Meeting Report

Ninth Canadian Cancer Treatment Hackathon

July 22, 2025

Toronto, CANADA

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Executive Summary

The Ninth Canadian Cancer Treatment Hackathon, held on July 22nd, 2025, convened diverse healthcare stakeholders to explore delays in patient access to cancer drugs during the post-Letter of Intent (LOI) phase of the pan-Canadian Pharmaceutical Alliance (pCPA) process. Despite modest improvements in recent years, Canadian patients continue to face lengthy waits—averaging 598 days from Health Canada approval to first provincial listing—with substantial variation across provinces.[1] Even after successful pCPA negotiations, additional delays occur as each jurisdiction finalizes Product Listing Agreements (PLAs), creating inequities in patient access.[2] Hackathon #9 aimed to identify actionable solutions to streamline post-LOI processes, improve coordination, and enhance transparency.

The event, organized by Colorectal Cancer Canada with support from pharmaceutical sponsors, included pre-panel presentations, breakout discussions by stakeholder type (industry, HTA bodies, public payers, and patient groups), and plenary sessions. The breakout discussions focused on three key themes: accountability and collaboration, transparency and reporting, and barriers and solutions, with the goal of identifying practical strategies to reduce delays and promote equitable access to new cancer therapies across Canada. Participants had the opportunity to move between all three breakout groups — allowing them to build on ideas across themes and ensure comprehensive, integrated discussions. This format fostered integrated thinking and a more comprehensive approach to identifying actionable solutions.

Major Findings:

- Post-LOI implementation requires clear accountability across federal, provincial, and territorial stakeholders. Variation in structures, budgets, and administrative capacity contributes to inconsistent timelines. Successful provincial models (e.g., Quebec, Ontario, Nova Scotia) highlight the value of top-down prioritization and dedicated implementation teams.
- Gaps in public reporting limit visibility into timelines from LOI to PLA and first patient treatment. Standardized metrics, a national coordinating body, and public dashboards could improve monitoring, accountability, and resource planning.

[1] https://innovativemedicines.ca/newsroom/all-news/more-than-just-medicines-canadas-innovative-pharmaceutical-industry-is-contributing-to-the-countrys-overall-health/
[2] https://www.conferenceboard.ca/wp-content/uploads/2022/10/access-and-time-to-patient_jan2024.pdf

- Redundant and siloed PLA processes across provinces create inefficiencies. Standardized templates, contract management practices, and integrated implementation teams can streamline timelines.
- Sequential budgeting slows post-LOI decisions. Early alignment of budgets with pCPA negotiations and preparation for infrastructure and implementation needs are essential.
- Limited resources, expertise, and infrastructure, particularly in smaller or rural provinces which affect timely access to complex therapies. Centralized monitoring, shared resources, and targeted support can reduce inequities.
- Performance-based funding models and predictable, transparent timelines incentivize timely implementation, support industry engagement, and encourage sustainable innovation.

Recommendations:

1. Standardize PLA processes across provinces with templates, contract management practices, and integrated implementation teams to streamline timelines.
2. Establish a national coordinating body to collect, track, and publicly report on post-LOI metrics, including time to PLA, time to first patient treatment, and jurisdictional variability.
3. Promote top-down prioritization and dedicated implementation teams within provinces to ensure operational readiness and faster patient access.
4. Implement interjurisdictional agreements and flexible approaches to facilitate equitable patient access, particularly in smaller or resource-constrained provinces.
5. Leverage technology, centralized monitoring, and horizon scanning to anticipate implementation needs, reduce duplication, and improve efficiency.
6. Explore performance-based and risk-sharing funding models to support timely implementation, align incentives, and encourage sustainable innovation.

Hackathon 9 reinforced that delays in the post-LOI phase are multifactorial, spanning governance, transparency, infrastructure, and operational capacity. Addressing these challenges through coordinated national strategies, enhanced reporting, and process standardization is critical to ensuring timely and equitable access to new cancer therapies for all Canadians

1.0 Introduction

1.1 Background

Canadian patients face long, uneven waits to access newly approved cancer treatments through public drug plans. In 2024, the average time from Health Canada regulatory approval to a first provincial listing was 598 days, an improvement from 677 days in 2023, but still slower than 541 days in 2020.[1] A key bottleneck within this pathway is the price negotiation process led by the pCPA price negotiation stage: only 35% of negotiations met the 6.5-month target in 2024, with an 8.35-month average.[2] Even after a successful negotiation and issuance of a LOI, further steps, most notably the jurisdiction-by-jurisdiction PLAs, introduce additional and highly variable delays before patients are treated.

LOI-to-listing timelines vary dramatically across provinces and territories, reflecting differences in structures (cancer agencies vs. ministries), capacity, budgeting cycles, and implementation readiness (e.g., diagnostics and operational resourcing). Illustratively, recent averages cited include ~44 days in Québec versus ~662 days in Prince Edward Island, with Ontario, British Columbia, and Alberta around 169, 168, and 273 days**,** respectively.[3] These disparities translate directly into inequitable access and outcomes and underscore the need to focus specifically on the post-LOI "last mile**"**.

Purpose of Hackathon 9

Building on the outcomes of the previous eight hackathons, Hackathon 9 brought together key stakeholders to examine the LOI-to-listing-to-treatment pathways, with a goal of generating actionable insights and recommendations to enhance system efficiency and equity. The session focused on identifying the critical success factors required to optimize post-LOI processes from the perspectives of multiple stakeholders, including industry, patient groups, public payers, and regulatory agencies. Participants collaboratively explored:

- **Accountability and collaboration** mechanisms to ensure timely PLA negotiations and consistent federal, provincial, and territorial roles
- **Transparency and reporting** strategies to track and publicly share timelines from LOI to PLA to listing and first patient treatment
- **Barriers and potential solutions,** such as concurrent budgeting, implementation teams, interprovincial portability, and digital contracting

Hackathon 9 was a three-hour virtual session moderated by Bill Dempster (CEO, 3Sixty Public Affairs), with opening and closing remarks by Barry Stein (President & CEO, Colorectal Cancer Canada). Approximately 20–30 participants joined the session, including representatives from pharmaceutical manufacturers, patient organizations, government agencies, healthcare and research organizations, and health technology assessment (HTA) professionals. *The detailed agenda for Hackathon #8 is provided in* ***Appendix 1****.*

The session was structured around:

- **Two pre-recorded panel discussions** were shared before the event to provide context on current negotiation processes and innovative practices
- **A live plenary session** to introduce the agenda, review prior hackathon outcomes, and set the stage for the day's objectives
- **Breakout group discussions** segmented by theme (Accountability & Collaboration, Transparency & Reporting, Barriers & Solutions) to explore focused questions
- **Plenary report-outs,** where each group presented key findings and proposed solutions
- **Post-hackathon activities**, including participant surveys and the development of a comprehensive report summarizing insights and recommendations

2.0 Pre-Recorded Panel Discussions

A complete list of panellists and their affiliations is available in ***Appendix 2****.*

2.1 Panel Discussion 1

Title: Reimagining the Post-LOI Process: Innovative Solutions for Improving Access to Cancer Treatments
Panel Format: Pre-recorded session for Hackathon 9
Moderator: Bill Dempster, President, 3Sixty Public Affairs
Panelists:

- Dr. Nigel Rawson, Pharmacoepidemiologist and Pharmaceutical Policy Researcher (Senior Fellow, Macdonald-Laurier Institute; Senior Fellow, Fraser Institute; Affiliated Scholar, Canadian Health Policy Institute)
- Eddy Nason, Director, Health Knowledge Area, The Conference Board of Canada
- Alexandru Dobrescu, Senior Research Analyst, Innovative Medicines Canada

Objective

This pre-panel discussion introduced LOI phase in Canada's oncology drug access pathway. The session examined why post-LOI activities are a persistent source of delay, how jurisdictional differences contribute to variable timelines and listing rates, and which practical measures and governance options could accelerate listings and improve equity for patients across provinces and territories.

1. What the Post-LOI Phase Is and Why It Matters

- **Definition and place in the pathway:** After Health Canada authorization, HTA and price negotiation via the pCPA, a successful LOI sets out negotiated listing terms. However, the LOI is not a commitment to list. Provinces and territories must still finalize PLAs and operationalize access on their formularies.
- **Multiple decision-makers:** Canada's federated structure means drug funding decisions rest with provincial/territorial public drug plans or cancer agencies. This creates variation in capacity, prioritization, and implementation steps after the pCPA negotiation.
- **Why delays occur:** Additional provincial assessments, province-specific terms, and local budgeting steps can extend timelines beyond pCPA targets. Smaller jurisdictions may face resource constraints that prolong contracting and operational readiness.

2. Effects on Patient Access and Equity

- **Timeliness versus completeness:** Faster provinces may list a smaller proportion of negotiated products, while others achieve broader coverage but more slowly. Listing does not automatically translate to patient access when criteria are highly restrictive or delivery capacity is limited.
- **Infrastructure and geography:** Even when a therapy is listed, access depends on delivery capacity and clinical expertise, which may be concentrated in major centres. Patients in rural or smaller regions may experience additional delays.

3. Jurisdictional Differences and Accountability

- **Variation by province/territory:** Panellists noted substantial differences in post-LOI timelines and approaches. Quebec is often quicker to operationalize listings; Atlantic provinces have demonstrated recent improvements following targeted funding.
- **Decision ownership:** Accountability for final funding decisions resides with provincial drug plan managers and cancer agencies. Provinces may deprioritize additional products

in a class if one therapy is already funded, contributing to uneven uptake of subsequent options.

- **Budget processes**: Some jurisdictions implement products in tranches aligned to fiscal cycles, which can delay activation even after an LOI is in place.

4. Data Signals on Timelines, Targets, and Listing Rates

- **Performance against targets:** Publicly visible figures indicate frequent exceedance of pCPA decision and negotiation targets, adding time before provinces can proceed to PLAs. Median HTA timeframes and post-LOI periods often surpass stated benchmarks.
- **Oncology versus non-oncology:** Oncology products generally progress somewhat faster than non-oncology therapies, although differences vary by year and sample size.
- **Listing rates by region:** Western provinces and Ontario tend to have higher listing rates for products that reach LOI, while rates in Atlantic provinces have historically been lower but are improving.

5. Key Bottlenecks in the Post-LOI Process

- **Sequential steps:** Regulatory review, HTA, and pCPA negotiations frequently occur in sequence rather than in parallel, extending total time to access.
- **Re-assessment at the provincial level:** Additional jurisdictional reviews after pCPA can duplicate effort and add delay.
- **Capacity constraints:** Smaller jurisdictions may lack specialized contracting resources and implementation capacity to finalize PLAs quickly.
- **Operational activation:** After a PLA is signed, formulary updates, clinical criteria, site readiness, and e-prescribing/administrative enablement can add further time.

6. International Reference Points and Practices to Consider

- **Implementation obligations:** In England and Wales, NICE decisions are accompanied by obligations for local implementation within defined timeframes, which reduces the post-negotiation lag.
- **Embedding research within care:** The UK's national health research structures (e.g., NHS-aligned research programs) support a pro-innovation posture and more rapid adoption of new therapies.
- **Early access mechanisms:** Several systems provide provisional access while HTA and pricing processes conclude, with later adjustments to price or criteria.

7. Practical Opportunities and Governance Options

- **Parallel processing:** Increase use of parallel or overlapping steps—such as aligned regulatory/HTA review and earlier initiation of pCPA discussions where appropriate—to shorten overall timelines.
- **Shared capacity:** Establish mobile or centralized contracting and implementation support that smaller jurisdictions can draw upon to finalize PLAs and operational details more quickly.
- **Transparency on timelines:** Clarify and monitor post-LOI milestones and publish time-to-activation metrics by jurisdiction to identify and address systemic lags.
- **Pan-Canadian expectations:** Explore whether the pCPA Memorandum of Understanding could include non-binding expectations or service-level targets for time-to-listing following a completed negotiation, while respecting provincial decision authority.
- **Early budgeting signals:** Align fiscal planning with anticipated LOIs to reduce lag between agreement and activation, especially in jurisdictions that batch implementations.

8. Ideas to Test at Hackathon 9

- **Time-bound commitments:** Consider model language that encourages listing within a defined period (e.g., 30–90 days) after a completed pCPA negotiation, with transparent reporting.
- **Criteria harmonization:** Identify areas where alignment of clinical criteria across jurisdictions would prevent re-litigation and speed activation.
- **Access readiness checklists:** Develop standard provincial checklists for post-LOI operational steps (formulary updates, criteria communication, site enablement, data capture) with target durations.
- **Capacity exchange:** Pilot a shared expert pool to assist smaller jurisdictions with contracting and implementation.
- **Early access pilots:** Where appropriate, define controlled early access models that transition to standard funding once HTA and pCPA steps are finalized.

Conclusion

Panellists underscored that the LOI represents negotiated terms rather than a binding commitment to list, and that the decisive delays often occur during provincial activation. Variability in capacity, budgeting processes, and additional provincial steps contributes to inequitable

timelines across Canada. Concrete opportunities exist to compress the post-LOI period through parallel processing, shared contracting capacity, clearer expectations for time-to-listing, and standardized operational playbooks. Implementing these measures would support faster and more equitable access to cancer treatments for patients across provinces and territories.

2.2 Panel Discussion 2

Title: Unpacking the Post-LOI Bottleneck: Delays, Drivers, and Opportunities for Change
Panel Format: Pre-recorded session for Hackathon 9
Moderator: Bill Dempster, President, 3Sixty Public Affairs
Panelists:

- Judith Glennie, President, J.L. Glennie Consulting Inc.
- Sang Mi Lee, Executive Director, MORSE Consulting
- Alex Chambers, Senior Market Access Manager, Bayer Inc.

Participant (patient-leader perspective): Barry Stein, Colorectal Cancer Canada

Objective
This session examined the “last mile” of Canada’s oncology access pathway—what happens after a pCPA LOI is reached and why patients still face delays before funded access. Panellists clarified what the LOI does and does not do, described jurisdictional variation and implementation challenges, and outlined practical measures to shorten the time from LOI to listing and from listing to patient use.

1. **What the LOI is and what it is not**

- **Nature of the LOI:** An LOI reflects negotiated pan-Canadian terms (confidential net price and high-level funding parameters). It is **not** legally binding. Each province/territory must execute its own PLA or equivalent contract to activate funding.
- **Contents and complexity:** Pricing terms are relatively consistent; clinical criteria can be the main source of back-and-forth. Alignment with HTA language is common, but not universal, and prior provincial criteria in a class can shape final wording.
- **Multiple layers beyond the contract:** A PLA covers payment and criteria; separate health-system work (testing pathways, site readiness, staffing, training, e-prescribing, ICU contingencies for certain therapies) determines whether clinicians can actually use the drug.

2. **Why timelines vary after a LOI is issued**

- **Budgeting and fiscal cadence:** Some jurisdictions stage listings based on available headroom, creating batch activations and variable lag from LOI to PLA.
- **Different starting points:** Provinces that begin implementation planning at initial HTA **or** during pCPA **move faster afte**r LOI. Where planning waits until LOI, timelines lengthen.
- **Structural differences:** Cancer-agency provinces often coordinate earlier across clinical and operational teams. Larger provinces can still be slower if responsibilities are fragmented.
- **Jurisdictional signals noted by panellists:** Quebec often converts LOIs to PLAs rapidly and probes implementation needs during review; Ontario has recently reduced LOI→PLA timelines; Alberta timelines have lengthened; PEI has at times been unable to list due to budget constraints.

3. **Data points highlighted in the discussion**

- **Median LOI→PLA timing:** For oncology, a typical median is approximately three to three-and-a-half months**,** with wide ranges by product and province. Additional time is required from PLA to first patient treated.
- **Listing vs. access:** A fast PLA does not guarantee timely patient use when criteria are restrictive or when delivery capacity (e.g., ICU back-up, specialized administration) is not ready.

4. **Implementation readiness: the core bottleneck after PLA**

- **Operational enablement:** Companion diagnostics, biomarker workflows, site training, and process changes frequently sit outside PLA scope and can delay first use.
- **Information flow:** Regional cancer leaders and hospital teams may learn of funding decisions late, limiting their ability to prepare.
- **Patient perspective:** For precision therapies that add months of survival, weeks lost to system readiness translate directly into foregone benefit; equity gaps widen for patients far from major centres.

5. **Accelerated pathways: promise and limits (case example)**

- **Time-limited reimbursement pilots:** Recent coordinated pilots enabled earlier price negotiations and rapid LOI→listing in Ontario for a complex lymphoma therapy.

- **Remaining constraint:** Despite faster funding decisions, **health-system implementation** (training, critical-care back-up, institutional processes) still took months, underscoring the need to run operational readiness **in parallel** with review and negotiation.

6. Jurisdictional practices and emerging themes

- **Quebec:** Faster LOI→PLA conversion, with earlier probing of implementation details during review; however, overall HTA stringency can affect which products enter the funnel.
- **Cancer-agency provinces:** Integrated structures can enable earlier, cross-functional planning.
- **Smaller systems:** Nimble decision pathways and closer proximity of decision-makers can offset resource constraints when leadership is aligned.

7. Opportunities to shorten the "last mile."

- **Start earlier, together:** Initiate implementation planning at **initial HTA** or **during pCPA** (not post-LOI). Include cancer centre operations, diagnostics leaders, pharmacy, and critical-care representatives.
- **Run steps in parallel:** Align PLA drafting, fiscal planning, clinical-criteria finalization, site enablement, and testing logistics to compress the path from LOI to first administration.
- **Clarify expectations:** Establish pan-Canadian, public-facing **service-level expectations** or targets for LOI→listing and listing→patient use, while respecting provincial authority.
- **Transparency tools:** Maintain a public dashboard that tracks time to PLA and time to first patient treated, by jurisdiction and product (oncology).
- **Implementation checklists:** Standardize provincial "go-live" checklists (criteria dissemination, testing availability, order sets, training, ICU contingency, e-prescribing build) with target durations.
- **Direct engagement:** Encourage manufacturers to brief regional operational leaders early for complex therapies; improve "last-mile" communications from drug plans to delivery sites.
- **Distinguish two clocks:** Track and manage **LOI→PLA** and **PLA→first patient** as separate intervals with accountability for each.

8. "If You Had a Magic Wand…" (Panellists' Emphases)

- Make early implementation planning the norm across the pathway; fix the “broken telephone” between funding decision-makers and delivery teams.
- Increase transparency via a public dashboard and illuminate time-to-patient (not just listings).
- Create shared expectations for what an LOI should mean for patients, time-bound provincial commitments where feasible, accompanied by clearer accountability.

Conclusion

Panellists agreed that the LOI is only a waypoint: patients feel delays most acutely in the conversion to PLA and, especially, the operational activation that follows. Jurisdictional variation stems from budget timing, planning start points, and structural differences in cancer program organization. The most actionable levers are earlier cross-functional planning, parallel processing of post-LOI tasks, clear time expectations for both LOI→PLA and PLA→patient, and better visibility through public tracking. Embedding these practices would reduce avoidable delay and support more timely, equitable access to cancer treatments across Canada.

3.0 Breakout Group Discussions

3.1 Breakout Group 1: Accountability and Collaboration

This breakout examined roles and responsibilities across the post-LOI pathway and explored governance and collaboration mechanisms to shorten LOI → PLA → listing timelines while safeguarding equity across jurisdictions.

Shared Accountability, Scope of Roles, and Provincial Variation

- All stakeholders—Health Canada, CDA/INESSS, pCPA, provincial ministries, cancer agencies, clinicians, patient leaders, and industry—play a role in enabling timely access.
- Industry is responsible for early, comprehensive pipeline briefings; the public system is ultimately accountable for patient access.
- Distinction between “time to PLA” and “time to patient”: delays can occur post-PLA due to implementation requirements (e.g., diagnostics, staffing, operational resourcing) that fall under different funding streams.
- Wide provincial variation exists in PLA leadership, processes, and the influence of budget cycles. Non-legally binding LOIs mean provinces may adjust timelines or terms due to fiscal constraints.

Federal, Provincial, and Territorial Roles—Signals, Readiness, and Exemplars

The group explored how federal signals could better translate into reimbursement readiness:

- **Carry regulatory/HTA signals through to reimbursement.** Participants asked whether Health Canada priority reviews and Project Orbis designations could be recognized within HTA and pCPA and then propagate to provincial implementation plans, improving "last-mile" readiness.
- **International collaboration models.** Elements from EU collaboration and Project Orbis were raised as references for coordination across multiple decision bodies on compressed timelines.
- **Provincial exemplars.**
    - **Ontario**: process improvement methods such as Lean Six Sigma were cited as relevant to streamlining.
    - **Nova Scotia**: noted as having made recent gains on timelines; participants flagged it as an instructive case to study further.
    - **Québec**: speed was linked to a policy-level commitment embedded in the province's life sciences strategy**,** co-created across ministries (Economy/Innovation and Health), positioning Québec to be among the first to list, while still subject to budget realities.

Collaboration Mechanisms to Reduce Duplication and Address Capacity Gaps

Participants recommended concrete collaboration approaches to reduce interprovincial variability and manage capacity constraints:

- Formal pan-Canadian implementation framework. Define shared timelines, role clarity, milestones, and reporting requirements so that jurisdictions can work from a common playbook.
- Resource pooling for smaller jurisdictions. The Atlantic provinces were cited as candidates for pooling patients and expertise, avoiding duplication and leveraging shared capacity instead of each building parallel systems.
- Interprovincial portability. Explore agreements that allow patient access out-of-province when home provinces lack capacity. Participants referenced CAR-T arrangements as an

analogy and discussed “securing treatment slots” in higher-capacity centres for residents of smaller provinces.

- Compassionate access pathways. Québec’s approach was highlighted; participants cautioned that a “one-size-fits-all” model may not be feasible, so portability and compassionate paths should coexist as pragmatic interim solutions.
- Rolling/graduated submissions. Consider graduated or rolling submissions to allow earlier, parallel work across HTA/pCPA/provincial implementers, so implementation “ducks” are lined up in advance of final negotiations.

Throughout, equity was a guiding principle. Participants emphasized that failure to list post-LOI directly harms patients, reinforcing the case for portability and shared-capacity strategies.

Governance and Oversight—From Intent to Commitment

To strengthen execution discipline, the group proposed governance levers:

- **Embed implementation commitments in pCPA frameworks.** Drawing on the bulk purchasing discussion, participants asked whether participation in pCPA should entail a commitment to list under agreed terms—reframing LOI from “intent” to mandated follow-through and potentially requiring jurisdictions to cede limited authority to ensure consistency.
- **Create a coordination body for implementation.** A national or pan-provincial implementation coordination function could oversee rollouts, minimize duplication (templates, contracting, workflows), and maintain visibility of system readiness (e.g., diagnostics, workforce, site activation).
- **Legislative and public-accountability levers.** Participants pointed to successful top-down models (e.g., the UK NHS) and suggested exploring legislative mechanisms or public reporting/advocacy that make commitments visible and actionable.
- **Economic framing of performance.** One discussant suggested treating healthcare as an economic driver**,** aligning metrics and incentives (e.g., time-to-listening) with broader economic and societal value from earlier access to effective therapies.

Practical Implications for “Last-Mile” Readiness

The discussion converged on several operational implications:

- Plan implementation in parallel with CDA/INESSS review and pCPA negotiation (not sequentially).
- Anticipate non-drug enablers early (diagnostics, staffing, site readiness) and budget for them.
- Clarify who does what, when—from pipeline briefings and horizon scanning to contracting and activation.
- Use shared tools and templates to cut cycle time and reduce rework across jurisdictions.

In sum, participants called for clearer role definition, policy-level commitments that convert LOI intent into actionable obligations, and creative collaboration models (portability, pooled capacity, rolling submissions) to minimize duplication, overcome resource constraints, and advance equity in the post-LOI phase.

3.2 Breakout Group 2: Transparency and Reporting

This breakout explored how better measurement, public reporting, and performance management can reduce time from LOI → PLA → provincial listing → first patient treated. Participants assessed legacy tracking efforts, defined priority metrics, considered potential stewards, and discussed the design and resourcing of a pan-Canadian dashboard that is useful to patients, clinicians, administrators, and decision-makers.

Problem Framing and Legacy Tracking

- Legacy precedent (pCODR): When the pan-Canadian Oncology Drug Review (pCODR) operated, it tracked and reported jurisdictional funding decisions. Participants questioned why this ceased after the transition to Canada's Drug Agency (CDA) and recommended reviving such reporting under the current system.
- Current visibility gaps: Patient organizations and many stakeholders lack post-LOI information. With 13 jurisdictions plus the federal government, manually verifying status is onerous and error-prone. Without a single reference point, transparency is inconsistent, and delays remain opaque to the public and providers.
- Purpose of renewed reporting: Systematic, timely reporting would allow stakeholders to monitor performance, identify bottlenecks, and benchmark jurisdictions, enabling targeted solutions rather than anecdotal workarounds.

What to Measure: Core Metrics and Levels of Detail

Participants converged on a practical set of priority metrics that balance feasibility with usefulness:

1. **Milestone Timers**
    - LOI → PLA signed (per jurisdiction).
    - PLA signed → First formulary listing.
    - Listing → First patient funded and treated (recognized as harder to capture but highly valuable).
2. **Status Flags (Yes/No)**
    - Has the product completed pCPA negotiations?
    - Is the product listed on at least one formulary (first listing)?
    - Is the product funded in each specific jurisdiction?
3. **Statistical Summaries**
    - Both average and median time-to-events by province/territory (median avoids skew; average reflects overall burden).
    - Time to list is identified as the “big one” for consistent cross-provincial comparison.
4. **Contextual Indicators (where feasible)**
    - Diagnostic/implementation readiness variability (e.g., companion diagnostics, site readiness) is acknowledged as important but harder to standardize; note these as explanatory contexts where they materially affect timelines.

Data Sources, Linkage Challenges, and Publication Gaps

- Traceability: CDA project numbers can be tracked through to LOIs, creating a backbone for linking end-to-end.
- Public formulary pages: Most provinces publish formulary decisions, but some do not (e.g., Cancer Care Manitoba, Nova Scotia, among others), undermining completeness.
- Commercial data (e.g., IQVIA): Tracks certain access signals but is subscription-based and not a public solution.
- CIHI Pharmaceutical Data Tool: Useful but requires knowing product names, is chart-based, and publishes annually; it does not track CDA project numbers that would enable clean linking from HTA to LOI to listing.
- Interpretation caveat: Listing ≠ access. Even after listing, post-PLA implementation may lag; the dashboard should, where possible, distinguish listing from first patient funded/treated.

Stewardship: Who Should Measure and Report?

Participants discussed options and division of responsibilities:

- Jurisdictions/Payers: Many argued payers should be responsible for measuring and reporting time to public listing, supported by collaboration with administrators and clinicians to ensure data availability and accuracy.
- National Steward Options:
    - pCPA (already tracks post-HC/HTA timelines).
    - Canada's Drug Agency (CDA) (system coordination role).
    - PMPRB (data-monitoring mandate).
    - CIHI (could "wrap up" jurisdictional data if linkage and cadence issues are addressed).
    - CACC-style report card (independent multi-stakeholder evaluation model).
    - Multi-stakeholder forum (to set metrics and oversee adherence).
- Advocacy and obligation to report: Participants suggested that the pCPA should have an obligation to report post-LOI status. They also stressed that provinces must publish formulary decisions and, crucially, transparently report when there is no intention to list—so patients and clinicians receive clear signals and expectations.

Dashboard: Design Principles and User Experience

Participants articulated design requirements to ensure adoption and practical value:

- Lay-friendly, filterable, and concise. Avoid a "massive data table." Provide simple filters (e.g., province/territory, drug, indication, status, dates).
- Real-time (or near-real-time) updates rather than annual snapshots, to support timely decision-making for patients and clinics.
- Coverage and formulary clarity. Show what is available, when it became available, and under which formulary; include a clear indication of pCPA completion, first listing, and jurisdictional funding status.
- Statistical views. Present both median and average time-to-list by jurisdiction, with trend views over time.
- Transparency notes. Indicate data limitations, non-publishing jurisdictions, and differences in implementation policies (e.g., provinces that wait for full implementation readiness before listing).
- Patient-centric exemplars. The CBCN "MedSearch" tool was cited as a concrete example of what patients value—clear, accessible, province-specific funding information. Participants felt an oncology-wide analog would be highly beneficial.

Resourcing, Governance, and Buy-in

- Resourcing is the binding constraint. Participants repeatedly observed that the chief barrier is capacity and sustained funding, not the visibility of delays.
- Buy-in strategy: A dashboard should not be "build it and they will come." It needs:
    - Defined governance (who owns accuracy, cadence, and change control).
    - Formal participation by provinces/payers (standard files/feeds).
    - Standard definitions and shared submission templates to reduce burden.
    - A feedback loop so data leads to action (e.g., targeted support for lagging jurisdictions).
- National vs. provincial locus: Some favoured a national body (for consistency and comparability). Others emphasized provincial accountability—jurisdictions must explain what is behind their numbers and how they will improve. Both views agreed on the need for clear roles and accountability pathways.

Role for Canadian Cancer Society (CCS) and Other Partners

- CCS dashboard concept: A CCS representative outlined a scoped, pragmatic dashboard that could start with basic elements (coverage by province, dates, formulary type), be lay-friendly, and expand over time.
- Consultation required: This would require broad consultation to ensure it meets the needs of patients, providers, and drug access navigators and does not duplicate existing efforts.
- Ecosystem fit: Participants were enthusiastic about CCS's potential role and encouraged continued exploration and alignment with pCPA/CDA/CIHI efforts.

Cancer Centre Visibility and Pipeline Coordination

- Visibility gaps: Many cancer centres lack clarity on post-LOI timelines and funding agreements, complicating clinical and operational planning.
- Jurisdictional variation: Western cancer agencies (e.g., Saskatchewan) were cited for stronger coordination with Ministries; some western provinces will not list until all implementation issues are in place—a policy choice that lengthens timelines but reduces downstream friction.
- **Mechanisms to improve coordination:**
    - Include cancer centres in pipeline briefings and resource planning.

- Encourage industry pipeline briefings to be shared in a structured way with implementers, enabling earlier staffing, diagnostic capacity planning, and site readiness.

Policy and Advocacy Guardrails

- Transparency with purpose: Participants asked, “Should all data be public in the absence of change or improvement?” The consensus was that data must be public, but jurisdictions should be accountable for explaining the drivers behind their numbers and how they will act on them.
- Standards and guidelines: Once core data are consistently available, national standards and guidelines can be built on top to drive quality and equity.

Near-Term Recommendations

1. Stand up a Pan-Canadian Metrics Working Group (pCPA, CDA, CIHI, provinces, CCS, patient reps) to finalize metric definitions, data flows, update cadence, and governance.
2. Pilot a Public Dashboard with two to four jurisdictions to prove data pipelines (LOI → PLA → listing; Y/N status; average/median time-to-list) and publication cadence, then scale nationally.
3. Re-establish Jurisdictional Reporting of formulary decisions as a minimum requirement, including explicit “no intention to list” signals where applicable.
4. Link to CDA Project Numbers across the workflow to enable end-to-end traceability from HTA to LOI to listing.
5. Embed a Use-to-Improve Loop: Pair public reporting with support for lagging jurisdictions (technical assistance, shared templates, capacity-building) so data directly drives performance gains.

In sum, participants endorsed a pragmatic, patient-centred transparency agenda: standard metrics, public and timely reporting, clear stewardship, and a fit-for-purpose dashboard that is simple to use, credible, and action-oriented—with resourcing and governance explicitly addressed from the outset.

3.3 Breakout Group 3: Barriers and Solutions

This breakout group focused on identifying the structural, resource-related, and jurisdictional barriers that create variability in timelines following an LOI and explored potential solutions to

address them. Discussions highlighted both systemic bottlenecks and opportunities for pragmatic reforms, ranging from process redesign to digital tools and collaborative mechanisms.

Structural and Operational Barriers

Budgeting and Fiscal Cycles

- Budget alignment was described as the “single biggest barrier.” Many provinces finalize drug budgets only after pCPA negotiations, forcing sequential steps rather than parallel planning.
- Without concurrent budgeting, even when LOIs are signed, patients may wait for the next budget cycle before funding is allocated.
- This lag disproportionately affects smaller jurisdictions with tighter fiscal envelopes and less flexibility to absorb unplanned costs.

Administrative and Human Resource Constraints

- Ministries and cancer agencies often lack dedicated implementation teams to translate LOIs into operational readiness.
- Staff shortages in contracting, policy, and clinical operations contribute to delays.
- Participants noted that some jurisdictions require significant administrative effort to “get ducks in a row” before launching a new therapy, particularly for complex modalities.

Infrastructure and Implementation Readiness

- Diagnostics and companion tests were frequently cited as chokepoints. Provinces cannot list drugs until lab capacity, testing equipment, and pathways are ready.
- Site readiness issues (staff training, physical infrastructure, IT systems) create additional delays, especially in smaller or rural jurisdictions.
- Operational bottlenecks mean that even when a drug is listed, patients may not immediately access it due to implementation lags.

Geographic Inequities and Jurisdictional Size

- Smaller provinces face capacity limitations (financial, administrative, clinical) that lengthen timelines.
- Larger provinces, by contrast, sometimes have complex bureaucracies that also slow decisions, though they may eventually achieve economies of scale.

- The group agreed that jurisdiction size alone does not determine efficiency; rather, it is how resources and processes are organized.

Industry-Specific Challenges

- Industry participants acknowledged delays can also stem from internal readiness (contracting, evidence generation, or rollout planning).
- They expressed willingness to coordinate earlier with governments and cancer agencies to facilitate smoother implementation, provided expectations are clear.

Proposed Solutions

Concurrent Budgeting and Planning

- Budgeting should occur in parallel with pCPA negotiations, rather than sequentially.
- This would allow funding allocations to be ready as soon as LOIs are finalized.
- Participants suggested formal mechanisms to embed concurrent budgeting into federal-provincial processes, ensuring that fiscal approvals align with negotiated terms.

Implementation Teams and Horizon Scanning

- Establish provincial or regional implementation teams tasked with preparing operational requirements (diagnostics, workforce, site readiness) during CDA/INESSS review and pCPA negotiations.
- These teams would coordinate across ministries, cancer agencies, hospitals, and labs to ensure “day one readiness.”
- Horizon scanning should be expanded, with structured pipelines provided by industry and CDA, enabling early preparation across jurisdictions.

Digital Tools and Standardized Processes

- Participants proposed digital contracting platforms to reduce manual administrative work.
- A national formulary management tool could provide real-time updates on listing and funding status, supporting both administrators and patients.
- Shared templates for contracts and agreements would reduce duplication and speed up PLA finalization.

Outcomes-Based and Innovative Agreements

- Outcomes-based agreements were seen as a mechanism to address payer concerns and enable earlier access with managed risk.
- Jurisdictions could pilot innovative PLA models to shorten negotiations and allow for rapid implementation while evidence continues to build.

Interprovincial Collaboration and Portability

- Smaller provinces could pool resources or share capacity for implementation, reducing duplication of effort.
- Portability agreements could allow patients to access therapies in larger provinces if their home jurisdiction lacks capacity, with reimbursement reconciled between governments.
- Examples like CAR-T therapy and cross-jurisdictional arrangements were cited as models to adapt.

National Standards and Pharmacare Implications

- Participants raised the possibility of developing national standards for post-LOI implementation, creating a consistent baseline for timelines and processes.
- The group acknowledged that broader reforms, such as national pharmacare, could address structural inequities, though this would require significant policy shifts and political will.

Illustrative Provincial Practices

- **Québec**: Benefits from a policy-level life sciences strategy that mandates rapid listing, providing an instructive model of political commitment translating into faster access.
- **Ontario**: Process improvements through Lean Six Sigma methodologies could be applied to PLA execution and implementation workflows.
- **Nova Scotia**: Highlighted as having improved timelines recently, making it a useful case study for effective practices in a smaller jurisdiction.

Cross-Cutting Insights from the Discussion

1. **Equity as a guiding principle**: Patients in smaller or under-resourced provinces should not wait significantly longer than those in larger provinces.
2. **Reduce duplication**: Shared templates, digital platforms, and interprovincial pooling can free capacity and shorten cycles.

3. **Advance readiness in parallel**: Budgeting, diagnostics, staffing, and contracting should all move forward **concurrently** with HTA and pCPA processes.
4. **Policy-level commitments matter**: Jurisdictions with clear political mandates and strategic frameworks (e.g., Québec) consistently move faster.
5. **Balance ambition with feasibility**: Participants stressed the need for incremental**, testable reforms** (e.g., pilot digital tools, outcomes-based agreements, or regional collaboration) rather than waiting for wholesale system change.

In summary, Breakout Group 3 concluded that post-LOI delays are driven by a combination of budgeting lags, capacity gaps, and operational readiness barriers. Solutions centred on concurrent budgeting, early implementation planning, digital and standardized processes, outcomes-based agreements, and interprovincial collaboration. While broader reforms like national pharmacare may ultimately be needed, near-term, pragmatic steps can meaningfully shorten timelines and improve equity for patients awaiting cancer therapies.

4.0 Conclusion

Hackathon 9 highlighted the complexities and persistent challenges that characterize the post-LOI phase of drug access in Canada, while also surfacing pragmatic and forward-looking solutions that could accelerate progress. Across all discussions, participants acknowledged that although the LOI is intended to be a major milestone in the pCPA process, it does not, in practice, ensure timely or equitable patient access. Instead, jurisdictional variation, resource and budgetary constraints, and the absence of consistent accountability and reporting mechanisms continue to produce delays that can stretch from months to years.

A cross-cutting theme emerging from all three breakout groups was the need for greater accountability and commitment within and across provinces and territories. Participants emphasized that the non-binding nature of LOIs undermines their impact and allows jurisdictions to defer or alter implementation timelines, often citing fiscal limitations. The absence of a pan-Canadian governance or oversight structure leaves decisions fragmented, with responsibility and accountability diffused across ministries, cancer agencies, and other provincial actors. This fragmentation has direct consequences for patients, who may face inequitable access depending on their province of residence.

Equity and portability surfaced repeatedly as fundamental principles that should underpin system reform. The notion that patients in smaller or resource-limited provinces might be denied timely access while others progress more quickly was seen as unacceptable. Innovative solutions such as interprovincial agreements, compassionate access frameworks, or mechanisms to “secure spots” for patients across provinces were raised as ways to address these disparities. These ideas reflect a broader recognition that national collaboration, rather than siloed provincial approaches, will be required to ensure Canadians benefit equitably from advances in cancer treatment.

Participants also identified the critical importance of transparency and real-time reporting**.** Without clear data on time to listing, PLAs, and patient access, it is difficult for patients, providers, and policymakers to understand the scope of delays or hold decision-makers accountable. Proposals ranged from reinstating earlier tracking mechanisms that existed under pCODR to developing new national dashboards managed by organizations such as CIHI, CCS, CDA, or pCPA. Patient organizations highlighted how access to user-friendly, province-specific data, similar to CBCN’s MedSearch initiative, which empowers patients and providers and can create public pressure for

improvement. However, the discussions underscored that measurement alone is insufficient; data must also drive change by being linked to commitments, accountability frameworks, and resource allocation.

Another unifying insight was the recognition that budgeting and system readiness must be integrated into the negotiation process rather than addressed sequentially. Current practices often leave provinces scrambling to align budgets, infrastructure, and human resources after an LOI is issued, which results in extended delays. Participants proposed concurrent budgeting alongside negotiations, the creation of dedicated implementation teams within provincial health ministries, and early pipeline monitoring to anticipate needs such as companion diagnostics or specialized infrastructure. These proposals reflect a shift toward a proactive rather than reactive model of drug implementation.

Finally, Hackathon 9 reinforced the risks of duplication and inefficiency across provinces, which waste limited resources and contribute to inequities. Participants pointed to opportunities for harmonization, knowledge sharing, and even national pharmacare-style approaches to reduce redundancy and align decision-making. International examples such as the UK's NHS and Project Orbis were cited as models that Canada could adapt to support timelier and more predictable access.

Taken together, these discussions demonstrate that the barriers to post-LOI implementation are not insurmountable, but they require a rethinking of how Canada organizes accountability, transparency, resourcing, and collaboration. The solutions proposed—pan-Canadian implementation frameworks, interprovincial agreements, national dashboards, dedicated implementation teams, and concurrent budgeting—are not theoretical but actionable steps that can be piloted and scaled.

In conclusion, if Canada does not address the inefficiencies of the post-LOI phase, patients will continue to face inequitable and delayed access to life-saving cancer therapies. By contrast, if the innovations and commitments identified in this Hackathon are acted upon, Canada can move toward a system that delivers faster, fairer, and more predictable access to new treatments, closing the gap with international peers and fulfilling the promise of equitable cancer care for all Canadians.

5.0. Post-Event Survey Report

Overview

A post-event survey was distributed to participants following Hackathon 9 to collect feedback on accountability for post-LOI implementation, measurement and reporting responsibilities, preferred metrics, and priorities for future hackathons. Eight participants completed the survey, representing a range of perspectives across the cancer drug access ecosystem.

1. Participant Roles

- 50% of respondents identified as industry leaders.
- 25% identified as patient group representatives.
- Other roles included HTA leaders (12.5%), researchers (12.5%), clinicians (12.5%), and consultants (12.5%).
- No respondents identified as government or payer representatives.

2. Accountability for Timely PLAs

When asked who should be responsible and accountable for ensuring timely PLAs across provinces and territories:

- 50% selected payers representing jurisdictions.
- 37.5% selected all of the above, including payers, industry, and HTA bodies.

These results indicate that payers are viewed as the main decision-makers, while many respondents recognized shared accountability across the system.

3. Measuring and Reporting Timelines

On the question of who should be responsible for measuring and reporting the time from LOI to public listing:

57.1% identified HTA organizations such as CDA, INESSS, or the pCPA.

42.9% selected all of the above, which includes industry, payers, HTA bodies and Canadian Institute for Health Information (CIHI).

4. Suggested metrics to effectively measure time from LOI to public listing

Survey respondents proposed a wide range of metrics to monitor progress from LOI to public listing. These included end-to-end measures such as the total time from NOC to public listing and the time from Health Canada approval to when a drug is available to at least half of public drug

plan beneficiaries. Key milestones identified for tracking included HC approval to HTA submission and recommendations, HTA to LOE, LOE to LOI, LOI to negotiation start, agreement-in-principle to signed PLA, and PLA to jurisdictional approval and formulary listing. Respondents also recommended monitoring LOI to each F, P, T listing date with criteria, as well as the interval from listing to first patient access. Performance indicators suggested included the number of provinces listing within 90 days of LOI, the percentage of population covered within 90 days, adoption rates, and variation across provinces. Some respondents also emphasized capturing patient impact, such as survival outcomes, out-of-pocket costs, delayed return to work, and patient-reported burden. If only one metric were feasible, LOI to PT listing date was considered the most important, with additional granularity possible by tracking LOI to PLA, PLA to listing, and listing to first patient access.

5. One Change to Improve Timeliness

When asked what single change would most improve the post-LOI process, participants emphasized the need for greater predictability, earlier planning, and elimination of unnecessary duplication. Suggestions included securing public budgets in advance of LOI implementation, removing additional provincial reviews, and adopting standardized, time-bound service level agreements across jurisdictions to improve accountability and reduce interprovincial variation. Several respondents called for Health System Readiness planning, with payers, cancer agencies, and manufacturers working together before HTA recommendations and LOIs are finalized, so that patients can gain timely access once agreements are in place. Others recommended making processes pan-Canadian rather than jurisdictional, aligning timelines with CDA reviews, and requiring earlier review of implementation logistics, budgets, and decision-making criteria to avoid sequential delays. Collectively, these responses underscored the importance of transparency, consistency, and proactive preparation in accelerating patient access.

6. Priorities for Hackathon 10

When asked about preferred topics for Hackathon 10, responses were divided across several themes.

- Ontario’s Accelerated Access Pilot was selected by 37.5% of respondents, with comments noting its actionability, scalability, and relevance to current system challenges.
- The use of innovative technologies to improve access was chosen by 25%.

- Examining system barriers with the I2U Readiness Tool and addressing fragmentation and decentralization using a systems theory approach received no direct selections, although free-text responses highlighted fragmentation as a critical underlying issue.
- Other priorities (37.5%) included considering the feasibility of bulk purchasing consultations led by CDA-AMC, as well as reiterations of Ontario's Accelerated Access Pilot and systemic fragmentation as the most urgent topics.

7. Attendance at Hackathon 10

Respondents indicated their availability for Hackathon 10 (November 20, 2025):

- 62.5% confirmed attendance.
- 25% indicated maybe.
- 12.5% indicated they would not attend.

Table 1. Key Themes and Implications

Theme	Implication
Accountability	Payers are viewed as primarily responsible for timely PLAs, although many respondents emphasized shared accountability.
Measurement	HTA bodies and the pCPA were identified as best placed to track post-LOI timelines, with support from other stakeholders.
Metrics	Key milestones include LOI to PLA, PLA to listing, and listing to first patient access. Both average and median times should be reported.
Implementation Challenges	Respondents stressed the need for earlier planning, clear targets, and elimination of duplication in the process.
Future Focus	Ontario's Accelerated Access Pilot and addressing system fragmentation emerged as top priorities for Hackathon 10.

Conclusion

The survey findings reinforce the discussions from Hackathon 9, particularly the importance of clearer accountability, consistent measurement, and transparent reporting of post-LOI timelines. Respondents highlighted the need to capture the full sequence from LOI through to patient access, with both average and median measures to reflect jurisdictional variation.

Recommendations focused on early planning, defined timelines, and reducing duplication, with participants emphasizing that predictability is as important as speed. Looking forward, Ontario's

Accelerated Access Pilot and the issue of fragmentation were identified as key areas for exploration in Hackathon 10.

Appendix 1: Hackathon #9 Agenda

Time Agenda item Lead	Time Agenda item Lead	Time Agenda item Lead
1:10 – 1:15 pm	Opening remarks	Barry Stein
1:15 – 1:25 pm	• Review agenda and highlight purpose and intended outcome. • Roundtable introductions • Review purpose and objectives of Hackathon 9 • Review format and breakout group assignments	Bill Dempster
1:25 –2:25 pm	Breakout groups: 5-6 participants per group will enter their pre-assigned breakout rooms	All
2:25 – 3:15 pm	Group presentations to the plenary (10 mins. per group)	All
3:15 – 3:30 pm	Closing remarks and next steps	Barry Stein
3:30 pm	Session adjourns	All

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

Panel Discussion #1: Reimagining the Post-LOI Process: Innovative Solutions for Improving Access to Cancer Treatments

This panel discussion will explore the post–LOI phase of the drug listing process, with a focus on understanding the root causes of delays and identifying actionable strategies to streamline post-LOI negotiations. Drawing on insights from academics and health economists, the discussion will reimagine this critical phase through innovative, evidence-based approaches aimed at accelerating and improving equitable access to cancer treatments.

Panelists:

- Eddy Nason – Director of the Health Knowledge Area at The Conference Board of Canada
- Nigel Rawson – Pharmacoepidemiologist & Pharmaceutical Policy Researcher, Fraser Institute, Canada
- Alexandru Dobrescu – Senior Research Analyst at Innovative Medicines Canada

Panel Discussion #2: Unpacking the Post-LOI Bottleneck: Delays, Drivers, and Opportunities for Change

This panel will explore the post-LOI phase of the cancer drug listing process — a key stage that often contributes to delays in patient access. We'll dive into the drivers behind these delays and discuss jurisdictional challenges and evidence-based strategies to streamline the process and improve timely, equitable access to cancer treatments across Canada.

Panelists:

- Judith Glennie – President of J.L. Glennie Consulting Inc
- Sang Mi Lee – Executive Director at MORSE Consulting
- Alex Chambers – Senior Market Access Manager, Bayer Inc.

[1] https://innovativemedicines.ca/newsroom/all-news/more-than-just-medicines-canadas-innovative-pharmaceutical-industry-is-contributing-to-the-countrys-overall-health/
[2] February 2025 Dashboard. pan-Canadian Pharmaceutical Alliance (pCPA). https://www.pcpacanada.ca/sites/default/files/eng/pCPA_Dashboard_February_2025.pdf
[3] Access and Time to Patient: Prescription Drugs in Canada—January 2024. The Conference Board of Canada. https://www.conferenceboard.ca/wp-content/uploads/2022/10/access-and-time-to-patient_jan2024.pdf