OUTPATIENT ONCOLOGY CARE IN FRANCE
LEVERS AND BARRIERS FOR HOME CHEMOTHERAPY

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Paris, 1st November 2016
HOME HOSPITALISATION (HH) FOR CHEMOTHERAPY IS NOT THAT COMMON AND CONCENTRATED IN A FEW FRENCH CENTRES ONLY

➢ Today, HH is quite rare in any therapeutic areas. It only exists in isolated centres and represents ~1% of total hospital care expenditure
  ▪ Availability varies throughout France
    (5 regions generating 50% of the business, discrepancies within regions)
  ▪ Centres rarely function on a for-profit basis
  ▪ With limited chemotherapy services
    ✔ Even if a range of services is available, activity tends to focus on complex dressings, intensive nursing / palliative care and enteral nutrition
    ✔ Chemotherapy comes in 12th position

➢ When considering all hospital stays combined, chemotherapy at home barely represents 3% of HH services, and 0.7% of chemotherapy stays.
  ▪ Chemotherapy at home has a high regional concentration,
    with just 4 regions representing more than 80% of the French national total
  ▪ 3 of 215 authorised centres provide 40% of the national total (number of days):
    Santé Service, APHP, Centre Léon Bérard

➢ Recent signs of change on a national level and in certain regions:
  ▪ A shift towards outpatient treatment
  ▪ Ministerial budget granted to help cover some costs
  ▪ Commitment shown by certain Regional Health Agencies (ARS)
4 regions represent 83% of the HH for chemotherapy.
Due to its perceived complexity, HH is only available for a few chemotherapy drugs

- Organisation and operational procedures within HH centres are vastly different and dependent on
  - Prescribing centres for the choice of products
  - Each HH with specific organisation and procedures (use of Chemo software interface, private/salaried nursing staff, in-house pharmacy or dependent on prescribing centre, etc.)

- The complexity of chemotherapy at home being perceived as high, suitability is limited to a few protocols to enable capitalisation on investment and expertise, and to ensure a regular flow of patients
  - Hematologic malignancies are the most common forms of cancer benefiting from HH (50% of hospital stays) mostly using drugs on the list (Velcade, Vidaza and Mabcampath)

- Until now, HH has ensured that chemotherapy at home is provided with the same quality and safety conditions as for outpatient departments
TODAY THERE ARE FOUR MAIN HH ORGANIZATIONAL MODELS

1. Large multipurpose HHs collaborating with several prescribing centres
   - Santé Service Ile de France
   - APHP

2. HHs as part of a cancer centre, specialised in the management of cancer patients
   (chemotherapy at home, palliative care, transfusions)
   - Léon Bérard (Lyon)
   - Bagatelle (Bordeaux)

3. Multipurpose HHs organised into networks within their regions (same methods of working & protocols)
   - ESCADEM network in Limousin
     - Organised on the impetus of a HEMATOLIM network and the regional health agency,
     - Based on 4 medium-sized HH centres

4. Multipurpose medium-sized HHs offering limited chemotherapy services
   - Wide availability of drugs
   - > 1000 patients / year
   - Flexibility of organisation
   - HH’s own in-house pharmacy & cytotoxic rehabilitation unit (CRU)

   - Wide availability of drugs
   - 1600 patients / year
   - In-house pharmacy & CRU shared w. centre
   - Significant delegation of patient care

   - 3 drugs
   - < 100 patients/ year/ HH
   - Standard protocols
   - Disparate organisation
   - Limited delegation of responsibility

   - 1-2 drugs
   - < 50 patients/ year
   - Limited delegation of responsibility
DECISION CRITERIA FOR HH MIGHT VARY FROM CENTRE TO CENTRE WITH COMMON FEATURES

- Saturation of outpatient departments
- Specific features and skills of the HH in question
- Drug profile (*toxicity, stability, reconstitution*)
- Feedback on experience from the prescribing centre and trust vis a vis the HH organization
- Operational methods & communication between departments and HH
- Patient profiles & selection
- Economic factors
**LEVERS AND BARRIERS FOR THE USE OF HH...**

**Levers encouraging the development of HH**

- *Saturation of outpatient departments*
- Encouragement from regional health agencies (ARS)
- Strength of conviction by a **charismatic coordinator** & vision of certain prescribers
- **Reputation of HH** (proximity, experience, qualifications in oncology, team/ trained nurses)
- **Clear procedures and interfaces**
- Seen as a **solution that is suited to certain drugs and patient profiles** (older patients living a long way from prescribing centres)
- **Drug knowledge** (experience) and usage limitations
- **Economic factors** (cost of drugs)

**Barriers/ concerns which may be significant**

- **Potential loss of business** & resource subsidies
- **Fear of additional, unpaid workload** for the prescribing centre (*e.g. in the absence of onco-haematological expertise within the HH*)
  - Coordination
  - Difficulty in involving GPs/ Family Doctors
  - Response to cases of adverse reaction
- Lack of well defined interfaces (*prescription software, etc.*) **and faith** in HH
- In some regions, services are already available (*e.g. Franche Comté*) in terms of local outpatient care (*specific network – public hospitals*)
HH RECOMMENDATION FOR A NEW PROTOCOL DEPENDS ON THE PLAYERS INVOLVED AND SOME SPECIFIC CRITERIA...

- 4 key players are involved in the decision process
  - *Prescribing centre: the prescriber and the hospital pharmacist*
  - *HH: the treatment director / coordinating physician and the pharmacist*

- The decision to offer a new HH protocol lies within the hands of the prescribing centre (*physician and pharmacist - feasibility of cooperation with the HH*)
  - Drugs that have **already been used** in outpatient care for at least 1 to 3 years and meet certain criteria (*toxicity, stability, administration, chemo go-ahead*)

- Patient selection depends on a wide range of criteria included in French national health authority - ANAES - recommendations
  - *Patient distance from hospital* is the main Environment criterion
  - Availability of the *family doctor* may be a key condition in some HHs, but...
    - ✓ Protocol complexity and management of adverse reactions
    - ✓ Significant investment for a small number of patients,...

- Economic criteria may be included when drugs are expensive and not included on the drug list
  - In the case of very high costs, discussions may be undertaken with regional health agencies / French national health services
1. **Drug's toxicity profile**, analysed by both the hospital pharmacist and the HH pharmacist
   - Drug toxicity (administration between injections)
   - Interaction with other medicines

2. **Reconstitution** *(for HHs with a cytotoxicity rehabilitation unit)* and **stability of the drug** *(when the drug is prepared and sent out by the hospital's in-house pharmacy)*
   - Ideal: 48 hrs.
   - Usually: 24 hrs
   - Exceptional but manageable: 6 hrs.
   - Conditions for transportation

3. **Administration**, under the stewardship of the HH treatment director *(coordinating physician)*
   - Procedures for basic *chemo go-aheads*
   - **Administration duration**, with specific rules depending on HHs *(option of using private nursing staff): 2 hrs. on average*
   - Basic *administration method* with a preference for either subcutaneous administration or a central venous catheter (CVC)
     - Preliminary identification of potential discrepancies / errors / risks for the patient, and behaviours to adopt
IN AN ENVIRONMENT THAT IS FAVOURABLE TO THE DEVELOPMENT OF OUTPATIENT CARE, HHS NEED TO BE MORE PROFESSIONAL AND SPECIALISED

Support from Authorities

- Additional 4 M€ budget envelope for drugs
- A shift towards outpatient treatment
- Elimination of authorisation requests for beds
- Recent increase in fixed price groups (GHT - especially in chemotherapy)
- Inclusion of HH in regional health agency treatment plans

A significant development potential

- Increasing number of patients
- Patient willingness
- Evolution in treatments: increasingly fragmented and more prolonged, with simplified administration methods that suit HH.

HH requires high professional standards to meet expectations

- **Interfaced information systems** between HH and prescribers (chemo software)
- **Professionalisation of those involved in HH** to reassure prescribing physicians
  - Medicalisation of teams (onco-hematological expertise)
  - Chemo go-ahead and adverse reaction management
  - Training for nurses
- **Investment in cytotoxicity rehabilitation units / in-house pharmacies**
  - Optimisation lever for logistics as long as a certain number of services are performed