Pharmacy Utilization Meeting

September 16, 2022

**Attendees**

Linda Coyle (IMS)
Jennifer Stevens (IMS)
David Angelaszek (IMS)
Chuck May (IMS) – absent
Emily Carver (IMS)
Kevin Ward (Georgia)
Randi Rycroft (Idaho) – absent
Serban Negoita (NCI)
Peggy Adamo (NCI)
Marina Matatova (NCI)
Nadia Howlader (NCI) – absent

Jennifer Hafterson (Seattle)

Tiffany Janes (Seattle)

1. Serban introduced Jennifer Hafterson and Tiffany Janes, both from the Seattle registry, to the workgroup.

* Seattle receives data from Kaiser so they are interested in how they could apply approaches used here to that data.
* They would also like to be able to use the approaches in this workgroup as concrete examples of how they will utilize data from other vendors they reach out to.

2. Jennifer Stevens asked about if these analyses will always be done externally with submission data or if we will add the augmented fields and business logic into SEER\*DMS. This is an important distinction since submission data does not have the day part of dates whereas day is available in SEER\*DMS.

* Serban indicated that the approach of the workgroup for now will be developing the external datasets for research purposes via programs like SEER\*Stat.

3. David introduced the new Pharmacy Utilization page available on the SEER\*DMS portal and mentioned that a document is in development that will describe and summarize the workgroup's efforts in a single place.

4. We reviewed the follow up analysis of pharmacy transactions being received before diagnosis.

* David mentioned that he reviewed some cases in SEER\*DMS of patient sets with single CTCs with transactions before diagnosis. Prior to diagnosis they seemed to be administered drugs that could also be used to treat other conditions like osteoporosis. After their diagnosis they switched to other medications. David pointed out that agreements with CVS and Walgreens does require them to send "ancillary" medications 1 year prior to the first anti-neoplastic medication. This might help to explain some of these cases.
* Emily presented her results breaking out counts by patients that have only a single 00/01 case and those that 02+ cases. She also presented counts of the numbers of patients/CTCs that showed only a small fraction of the total cases with pharmacy transactions have dispense dates before diagnosis. For hormone, a small fraction of such cases were 00/01. For chemo, the majority of such cases were 00/01.
* Emily also presented the list of drugs that were administered for all cases (both 00/01, 02+). Kevin thinks breaking this list down further to 00/01 drugs only would show that only a small number of drugs with multiple purposes other than cancer treatment are included. This would indicate we are fine to ignore cases with dispense dates before diagnosis dates - it is likely not an indication of bad diagnosis dates or missed cases.
* **Action**: Emily will break down the drug lists further so that we can see the agents administered for the 00/01 cases.
* **Action**: NCI will investigate if there is a way in CANMed to screen for drugs that have typical uses other than cancer treatment.

5. Emily presented some of the augmented data set results.

* Emily showed the data sets for chemotherapy using GA and ID data. The results showed that the registry data had already captured chemotherapy treatment data very well. The augmented pharmacy fields showed very little updates from the registry data.
* Walking through the results shows that it might better to clarify how FCOT drugs are being considered in the various tables. For example - the Phar- Rx Summ Hormone field is updated when a case has a FCOT hormone transaction within 1 year of the diagnosis date. This is a subset of the cases that received any FCOT transactions at all. Some tables showed results for all cases that received FCOT and not just the ones that received FCOT within 1 year.
* **Action:** We should try to make sure it is clear when results are using cases that received FCOT within 1 year - the terminology FCOT might make some think the 1 year timing rule is being applied when it is not. We have mainly used FCOT as a flag on drugs to indicate they are used in first course treatment regimens. We should update table counts to reflect the updated terminology if needed.
* Emily showed some results by registry and modality. A first look showed consistent results across registries for the individual modalities.
* We received clarification that unknown dates can be updated to known dates with the pharmacy data. There was some question as whether we should only update known dates to better known dates. The consensus was a known date is always better than unknown with the pharmacy data.