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SP506 **STAKEHOLDER SUMMIT.** Coverage from the AJMC® gathering of 4 community oncology leaders, who discussed what implementing the Enhancing Oncology Model might look like in everyday practice and what features they would change, **SP506**.

NCCN PATHWAYS. Roy Beveridge, MD, of Avalere Health discusses the importance of clinical pathways in selecting therapies in non-small cell lung cancer, and the use of pathways and guidelines from the National Comprehensive Cancer Network (NCCN), **SP512**.

IVBM. Full coverage from our Institute for Value-Based Medicine® (IVBM) sessions with Oncology Consultants of Houston, Rocky Mountain Cancer Centers, Astera Cancer Care of New Jersey, and Vanderbilt-Ingram Cancer Center, **SP516-SP531**.

DRUG PRICING COMPLEXITY. Brian Corvino, MBA, of Deloitte Consulting, LLP, offered the Community Oncology Alliance Payer Exchange Summit an overview of how the surge of innovation in oncology and resulting drug approvals have dominated the biopharmaceutical sector, **SP542**.



CORVINO

NEW TO NASHVILLE. Our exclusive coverage from the inaugural OneOncology Physician Leadership Conference in Nashville, Tennessee, featured policy highlights from former Obama administration official Kavita Patel, MD, MS, and Adam Boehler, the former director of the Center for Medicare and Medicaid Innovation, **SP554-SP556**.

THERAPEUTIC ADVANCES

Data Sharing From Cancer Drug Trials Falls Short of Promises, Study Authors Say

Mary Caffrey

THE PRECISION MEDICINE ERA promises treatments for cancer and other diseases will be increasingly tailored to a patient's individual traits. That may mean finding therapies that target certain genes or proteins or using data to learn which regimens work best given a patient's sex, ethnicity, age, or other factors.

As study results are reported, some answers seem clear; others, less so. Results of a study published in May found that women in cancer clinical trials are far more likely than men to experience severe adverse events (AEs) from drug toxicity.¹ Meanwhile, investigators of a study published in 2021 asked whether different pharmacokinetic responses were due to ethnic differences or to factors such as age, diet, and other medicines patients were taking.²

One thing is certain: answering these questions requires more data, not less. And that's why investigators from Australia sounded the alarm with results from an audit published in the September issue of *JAMA Oncology*. They found that individual participant data (IPD) from 55% of the cancer clinical trials that led to FDA approvals over a 10-year period are not available to independent investigators, despite a 2014 pledge from the pharmaceutical industry to improve data transparency.³

Lead author and PhD candidate Natansh D. Modi, BPharm; and senior author Ashley M. Hopkins, PhD, both of the College of Medicine and Public Health at Flinders University in Adelaide, Australia, told *Evidence-Based Oncology™ (EBO)* in an interview how the audit was triggered by their individual frustrations in seeking trial data for other projects.



Natansh Modi, BPharm, left, and Ashley M. Hopkins, PhD, are first author and senior author, respectively, of an audit on clinical trial data transparency.

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INTERVIEW

COA's Bo Gamble: Slowing Down, but Not Stepping Away From Bringing Quality to Cancer Care

Interview by Mary Caffrey

BO GAMBLE, THE LONGTIME DIRECTOR of strategic practice initiatives at the Community Oncology Alliance (COA) and a go-to person for all things value-based care, will soon step down from his full-time role. Gamble was honored on October 24, 2022, at the COA Payer Exchange Summit in Tysons Corner, Virginia, for his service to the organization and his work to bring transformation to cancer care.

Gamble, who joined COA full-time in May 2011, will be transitioning to part-time status on January 1, 2023, when he will begin mentoring 2 new staff members taking on COA initiatives. Gamble will also work with the American Society of Clinical Oncology (ASCO) to implement the Oncology Medical Home (OMH) ASCO Patient-Centered Cancer Care Certification (APC4) program, a joint project of ASCO and COA.¹ Gamble helped develop the program using OMH standards and a systemic evidence review; the review panel toured cancer centers to evaluate how well they met the standards.

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COMMENTARY

PBM Fees Put the "GER" in Danger for Specialty Pharmacies

Darrell L. Willyard, PharmD; and Alexis V. Fanshier, BA

SHOULD MEDICALLY INTEGRATED specialty pharmacies (MIPs) be forced to lose money in order to serve their patients? What if a pharmacy would lose more than \$10,000 by filling a single prescription? Many MIPs face this situation because of a direct and indirect remuneration (DIR) fee known as a generic effective rate (GER).

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COA's Bo Gamble: Slowing Down, but Not Stepping Away From Bringing Quality to Cancer Care

INTERVIEW BY MARY CAFFREY

CONTINUED FROM COVER

A longtime board member for *Evidence-Based Oncology*[™] (*EBO*), Gamble spoke with *EBO* about his work with COA, his accomplishments, surprises, what he will miss, and some predictions for cancer care in the next 5 years. This interview has been edited for clarity.

EBO: What accomplishments during your time with COA are you most proud of?

GAMBLE: As far as specific accomplishments, I would probably name 3. One is the growth of our network for peer-to-peer support, the Administrators' Network. I started that process back when COA was young—we were like just a year or two getting started—and I was at a practice. Ted [Okon, MBA, executive director of COA] and the team said that we really want to engage the administrators. We started a group of maybe 5 people back almost 20 years ago, and now we have close to 1000, so we've been growing that network. And we don't have the magic sauce—we're just the conduit that says "talk to each other," and we'll facilitate those discussions so people who are doing great things can share with people who are struggling, and vice versa, to help each other to just grow. It has been phenomenal to see the growth. We've had calls once a month, usually sharing best practices [among] people. That's been one [accomplishment].

The second one, I'd say, is just being involved in the reform space. As you know, in this world of health care, the more we know, sometimes the more we feel, "This doesn't make any sense. We need to fix it." There's so much misalignment for patient care as it should be, and getting rid of obstacles so that care is for them. You see insurance premiums going up, coverage getting lower, obstacles all over the place [when you're] trying to help the patients. In cancer care particularly, we're seeing physicians leaving community practices and going to other sites of care, which is usually twice as expensive, and now we're arguing if the quality is good. That shouldn't happen; we should fix that. So, we're trying to create some visibility and some education, [the point of which is to] say preserve and protect and promote high-quality, value-based care. We would argue, and we want to prove, that it's on the community center. So, while we've made progress in that area, we're not there yet...and the more we know, the more we know there is to do. So, we're pondering—trying to find those issues, make them transparent and visible, and try to address them.

The third item is one that's near and dear to my heart. I shared it last week at our payer summit, and that is a collaboration and partnership with ASCO for the new and improved OMH APC4 Program, which is ASCO's patient-centered cancer care program.

We've challenged people and said, "Tell us what needs to be changed." We cannot come up with a single payment model that works for everybody. There are too many other ideas, and even pride and egos, "mine is better than yours." It would be a waste of breath if we tried to say [one solution works for] all. However, we are of the belief that we can come to an agreement on the specifics of what makes high-quality cancer care, specifically, for everybody—for the patient to look for, for insurance companies to look for, for employers, for providers, all moving in that direction—and then you can build anything you want to on top of it.

That's what's so magical about this program. To me, it's the most meaningful, important thing that I've seen in cancer care in the time I've been in cancer care—which is now about 25 years. It just makes good sense, and it's good for everybody. The standards are out there. You think you're doing it? Hey, go for it, do it. When you're ready for us to look behind you and see if you're there, we'd be glad, but go ahead, move in these directions.... Say I'm a patient coming in off the street, and I want the best cancer care. How do I know yours is best? You have to prove it to them." That's what makes this so good. I'm looking forward to the end of the pilot, which will be in June 2023, and hopefully we can start a national program [that will generate] lots and lots of interest. We've got a standardized blueprint that we'll continue to improve for all to follow for high-quality cancer care.

"We're not anti-340B; we're pro-patient. Therefore, if you're getting assistance to help patients, help patients. Don't help your profit center, your bottom line; that's not what it's about."

—Bo Gamble,
director, strategic practice initiatives
Community Oncology Alliance

EBO: What has surprised you over the years?

GAMBLE: One surprise that has really aggravated me [is that] COA has the reputation of being anti-340B. We are not anti-340B; we're pro-patient. Therefore, if you're getting assistance to help patients, help patients. Don't help your profit center, your bottom line; that's not what it's about. I grew up in health care—good gracious—before I got involved in cancer care. I don't know if you've ever heard of the Hill-Burton [Act and] program, which started in 1946. It was a [federal government] program that said, we want hospitals to be able to do the capital improvements to make sure that they provide [good] care. And we'll help you, we'll give you some low-interest loans, whatever, to give you some ability to make that happen. In exchange, you have to help patients. You had to have patients apply for [benefits] and prove their income level, and based on their income level, they got either free care or greatly discounted care. Just wrote it off. It was for the patient.

Why can't we get back to that? Because that was when health care prices were low, patients were getting access, they were getting care, there was no fear of going to the hospital because I'm going to bankrupt my family. It was about the patient. Why can't we get back to that? That's just so simple; it's not that hard. We need to have assistance programs specifically for the patient. To me, if there was 1 thing, 1 thing that I think we could accomplish that would send a signal like, "Nope, we're going to start doing things right," it would be to fix that program. It's just gotten crazy, it's just gotten out of control, and for all the wrong reasons. That's the one thing that surprised me. »



Bo Gamble, director,
strategic practice
initiatives, Community
Oncology Alliance.

There were other [surprises, too, like the] ways certain guidelines are written—for instance, Medicare Advantage and how they're allowed to have these obstacles in the way. Fix that, too. We need to get rid of all obstacles that are getting in the way of the patient getting their care. My argument is—and I think it's universal to COA—that we believe that community cancer care provides the best quality, best value, and best care. Level the playing field, and may the best man win. And if we're not [the best], we'll work hard to [become the best], but level the field so that we can play fairly all the way around, so there's incentive to do the right thing and not an incentive to do [something] that's just not healthy.

EBO: What's next for Bo Gamble?

GAMBLE: Well, I've got 5 grandkids and I want to find time to see them and introduce myself to them. We've also got some new members of our staff—they are sharp young people, eager, bright minds. I'm motivated to support them so that they can carry these issues forward and do it better than we've ever done it before.

The other thing is that I'll continue to work with ASCO, with a promotion of the OMH APC4 program, which to me is the most meaningful thing that we could do to help everybody involved in cancer care. Our challenge is that we need 10 of us to get out there and share it with the rest of the world, because this is so good. We feel that strongly about it. So, between all those [things], I'll be somewhat busy. I want to be busy. It's going to sound corny and clichéd, but we're on this planet to serve. And I want to continue to serve and encourage as long as I live.

So, even though I'll be slowing down a little bit, I'll go forward into next year with these young

people [and] I'll be there supporting them. As long as I'm adding value, I'll stay around. If I'm not adding value, you tell me, and I'll go fishing.

EBO: What will you miss?

GAMBLE: There is a reason they call it health *care*. I think [I'll miss] seeing the quality and quantity of genuinely caring people who want to do good. And the contacts and relationships I've developed along the years, and seeing these heroes who think outside the box and say, "This is the right thing to do. This is what I'm going to do." Being a part of that and watching it, it's just been incredible, and I'll miss that. I'll stay in touch with some of that. But before I die, I'd like to see cancer care, and maybe all health care, being reshaped into what it *should* be. Not what it is today. That's my goal.

EBO: We're going to do a lightning round. What are your 3 predictions for cancer care for the next 5 years?

GAMBLE: Number 1, I think that eventually we will address the 340B program. Hopefully, it will follow the patient—wherever the patient's getting care, [the program] will provide the assistance.

Number 2, I think we'll see some improvements on payment in a standardized way. Of course, the [Center for Medicare and Medicaid Innovation] is trying to do their thing, which is complicated—maybe some would argue a little overly complicated. You've got other people trying to keep up, just as we're seeing standards developed in care with ASCO, I think we'll see some standards in payment also, that reward [people] for doing the right thing.

Number 3, hopefully, you'll see a radical change in the way insurance benefits are structured, so that

benefits also aligned with getting the right thing done. I've shared this story before, and I'll share it again. Working with OMH APC4 program, there is a standard that says if you are a cancer patient, you must be introduced to a concept that if you have end-stage cancer, you must have a discussion about what are your wishes before you die. It's that simple: Ask the patient about where they want to be. We asked this question to all the pilot practices. And some said, "Yeah, we're doing it." And we were like, "OK, where is the proof of how well you're doing it?" And that's where they struggled.

So many arguments that we got back came down to, "Well, I want to [have the conversation], but the patient doesn't want to pay for another office visit." So, boom! Get rid of that patient out-of-pocket [expense].

That end-of-life discussion is so very important, not only from a quality standpoint, but from a *value* standpoint. Make it easy for the doctor and make it easy for the patients to do the right thing—to have that discussion. I've seen it play out in my family—close family, extended family—and that discussion is probably the most important discussion that will happen in their lifetime: "I'm dying from cancer, I want to go home," or "I'm dying from cancer. I don't want to be a burden to my family. I want to be in hospice," or "I don't want to have pain [even though I have] cancer." Have those discussions, and then help those patients with their needs. [Instead, what we] sometimes do is treat patients until death, and that's not healthy for the patient or the family. Start making it easy for the patient to do the right thing. I'd like to see that. ♦

REFERENCE

Caffrey M. ASCO, COA release updated standards for Oncology Medical Home. *Am J Manag Care*. 2021;27(SP6):SP247.

FROM OUR PARTNERS



AON to Become Public Company Through Business Combination Agreement

AMERICAN ONCOLOGY NETWORK (AON) announced October 6, 2022, that they have entered into a definitive business combination agreement with Digital Transformation Opportunities Corp. (DTOC) pursuant to which AON will become a public company (the "Business Combination").

Upon the closing of the Business Combination, AON's senior leadership team will continue to serve in their current roles. The combined company will be led by AON's CEO Todd Schonherz, President and Chief Development Officer Brad Prechtel, Chief Financial Officer

David Gould, and Chief Medical Officer Stephen "Fred" Divers, MD. AON's existing board, which is composed of practicing medical oncologists, is expected to remain in place and will be joined by additional members affiliated with DTOC.

"This transaction represents the next step in AON's journey to become the leading platform for community-based oncology practices. Since launching the AON platform in 2018, we've been able to drive consistently strong growth by providing our physician partners with a strong suite of practice management tools and ancillary services as well as access to the financial

benefits associated with being integrated with a scaled platform," Schonherz said in a statement.

"We look forward to continuing to grow our network of physician partners and supporting them with our physician practice management platform." ♦

REFERENCE

American Oncology Network, a rapidly growing network of community-based oncology practices, to go public through business combination with Digital Transformation Opportunities Corp. News release. October 6, 2022. Accessed November 30, 2022. <https://www.businesswire.com/news/home/20221005005683/en/>