 2 Reimagining the Path Forward - Enabling National Implementation

To explore how Ontario's Funding Accelerated for Specific Treatment (FAST) pilot program can be expanded and adapted across provinces and territories to improve timely and equitable access to cancer drugs in Canada. This includes examining the enabling policies, infrastructure, and advocacy steps required to scale the model nationally, building on insights from previous hackathons and related initiatives such as Project Orbis. The session will identify implementation barriers, opportunities, and evidence-based strategies to support broader adoption of accelerated access approaches across Canada.

**Panelists:** Andrea Masters, Bob Bick, and Dr. David Stewart