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THE CANCER LETTER

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DEVITA DENIES NCI BROKE FAITH WITH COMMUNITIES ON CHOP AWARDS, SAYS TOTAL OF 30 "NOT ABSOLUTE"

Director Vincent DeVita, responding to complaints by the Assn. of Community Cancer Centers over the number of awards being made in the Community Hospital Oncology Program, denied that NCI was breaking faith with the communities or had changed signals.

ACCC President Robert Frelick had charged in a letter to DeVita

(Continued to page 2)

In Brief

CANCER PANEL TO MEET AUG. 29; RFP ON IMPACT OF PLANNING CANCELED AS BEING "PREMATURE"

PRESIDENT'S CANCER Panel will meet Aug. 29 at NIH, Building 31 Room 7, at 8:30 a.m. It will be open to the public. . . . **ANOTHER IMPENDING RFP** was canceled by NCI, partially due to the cutback on contracts—"Evaluation of the Impact of Strategic Planning on Biomedical Research." Louis Carrese, associate director for program planning and analysis, said cuts in contracts was only part of the reason for dropping this effort now. "We decided it was premature to try to develop an approach to studying the impact of planning. It is too soon to evaluate it as a process." . . . **NEW FILM** for oncology nurses on administering antineoplastic agents, "Administering Intravenous Cancer Chemotherapy," is available from Adria Laboratories at no charge. Write to Adria, P.O. Box 16529, Columbus, Ohio 43216, or phone Patrick McCarthy, 614-764-8121. It is also available from local Adria reps. . . . **"CANCER & RISKS:** Facts, Fallacies and Philosophies" is the title of a clinical and public education seminar Nov. 5 sponsored by Miami Valley Hospital, Dayton. Contact Alfred Hicks or Dale Hines, Seminar, Miami Valley Hospital, One Wyoming St., Dayton 45409. . . . **"CANCER PREVENTION** and Screening" will be a postgraduate symposium Nov. 7-8 sponsored by the Claire Zellerbach Saroni Tumor Institute of Mount Zion Hospital and Medical Center in San Francisco. Contact the hospital, P.O. Box 7921, San Francisco 94120, or phone 415-567-6600, ext. 2405. . . . **"CURRENT CONCEPTS** in Cancer Diagnosis and Management" will be a multidisciplinary course Jan. 22-24 at the Century Plaza Hotel sponsored by the UCLA School of Medicine Surgical Oncology Div. and the UCLA Jonsson Comprehensive Cancer Center. Kristian Storm and Donald Morton are chairpersons. The cancer center also will sponsor "Recent Advances in Cancer Diagnosis" Feb. 28-March 1 at UCLA. Chairpersons are Richard Steckel and Robert Kagan. This course will focus on recent developments in cancer diagnosis and the interplay of diagnostic techniques in specific clinical situations and will be directed specifically toward the needs and interests of clinical oncologists.

FRELICK RENEWS DEMAND THAT NCI FUND ADDITIONAL MULTI-INSTITUTION CHOPs

(Continued from page 1)

(*The Cancer Letter*, Aug. 8) that the decision to fund more single hospital than multiple institution CHOPs "flies in the face of all of NCI's very clear signals." That, the funding of less than 30 CHOPs in all, and other factors could lead to the conclusion that "NCI is not to be trusted and is relatively arbitrary in changing signals," Frelick said.

DeVita in a letter to Frelick said "we clearly indicated two things" when the CHOP program was discussed at the ACCC annual meeting last March. "(1) that NCI would attempt to fund eight to 10 programs in each of the three categories, and (2) that funding for these programs might be late because of the lateness of the review." Frelick also had objected to the decision to fund some of the CHOPs with FY 1981 money.

"Dr. (William) Terry (acting director of the Div. of Resources, Centers & Community Activities) said that the important point was that high quality approved programs would be funded even if it was spread over the next fiscal year," DeVita wrote to Frelick.

"We are unable to do very much about the lateness of the review vis a vis the funding in 1980 vs. 1981 because contracts are difficult instruments to manage. We are under a considerable number of restraints in terms of timing of funding, negotiations, etc. So you are correct, it is likely that some of these CHOP programs will be funded in the next fiscal year.

"The figures 'eight to 10 per category' were estimates, not absolute figures, and the figure 30 should not be looked at as an absolute target by which to measure NCI intentions," DeVita insisted.

"As far as your capacity to trust us, our intentions, etc., Dr. Terry and I both put our intentions on the line at the ACCC meeting. It would be rather foolhardy for us to now turn around and do something entirely different unless drastic circumstances supervene. Nothing that has happened in the process of the long, tedious review has changed our intentions.

"We consider the CHOP programs of high priority and will give them sufficient funding to evaluate what we set out to evaluate."

DeVita said he would "be happy to come to the next ACCC meeting again and discuss the NCI position. Let me state again that we consider the CHOP programs of high priority; the review process is going, unfortunately, as slowly as we expected; and approximately the number of programs we anticipated would be funded will be funded, with the exception of one category where applications were lean."

That one category was in the rural hospital category, in which only three proposals were submitted and one approved.

DeVita did not refer to the controversy over multiple vs. single hospital awards. NCI plans to fund 13 single and nine multiple institution CHOPs.

Frelick, indicating ACCC does not intend to let the issue drop, replied to DeVita immediately, expanding on his previous arguments supporting an increase in the number of multiple institution awards. He also called for reissuance of the RFP to stimulate more participation by rural hospitals.

Excerpts from Frelick's response to DeVita's letter follows:

"We fully appreciate your commitment to community programs expressed at ACCC's annual meeting, in your recent letter, and in your support for community programs. We also recognize your overall commitment to a high quality National Cancer Program. It is in this context that I am writing in reply to your most recent letter with what we believe is a constructive approach to the development of the CHOP program.

"The recent announcement of only 23 CHOP awards confirms the concerns we expressed to you in our letter of July 18. As I now understand the distribution, one rural consortium was funded, as well as 13 single hospital CHOPs and 9 urban consortia CHOPs. It is the underfunding of an adequate sample of urban consortia CHOPs that remains the basis of our concern.

"The original urban consortia COPs (the predecessor to the CHOPs) demonstrated that a small amount of funding could significantly impact the quality of patient care. The COP program considered to be the most successful was the Grand Rapids COP, a consortium of five hospitals in a small urban community. Obviously the Grand Rapids model required further testing in similar communities to determine if the same configuration will work in multiple locations. This was the genesis of the urban consortia CHOP RFP.

"Just as clearly, the rural consortium CHOP and the single hospital CHOP deserved a broader range of testing.

"As you are aware, based upon signals from NCI, the bidders conference and a number of other presentations, the submission of multiple hospital CHOPs was significantly higher than the number of single hospital submissions (i.e., 33 vs. 23). Clearly, NCI, ACCC and others suggested that the Grand Rapids model offers several outstanding features including its cost effectiveness (i.e., multiple hospitals in the CHOP for the same federal investment as a single hospital CHOP—$400,000 over 3½ years), more patients affected and a more community wide approach. The promotion of a community wide cancer effort obviously also reduces competition for resources and facilities that funding multiple single hospital CHOPs in the same community might promote. Thus, in several ways the consortium CHOP model appears to

have more impact on cost effectiveness, and patient care.

"During the review process we learned that reviewers found urban consortia submissions split into two distinct groups: those from relatively small urban communities such as Grand Rapids and those from major metropolitan areas, such as Cincinnati, Minneapolis and New York City (this is a model we have never tested before). This was confirmed in the recent announcement of urban consortia awards which shows both types of urban communities large and small mixed together. Clearly practice patterns, patient loads and sophistication will vary radically between these types of communities, perhaps as radically as between a rural area and a small urban area like Grand Rapids. The success of a CHOP organization may also range with the size of the community. Thus, we believe that the sample size of both urban CHOP models needs to be adequate to ensure an adequate demonstration. Certainly a 10 hospital consortium in Cincinnati (a city with @ 35 hospitals) is difficult to compare with a five hospital consortium in Colorado Springs (a city with only five hospitals). With both large and small urban areas mixed together, the sample of both types seems woefully inadequate. If left as it stands the sample will be:

"• 13 single hospital CHOPs (out of 23 submissions

"• 1 rural consortia CHOP (out of 3-5 submissions)

"• @ 4-5 consortia CHOPs in major urban/metropolitan areas

"• @ 3-4 consortia CHOPs in smaller urban/metropolitan areas (these last two categories out of 33 submissions).

"A valid test of the urban consortia models and the rural consortia model may be impossible with these small samples.

"Since there are a significantly higher number of urban CHOP submissions than single hospital submissions, it is apparent that there should be enough quality submissions to fund an adequate sample of both urban models. Moreover, Dr. Terry made clear in our recent telephone conversation that available funding is not the problem, nor the number of approved submissions. While he noted that there was some drop in the priority scores between the ninth and 10th urban CHOP submissions, it seems apparent that there are additional quality applications and it does not appear that sample size was given any consideration. While Dr. Terry has noted that single hospital priority scores were higher than unfunded multiple hospital scores, it is obvious that any comparison of single and consortia CHOP scores has little meaning. Thus, we hope you and Dr. Terry will reconsider the number of urban CHOPs funded and attempt to ensure a sufficient distribution of both types to adequately test the CHOP configuration in both urban settings.

"As to the rural consortia category, it is clear that precluding facilities with medical oncologists substantially diminished the number of applications submitted. We hope that you and Dr. Terry will consider reissuing the RFP in the near future to allow rural areas to benefit from an adequate test of the CHOP mechanism.

"In your letter of Aug. 4 you stated that "the figure 30 should not be looked at as an absolute target by which to measure NCI intentions." In our telephone conversation Dr. Terry made a similar point that NCI's plans for the CHOP program solicitations were cast three years ago. In my opinion, it would be unfortuante if we are constrained from adequately studying the consortium model by three year old plans. And, I wonder if NCI, with its requirement for flexibility in research and other areas should feel constrained in this case (or any other) when the ultimate goal of improving community cancer care is considered. . . .

"Clearly, if a more cost-effective, community wide approach to quality patient care can be illustrated by one or more of these CHOP models, NCI will have sponsored a substantial contribution to cancer control in our nation's communities, where 85 percent of patients are treated. To ensure that the demonstration is adequate we hope you will increase the sample and attempt to fund all of the programs within the shortest possible time period."

DEVITA SWORN IN, ACCEPTS 'WITH RELISH' JOB OF MATCHING PRIORITIES, RESOURCES

The 1980s will be a decade of "extraordinary opportunity in cell biology" resulting from "an unparallelled explosion in technology in the biological sciences" in the past five years, Vincent DeVita said last week when he was sworn in as director of NCI.

Prevention, diagnosis and treatment of cancer as practiced now "will be outmoded and radically different by the end of the 1980s," DeVita said.

HHS Secretary Patricia Harris administered the oath of office to DeVita, commenting that he was "extremely well qualified to be the director of this $1 billion a year institute." Noting that his appointment was "extremely popular with his NCI colleagues," Harris said that it was in character for DeVita to retain the position of clinical director, "spending at least 10 hours a week making rounds, seeing patients, hearing their problems."

Harris said that "some individuals profess to be disappointed with the results" of the National Cancer Program. "I am in disagreement with them, and so is Dr. DeVita. Dr. DeVita has pointed out that we are approaching a cure rate of 50 percent." However, she said to him, "I share your dissatisfaction with the present and your optimism for the future."

NIH Director Donald Fredrickson, master of cere-

monies, noted that NCI "is the origin of approximately one half the support around the world of efforts to conquer this disease.

"We at NIH have a bent perception of ourselves as a university," Fredrickson said. "If a university is a community of scholars, we have more than 1,000 at work here on our campus. But we are not limited to the 300 acres here. Our scholars number 100,000, whose search for reality and truth is carried on under lamps fueled by NIH. Ours is a university of the universe."

DeVita said NCI's challenge will be "in the decisive matching of scientific priorities to scarce resources." He named several NIH colleagues who were helpful in his early years with the institute. He finished with a moving reference to his family, including his son Ted who died last May after an eight year struggle with aplastic anemia.

DeVita's remarks follow in full:

"I am honored by the unique opportunity to serve the National Cancer Institute as its ninth director. This institute has had a major impact on cancer research in the world since its inception in 1937, and it is important that it maintain this role in the exciting decades to come.

"As a result of the institute's support for basic research over its 43 years of existence, we can speak of progress made in our basic understanding of cancer, its diagnosis and treatment, and we have made considerable progress and can realistically hope for more.

"We can speak of the critical mass of information and interest we now have in cancer prevention, and our recent organizational changes to meet these opportunities, and we can expect an impact on cancer prevention.

"But there is to me only one thing we can say with considerable certainty. What we now know of the cancerous process, and what we do to prevent, diagnose, and treat it will be outmoded and radically different by the end of the 1980s. How different depends a great deal on how the National Cancer Institute operates.

"We are now entering a decade of extraordinary opportunity in cell biology. In the past five years there has been an unparallelled explosion in technology in the biological sciences that is daily changing our appreciation of how cell growth and differentiation are regulated. This is the very essence of the difference between a normal cell and a cancer cell.

"The acceleration of the development of new knowledge is increasing daily. Those of you in the field know that experiments requiring DNA sequencing, for example, that took two years to complete five years ago can now be done in two days with current technology. This is an extraordinary change that, by all rights, should yield extraordinary information.

"It seems to me that in the 1980s we will be faced with unique scientific and managerial challenges at NIH. The challenge of the institute in science is to foster the continued expansion of our knowledge base, using the new technology, and at the same time, to harness it to better prevent the disease and treat it more humanely.

"The management problem is this. We are faced with a time when all Americans must conserve their resources, and the institute is no exception. Faced with a wealth of opportunity, the challenge on the management side will be in the decisive matching of scientific priorities to scarce resources. This is an extraordinarily important task for cancer researchers everywhere, and I accept it on behalf of the institute with relish.

"If I may, I would like to make a few personal comments.

"I owe a great deal to many people here. When I came for my interview at NIH years ago, I emerged shaken from an interview with Dr. (Robert) Berliner (then NIH associate director for science). I was next greeted and comforted and reassured by Dr. Fredrickson, who has been comforting and reassuring me ever since. It looks like you are in for more of the same, Don. Dr. David Rall (now the director of the National Institute of Environmental Health Sciences and then with the intramural clinical program at NCI) brought me here and he, Dr. Gordon Zubrod (former Div. of Cancer Treatment director) and Dr. Vince Oliverio (now head of NCI's Developmental Therapeutics Program) taught me much of what I know about cancer. I'm still waiting for them to teach me all they know of cancer.

"These positions also make demands on our time and constitution that are only possible to meet with equanimity with the strong support of our families. I am no exception.

"I have been blessed with wonderful parents and a sensitive brother and sister—and supported during the most difficult of times by my loving wife and daughter, Mary Kay and Elizabeth, and my son, Ted.

"Because the DeVita family has had to endure a most difficult ordeal in the past eight years, we have also developed a large extended family. Many of them, I'm pleased to see, are in the audience today.

"Since I cannot name or reach all of you from this podium, I hope you will come by the receiving line and let one of us give you a hug, since there are no words I can command, or keep under control, to express our gratitude to you.

"Then there was Ted. He was a unique person. He brought out the best in people. He galvanized all of us and taught us all the meaning of love, friendship, and, most of all, courage.

"Madam Secretary, I have only one major personal goal left in life—that is to be privileged to grow up

someday to be like my son—and if I do, I assure you the Cancer Institute will be in good hands.

"I thank all of you very much."

NCI DENIES GAO CHARGE THAT CANCER CONTROL CONTRACTS WERE MISHANDLED

NCI's response to the General Accounting Office report of its investigation of the Cancer Control Program disputed most of the adverse conclusions reached by GAO. The first portion of NCI's response appeared in last week's ***Cancer Letter;*** the balance follows:

II. PROCEDURES REQUIRING REVISED PROJECT PLANS NOT FOLLOWED

The GAO report alleged that in the case of the contract with the Univ. of Louisville, NCI should have prepared a revision to the original project plan, since the project plan estimated costs at $880,000, while the amount negotiated with the Univ. of Louisville was $2.8 million. The GAO is correct; under these circumstances a revision is required. NCI contends, however, that this revision was accomplished and documented in the form of a source selection sheet, which provided the documentation for the review that, among other things, approved the increase in costs from that amount estimated at the time of the preparation of the project plan to that amount determined to be needed after review of the responses to the RFP. The responsible officials, with the exception of the former director, DCCR, who was out of the country, attended the selection panel meeting. The documentation for that meeting, the source selection sheet, was signed several days later by all of the appropriate officials, including the former director. This sequence of events accounts for the inability of the former director to remember exactly what happened. In any event, the source selection sheet was signed and, had that source selection sheet been completely filled out, NCI's procedures would have been correct. There was an error, however, in that the portion of the source selection sheet specifying costs was left blank. Thus, although the revision of cost estimate was reviewed and approved, and although all individuals involved in the review and approval knew the specific costs, (these costs were specified on the summary statement reviewed by this group), the certifying document was incompletely filled out. NCI agrees, therefore, that in this instance, there was a clerical error, but does not agree that NCI failed to follow the procedures for revising project plans.

The GAO report also alleged that in the case of the contract with New York State, proper procedures for revising the project plan were not followed. NCI contends that this is an incorrect conclusion. In this instance, the review summary sheet was prepared for 15 cervical cancer screening contracts. The revision for New York state was documented within the review summary sheet that covered the entire set of projects. This information was supplied to the GAO on Feb. 14, 1980.

Another alleged deficiency concerns the modification to an existing contract. The particular contract cited was with the Texas Chest Foundation/East Texas Chest Hospital in Tyler, Texas. The GAO report indicates that Modification 3 of this contract was accomplished without an appropriate amendment to the project plan. NCI contends that there must have been a project plan amendment for Modification 3, since the project plan amendment is referred to on block C of the review summary sheet and the contract file index. The GAO is correct in indicating, however, that the project plan modification itself is missing. Thus, although NCI is confident that the proper procedure was followed and although there is corroborating evidence to substantiate this, the key document is missing. NCI notes that this particular contract file has been repeatedly entered by non-NCI personnel due to litigation concerning this contract and that maintenance of the integrity of this file has been difficult.

III. NCI HAS FAILED TO CORRECT DEFICIENCIES FOUND BY PRE-AWARD REVIEW GROUPS

The GAO report states that "our review showed that in 2 of the 5 contracts these groups (pre-award review groups) identified many problems in the propposed contracts and made 9 recommendations to correct the problems. However, we found no evidence that DCCR took any action to implement the recommendations prior to award of the contracts." In the report, six of the alleged deficiencies are not further identified and only three problems from the contract with the Univ. of Louisville are cited. NCI can only respond to those three particular problems, which were: 1) the absence of an individual to conduct the health education program for plant workers and their families of the hazards of vinyl/polyvinyl chloride; 2) the lack of coordination and cooperation among various parties in the program, and 3) the lack of a system for locating approximately 1500 former plant employees.

NCI agrees that these deficiencies were not corrected before the award of the contract and that they should have been corrected. It should be noted, however, that the health educator was hired three months after the initiation of the contract and, as the GAO report states, the coordination problem was later resolved. The issue of locating former plant employees was never successfully addressed. NCI notes again, however, that this failure to correct pre-award deficiencies is an example of contracting practices that occurred in 1974 and 1975 and that these practices have been corrected in subsequent years.

IV. ASSURANCES NOT OBTAINED FOR CONTINUATION OF SUCCESSFUL PROJECTS

There are two points that must be addressed with regard to this section of the report. The first is that GAO has concluded that it would be desirable to obtain assurances from contractors for continuation of successful projects. NCI contends that there is no federal requirement to do this and that NCI should therefore not be criticized.

The second issue concerns what NCI told the Congress with regard to this matter. The GAO correctly quoted NCI materials submitted for the 1977 Senate appropriation hearings in which NCI indicated that cancer control contracts are expected to ensure means of self-support following completion of the contract period. It must be pointed out, however, that this information was submitted 2-3 years after the initiation of the five contracts that were reviewed by GAO. These contracts, therefore, cannot be held to NCI's statement of 1977.

Subsequent to the 1977 Senate appropriation hearings, discussion between DCCR staff and NCI contract officers revealed numerous problems with contractual attempts to assure continued funding of demonstration projects. One example of such a problem is that obtaining funding for continuation of a project may require fundraising. This is an unallowable cost under Chapter 15 of the Federal Procurement Regulations. Accordingly, present policy does not require that demonstration or other projects ensure means of self support following completion of federal funding.

In summary, DCCR has not attempted to routinely obtain contractual assurances that projects will be continued by local communities, and DCCR believes that such a policy would be inappropriate and may be legally unenforceable.

V. NCI HAS NOT ADEQUATELY MONITORED CANCER CONTROL CONTRACTS. NCI HAS FAILED TO IMPLEMENT RECOMMENDATIONS OF POST AWARD REVIEW GROUPS

The report stated that for three of the five contracts reviewed, the review groups identified 52 problems and made 43 recommendations to DCCR. The report found no indica-

tion that NCI ever directed the contractors to implement the reviewers' recommendations. One of the three contracts referred to was with the Illinois Cancer Council. On Jan. 2, 1980, the former project officer for this contract sent a memorandum to the GAO refuting the allegations about failure of NCI to implement the one recommendation made by the Merit Peer Review Committee and providing information as to why the six "problems" identified by the Merit Peer Review Committee and referred to in the GAO report, were not real problems. NCI believes that the issues raised by GAO were addressed in that memorandum, that there is good evidence that this contract was adequately monitored and that NCI did implement appropriate recommendations of post award review groups.

A list of 30 recommendations concerning the contract at Tyler/Texas was identified by GAO. For each "recommendation" the project officer, in a memorandum dated Dec. 28, 1979, provided an explanation of what was done as a consequence of the recommendation. This memorandum addressed each of the issues raised by GAO. An additional 12 problems concerning the contract with the Univ. of Louisville were noted by GAO and responded to on Aug. 2, 1979. The attachments to that memorandum provide the available documentation relevant to the points raised by GAO.

Review of all of these documents confirms that in almost all cases, issues raised by the Merit Peer Review Committee or site visit teams were brought to the attention of the principal investigator and that there was sufficient followup on the part of NCI to determine that the contractor was taking steps necessary to correct those deficiencies that NCI desired to have corrected. (The Merit Peer Review Committee and site visit teams are advisory; NCI is not compelled to accept all of their recommendations.) However, NCI agrees that the records are not well documented in terms of specific directions from the project officer to the contractor. It must again be noted that this was more a failure of documentation than a failure to obtain the desired result and again, that this reflects practices of the early days of this program, rather than current practices.

It is also worth noting that the former chairman of the Cancer Control Merit Review Committee indicated in a telephone conversation that he does not think that he stated that his committee found "that DCCR apparently does little to implement the recommendations made by review groups." In fact, the former chairman indicated that his committee never received any information concerning the implementation of their recommendations and therefore had little basis upon which to evaluate this matter. He indicated that this lack of information was a source of frustration, but also indicated that neither he nor the committee had ever formally requested such followup.

VI. THERE WAS A LACK OF COOPERATION BETWEEN PROJECT OFFICERS IN DCCR AND THE NCI CONTRACTING OFFICERS

The report attributed to the chief of the Cancer Control & Rehabilitation Contract Section the statement that there was "a lack of cooperation between the project officers in DCCR and the NCI contracting officers." The section chief believes that this statement was taken somewhat out of context in that he indicated that there had been a lack of cooperation **early in the program** (five years ago), but that this had been recognized and that a series of procedures had been instituted to assure proper cooperation. Some of these mechanisms are listed on page 26 of the GAO draft report. The report acknowledged the mechanisms but concluded that "apparently they did not work." NCI feels this is an unjustified conclusion since the "failures of cooperation" occurred before the mechanisms were established and GAO has not alleged any "failures" since that time. Moreover, there are many documented examples of such cooperation, and one such example is the operational memoranda, which were cosigned by the contracting officer and project officer were standard in the management of the 27 Breast Cancer Detection Demonstration Project contracts.

The report stated that ". . . the large caseload of both grants and contracts assigned to some project officers may have contributed to the lack of cooperation and coordination." The work required to monitor a grant is very much less than that required to serve as project officer for a contract. The report information was therefore misleading when it lumped grants and contracts and stated that the ". . . caseloads vary from 3 to 44 projects. . . " since the individual with 44 projects was, in fact, project officer on only 19 contracts.

It should be further noted that in those instances where individuals were project officers on a large number of contracts, such as the 29 (not 30) attributed to the branch chief, the contracts were part of a program and each contract supported identical activities at different locations. An example would be the 27 Breast Cancer Detection Demonstration Projects. The amount of work required to monitor these 27 contracts is very much less than that needed to monitor 27 contracts, each with a different scope of work.

VII. NCI HAS NOT REQUIRED CONTRACTS TO COMPLETE REQUIRED TASKS

NCI rejects this allegation and wishes to point out that the contracts in question were "best effort" contracts where the contractor is required only to exert best effort to achieve the requirements of the workscope. There are many reasons why tasks are sometimes not achieved despite "best effort." For example, portions of the Louisville and Tyler/Texas contracts were predicated on the assumption that large numbers of tumors would develop in the exposed populations. The tumors never developed; the contractor therefore could not carry out all of the related tasks.

When NCI determines that best effort is not being exerted, contracts are terminated. This is precisely what happened with the New York State contract, as documented on page 30 and 31 of the GAO report. It should be noted incidentally that in the termination of that contract, costs were reduced by $1 million. The GAO report incorrectly states that "no records were available to show how the $1 million reduction was determined." There is a standard procedure for making this determination and the documentation is available.

CONCLUSION

NCI contends that:

- The five contracts selected for review by GAO represent only 1.5 percent of the 325 Cancer Control contracts.
- The contracts were not selected at random, with two preselected by Mr. Obey, and all five having been initiated more than 4½ years ago. These contracts therefore are not representative of current contracting practices.
- NCI was under no requirement to insist that contractors encourage or assist continuation of projects after federal funding stops.
- Contract administration problems identified by the GAO in general represented failures of documentation rather than failures to follow prescribed review and implementation policies.
- Contract administration problems described by the GAO occurred many years ago and are not representative of current contracting practices.
- Substantial changes in contracting practices have been introduced in the past several years.

NCI believes, therefore, that contracting practices within DCCR meet the standards set by federal requirements and are in compliance with the plan submitted by NCI to the Assistant Secretary for Management and Budget as followup to the 1978 reports by the Inspector General on NCI contract operations. It should be noted that GAO was unaware of this plan, or of the corrective actions taken in fulfillment of the plan,

until Feb. 14, 1980. Having seen the plan, GAO informed NCI that it would reconsider its recommendation that NCI contract operations be reviewed again by the Inspector General of HEW.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. Write to the Contracting Officer or Contract Specialist for copies of the RFP, citing the RFP number. Some listings will show the phone number of the Contract Specialist who will respond to questions. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Address requests to the Contracting Officer or Contract Specialist named, Research Contracts Branch, National Cancer Institute, Blair Building, 8300 Colesville Rd., Silver Spring, Md. 20910. Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NCI-CP-VO-01053-76

Title: *Holding facility for small laboratory animals*
Deadline: *Sept. 25*

NCI is seeking the support services of a contractor to provide small animal holding and technical effort in support of two separate Frederick Cancer Research Center laboratory operations. The contractor's facility must be located with a 35 mile radius of FCRC. Space must be provided for large numbers of mice (3,000-4,000) and fewer number of rats (200-400) and rabbits (8-12).

In addition to the care and maintenance of the above animals, the contractor will be reuqired to perform inoculations and weekly readings to determine the presence of tumors in the subject animals. The contractor will also be required to collect and prepare serum samples, perform organ removal and to deliver biological materials to FCRC.

Contract Specialist: Steve Metcalf
Biological Carcinogenesis & Field Studies
301-427-8888

RFP NCI-CP-FS-01054-65

Title: *Biomedical computing: Design and implementation*
Deadline: *Sept. 2*

The Div. of Cancer Cause & Prevention of NCI, Field Studies & Statistics, is seeking research and development and data processing support for the Environmental Epidemiology Program.

Prospective contractors must have expertise in biomedical/biostatistical computing. The estimated initial level of effort will be 21 person-years. All development and production processing will be done using the National Institutes of Health Computer Center. The contractor must maintain an office within one hour's commuting distance of Bethesda.

Contracting Officer: Sydney Jones
Biological Carcinogenesis & Field Studies
301-427-8888

RFP NCI-CP-FS-01046-65

Title: *Special support services for tracing individuals*
Deadline: *Sept. 2*

The Environmental Epidemiology Branch and other branches of the Field Studies & Statistics Program, Div. of Cancer Cause & Prevention, NCI, has on hand now, and is expected to have during each of the succeeding four years, between 15,000 and 20,000 individuals from epidemiologic and related studies who must be traced so as to ascertain their current address and vital (dead or alive) and/or health status.

In most cases another contractor has already performed an initial tracing activity for each individual, without uncovering the desired information within reasonable cost. This new procurement described herein, therefore, seeks to pick up where efforts under another contract have left off, for the specific purpose of ascertaining the information sought on so-called "difficult to trace" individuals. It is estimated that tracing effort for these individuals will involve about 5% minimal additional effort, 85% moderate additional effort, and 10% maximum effort. Some of the latter may not be located within reasonable time and expense.

Objectives. The objectives of this contract are to provide technical (non-professional), managerial, and clerical support for followup of mostly difficult to trace individuals, as defined in field studies directed by the Environmental Epidemiology Branch, Biometry Branch, and Clinical Epidemiology Branch of the FSSP. The contractor will function in a supporting role, carrying out specific tasks but no independent research, to be responsible only for locating individuals under study in accordance with the contractor's specialized procedures and direction by the NCI staff.

Contractor requirements, duties and personnel:

1. The contractor must have an operational office in the general Washington, D.C. metropolitan area to which the data collection manager (principal investigator) and programmer/analyst are permanently assigned. An operational office is defined as one which, if not the main office of the contractor, can operate independently of the main office and, in addition to the normal administrative and support staff, equipment, and facilities, shall possess at least one computer terminal and shall have the capability of providing at any particular time the current, cumulative status of tracing activities of all field offices in the network which are participating in tracing individuals under the contract, including tracing cost information, for inspection and review by the project officer(s).

2. It would be advantageous to the respondent to have had at least five years' experience in locating persons, in studies similar to those undertaken here.

This includes design of specialized protocols to be used for locating persons identified from medical or occupational records that have been maintained as far back as 1930, locating tracing resources, obtaining agreement for release of data where necessary, verifying records, updating computer and other files, locating next-of-kin when necessary, and obtaining death certificates.

3. Since tracing activities will be conducted simultaneously at widespread geographic locations, the contractor must have many ongoing actively operating offices in all parts of the U.S. Tracing individuals under this contract will be thus effected by utilizing this network of subsidiary or associated offices forming the respondent's country-wide organization.

4. Only two fulltime permanent persons will be required for this contract—a data collection manager (principal investigator) and a programmer/analyst. All other persons involved in the headquarters organization and its network are to be considered collectively as "tracing staff."

5. The contractor must determine the average cost for conducting any minimal-effort search, any moderate-effort search, and any maximum-effort search under this contract. It will document all steps and costs in the tracing process for each individual. Using the NIH computer facility, it will generate and maintain a computer file of individuals to be traced, and develop computer programs to update files as data from followup become available.

6. Considerable weight will be given to the past experience of the respondent in tracing persons under studies similar to this one, to its managerial organization and countrywide tracing network, to the experience and capabilities of the principal investigator, and to the replies to tracing problems which are given in the RFP.

7. It is mandatory that 10 percent of each annual budget be given to a small business subcontractor in a significant (not minor) aspect of the contract. Technical and business proposals will be required for the subcontractor as well as the contractor.

8. Monthly progress and financial reports will be provided for the NCI project officer, and special estimates of costs for tracing procedures will be prepared when requested. Quarterly, semiannual, and annual progress reports will also be prepared when due.

This will be a five year incrementally funded contract, meaning it will be funded separately each year, but succeeding funding can be assumed, if progress is satisfactory. This is a statement of requirements and general scope. The details are given in the RFP. The above requirement will be strictly followed in rating competitors.

The contract is expected to be initiated in September 1980, or soon thereafter, depending on availability of funds.

No contact can be made with any NCI personnel after appearance of this announcement. Only the contracting officer can be contacted to obtain an RFP and to answer questions.

Contracting Officer: Sydney Jones
Biological Carcinogenesis & Field Studies
301-427-8888

SOURCES SOUGHT

RFP NCI-CO-04348-41-S

Title: *Support of activities of the USA National Committee for the International Union Against Cancer (UICC)*

Deadline: *Sept 8 (for statement of qualifications)*

Interested sources are invited to submit five copies of their qualifications to support the activities of the USA National Committee for the International Union Against Cancer. This shall include providing the professional, technical and promotional guidance relative to this program in order to insure that one forum represents the views of the various cancer organizations of the United States in UICC activities.

NCI will consider to be qualified those organizations having a demonstrable capability to accomplish the above as indicated by previous organizational experience as well as staff expertise and experience. Information submitted should be pertinent and specific to the technical area under consideration for each of the following: (1) Experience—A description of related projects completed or in progress; and (2) Personnel—The name, professional qualifications and experience of key staff members who may be assigned to this project. Any other information that would enhance our consideration and evaluation of your response should be submitted.

Respondents should limit their responses to 10 pages or less. Six copies of the resume of capabilities must be submitted.

Contract Specialist: Diane Smith
Control & Rehabilitation
301-427-8737

NCI CONTRACT AWARDS

Title: Center for Radiological Physics
Contractors: Univ. of Texas System Cancer Center, $509,763, and Univ. of Wasington, $691,301.

The Cancer Letter _Editor Jerry D. Boyd

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