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# Cancer Centers Form Network To Compete For Managed Care, Develop Standards

A group of academic cancer centers has formed an alliance to develop marketing strategies based on practice guidelines and outcomes analysis for oncology.

The newly formed coalition of 13 cancer centers, called the National Comprehensive Cancer Network, has the immediate goal of enhancing the centers' position in competing for patients enrolled in managed care insurance plans.

However, if the endeavor succeeds in giving the academic centers the

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*In Brief*

## WHI Revises Protocol After Study Finds High Rate Of Endometrial Hyperplasia

**WOMEN'S HEALTH** Initiative participants who have an intact uterus will no longer receive unopposed estrogen as a result of findings from the Postmenopausal Estrogen/Progestin Interventions Trial (PEPI) of the National Heart, Lung & Blood Institute, NIH said last week. The PEPI study reported that hormone therapy decreases risk factors for heart disease, but noted an unexpectedly high rate of endometrial hyperplasia in women with a uterus who received unopposed estrogen. WHI participants with a uterus who had been assigned to estrogen alone are being changed to the combination estrogen/progestin. Women who have had a hysterectomy are not affected by this changed and will continue to be assigned to estrogen alone or to placebo. The WHI has enrolled 7,300 women to date. The hormone component of the study will follow more than 25,000 women for nine years. . . . **HILLARY RODHAM CLINTON** appealed to Congress not to undermine Medicare mammography benefits. Meeting last week with breast cancer survivors and their doctors at Beth Israel Medical Center in New York, Clinton said, "I hope that there will not be any changes [in Washington] that will make it more difficult for women to have mammogram tests. That would be wrong not only in terms of human cost but also in terms of economic cost." Clinton said she hoped the Administration would begin a breast cancer awareness program in the late spring. She suggested Mother's Day, May 14, be designated "Mammogram Day." . . . **ROBERT WARREN** was named director of clinical affairs, Georgetown Univ. Medical Center, Lombardi Cancer Center. A member of the clinical faculty in medicine at Georgetown since

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## Group Of 13 Cancer Centers Forms National Network

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edge in competition with for-profit providers and non-academic hospitals, it will also establish influential standards of care in oncology.

The formation of the network is scheduled to be announced at a press conference next week.

"We come together as a group to make sure that high standards of cancer care are maintained and that the public and payers understand what we believe to be top quality cancer care," said Joseph Simone, physician-in-chief at Memorial Sloan-Kettering Cancer Center, who also serves as medical director of the new group.

"The network wants to dispense state-of-the art care in a cost-effective manner," said Robert Young, president of Fox Chase Cancer Center and a member of the network's executive committee. "However, NCCN also wants to preserve what we believe the society demands of us, and that is to advance the state of cancer care and therapy—and to innovate.

"How you build this into the system is the real challenge," Young said.

The network includes eight NCI-designated comprehensive cancer centers. The members are: Memorial Sloan-Kettering Cancer Center, Fox Chase Cancer Center, M.D. Anderson Cancer Center, Johns Hopkins Oncology Center, Fred Hutchinson Cancer Research Center, Dana-Farber Cancer Institute, City of Hope National Medical Center, St. Jude Children's Research Hospital, Stanford Univ. Medical Center, Northwestern Univ. Lurie Cancer Center, Ohio State Univ. Comprehensive Cancer Center, the Univ. of Michigan Comprehensive Cancer Center, and the Univ. of Nebraska Medical Center.

Ultimately, the coalition could include as many as 40 cancer centers, Simone said to **The Cancer Letter**.

"We are concerned that as health care changes, cost will become the only criterion for measuring success," Simone said. "Then there is a chance that the quality of care would be sacrificed, and the movement forward that we have accomplished over the past 20 years would be stopped.

"Our No. 1 priority is to set high national standards based on the authority of this group," Simone said.

**Unified Marketing Strategy**

NCCN's marketing is focused on insurance companies and large companies that have employees throughout the US.

The network headquarters will develop a unified marketing strategy, implement practice guidelines, evaluate outcomes, as well as provide a mechanism for coalition members to learn from each other.

The headquarters, located in New York, will be supported through contributions from member institutions. The headquarters annual budget will be about $1.5 million, Simone said.

A staff of up to six employees will develop a marketing strategy and coordinate the work done by members of the network.

It will be up to the cancer centers to sell their services to employers and insurers. Similarly, projects including the development of practice guidelines and outcomes analysis will be carried out and financed by the institutions.

Within six months, NCCN expects to develop the marketing strategy and materials needed to seek contracts, said Catherine Harvey, NCCN executive director. Subsequently, the group expects to develop "carve-out" contracts in which the centers would provide the more specialized and expensive cancer treatments.

Ultimately, NCCN hopes to assist its members in offering fully capitated services, an arrangement under which employers or insurers would pay the institutions a negotiated fee to assume their entire cancer risk.

"This will be a learn-as-you-go process," Harvey said to **The Cancer Letter**.

Though NCCN needs to devote at least another year to drafting practice guidelines, within six months,

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cancer centers will be able to use some of the network-wide guidelines in their bids for managed care contracts, Harvey said.

"I don't think we can wait to have all the information before we go after a contract," Harvey said. "Rather, we have to decide what risks we can bear. As we proceed, we will acquire knowledge about measuring costs and utilization of resources."

**Regional Variability Recognized**

Since the structure of reimbursement for medical care varies tremendously throughout the US, early in the planning process NCCN founders ruled out the option of building a centralized management services organization, Young said.

"The challenges faced by a hospital in California are not the same as the challenges faced by a hospital in Ohio or Philadelphia," Young said.

Recognizing this regional variability, NCCN will evolve a spectrum of products, Young said.

"Some of these [products] will be applicable and useful to certain companies in certain regions, and others will not be.

"I see it as a menu of services that we can place before a variety of insurers or corporations, and they can identify things that make sense to them, and then contract either regionally or nationally," Young said.

According to Young, NCCN members are well positioned to offer specialized services, including bone marrow transplantation, chemoprevention or pediatric oncology.

"The network can address particular kinds of cancer care that are specialized and can be made more cost-effective by volume," Young said.

Since many NCCN institutions have network relationships of their own, the group's referrals will extend beyond the immediate membership, he said.

"The national distribution of [NCCN members] will allow us to say [to insurers or employers] that we will either care for all of your patients at one of the participating institutions or [another] institution that meets the standards that we have established," said Young.

The idea for starting a consortium of cancer centers emerged two years ago, during a meeting of top administrators from Memorial, Fox Chase, M.D. Anderson, Fred Hutchinson, and City of Hope.

Though the meeting was held for another reason—discussion of matters related to the centers' exemption from the Diagnosis Related Group method of reimbursement—the conversation turned to the problem of competing for managed care, Simone said to **The Cancer Letter**.

Following that, the centers considered a number of options on their own, and with the help of entrepreneur Michael Goldberg, president and CEO of Axion Inc., a San Francisco-based company that specializes in oncology disease management.

"We've gone through a number of iterations, gathering information on what was possible for us to do," Simone said. "Michael helped us a great deal to get organized and get focused."

Last spring, Goldberg recruited Harvey, associate director, administration, at the Hollings Cancer Center. Technically, Harvey is an employee of Axion. However, the company is reimbursed for her salary by NCCN, she said.

The arrangement avoids making Harvey an employee of any of the NCCN centers, she said.

As it stands, Harvey reports to the executive committee that includes Simone and Young as well as Steven Rosen, director of Northwestern's cancer center, and Charles Balch, executive vice president, health affairs, at M.D. Anderson.

**Guidelines and Outcomes**

Virtually every medical specialty is developing practice guidelines and methodologies for outcomes analysis. However, in cancer care, determining the guidelines and outcomes is a staggering task.

"Oncology is different from other disciplines," said Rodger Winn, a medical oncologist at M.D. Anderson Cancer Center, who is chairman of the committee that is developing practice guidelines for NCCN. "When you have a heart attack, basicaly three or four things happen. When you have breast cancer, 50 things happen."

Winn said NCCN has developed a template for practice guidelines. Also, the committee has identified 22 cancers for which guidelines will be written by the end of the year.

Seven of these guidelines—for cancers of the breast, colon, prostate and ovary as well as leukemia and small-cell and non-small cell lung cancer—will be completed by September, Winn said.

The guidelines will not attempt to anticipate every situation. Instead, they will reflect a consensus of NCCN institutions.

Typically, the finished product will contain around a dozen pages.

"These are not microscopic in detail," Young said. "They are not designed to be a cookbook for oncology. Rather, these are general guidelines that will allow us to estimate relative costs and resource utilization."

NCCN has also begun work on measuring outcomes. In March, the outcomes research committee plans to start measuring the rate at which NCCN hospitals conform to NCI consensus conference guidelines, Young said.

Ultimately, the guidelines and outcomes data will evolve into a centralized data base, Young said.

"We look forward to being able to measure the outcomes for specific stages of specific diseases that are treated across the network," he said.

## Broder To Leave In March; Sondik Will Be Acting Director

Edward Sondik will serve as NCI acting director when Samuel Broder steps down in early March, NIH officials said.

Broder, who announced he would leave by April, will step down a month earlier than anticipated.

NIH Director Harold Varmus made the announcement at an NCI staff meeting last week.

Sondik is the acting deputy director at the Institute.

Broder, who was present at the staff meeting where the announcement was made, appeared to be in good spirits, several sources said. Broder's accelerated departure is almost certain to mean that he would not testify at the House appropriations hearings, which are scheduled for mid-March.

At the staff meeting, Varmus said he and Broder had discussed the timing of the NCI director's departure and decided on an earlier date.

Varmus also announced the membership of the search committee formed to recommend Broder's successor. According to NIH officials, a list of candidates is expected to be submitted to the White House before May 1.

The 14-member search committee will be chaired by Paul Marks, president of Memorial Sloan-Kettering Cancer Center.

Other members are:

- Karen Antman, president of the American Society of Clinical Oncology and chief of the Div. of Medical Oncology at Columbia Presbyterian Medical Center. Antman is a member of the National Cancer Advisory Board Ad Hoc Working Group on NCI Intramural Programs.
- Fernando Cabanillas, chief of the lymphoma section at the Dept. of Hematology at M.D. Anderson Cancer Center.
- Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases.
- Harold Freeman, chairman of the President's Cancer Panel and professor of surgery at Columbia Univ. College of Physicians and Surgeons.
- Eli Glatstein of the Univ. of Texas Southwestern Medical Center, and a former NCI official.
- Joseph Goldstein, chairman of the Dept. of Molecular Genetics at the Univ. of Texas Southwestern Medical Center.
- Kenneth Olden, director of the National Institute of Environmental Health Sciences.
- Maxine Singer, president of Carnegie Institute.
- Shirley Tilghman, professor at Howard Hughes Medical Institute at Princeton Univ.
- Fran Visco, president of the National Breast Cancer Coalition and member of the President's Cancer Panel.
- Christopher Walsh, president of Dana Farber Cancer Institute.
- Samuel Wells, chairman of the Dept. of Surgery at Washington Univ. School of Medicine in St. Louis, a former NCAB member. Wells is a member of the NCAB Ad Hoc Working Group on NCI Intramural Programs.
- Charles Wilson, an NCAB member and a neurosurgeon at the Univ. of California, San Francisco.

*Reinventing NIH*

## NCI Remains An Exception To NIH Authority Over BSCs

The NIH director will have the final authority to appoint members of NIH Boards of Scientific Counselors under new procedures for review of the intramural research program.

However, advisory boards operated by NCI will continue to be appointed by the NCI director because of the provisions of the National Cancer Act of 1971.

The new procedures, contained in a revised chapter in the NIH Manual, were put in place as part of the restructuring of the intramural research program, as recommended last spring by the Marks-Cassell report.

Michael Gottesman, NIH deputy director for intramural research, described the new procedures with the chairmen of the Boards of Scientific

Counselors (BSCs) this week.

Under the new procedures:

●Nominations for new BSC members are to be solicited by the BSC chairman, current members, the scientific director, the institute director, Gottesman's office, and the NIH director.

●The BSC chairman should propose a slate of new members to the institute director, who will discuss the nominations with Gottesman. The slate will be sent to the NIH director for approval and formal letters of invitation will be sent by Gottesman's office.

●For NCI BSCs, the final appointment authority rests with the NCI director, as provided under the Public Health Service Act, which incorporates the National Cancer Act.

●Approximately one-third of BSC members should not receive their primary funding from the institute or division on whose BSC they serve.

●BSC members should have "international recognition as an authority" in one of the fields of research reviewed. BSCs should have a balanced membership among disciplines and with respect to gender, ethnicity, and geographical distribution.

●BSC members should serve five-year terms.

●The chairmen of the BSCs will be selected from past or current BSC membership by the institute director after consulting the former BSC chairman, the scientific director, and Gottesman. The chairman should serve a two-year term.

●A BSC may make use of ad hoc reviewers when the chairman deems it necessary.

●BSCs will meet often enough to ensure that the work of each tenured and tenure-track intramural scientist is reviewed at least once every four years.

**Independent Voices On Boards**

Several BSC chairmen said they opposed the requirement that one-third of the board members should receive no funds from the division or institute they advise.

"I think that should be removed," said Barry Pierce, chairman of the NCI Div. of Cancer Etiology BSC and professor at Univ. of Colorado. "It's demeaning."

The requirement was put in place in order to inclide independent representatives on the boards, Gottesman said.

Several chairmen argued that they should have access to letters of recommendation for intramural scientists who are being considered for tenure. Some BSCs see the letters, while others do not.

"One form of scientific evaluation is to look at what our peers say," said Dennis Smith, BSC chairman for the National Institute of Child Health & Human Development, and president of the Univ. of Nebraska. "We have an obligation to look at all sources of evidence."

Gottesman said allowing the BSCs to see the letters of recommendation present practical problems as well as potential problems of confidentiality.

**Review of Scientific Directors**

The boards will not be expected to review the scientific directors, Gottesman said. This idea was nearly put into place, but deemed inappropriate, he said.

Instead, ad hoc committees established by the institutes' advisory councils will review the scientific directors at least every four to six years.

One member of the review committee will be a current or former BSC member, while the other members may be drawn from the advisory council, former intramural scientists, and other senior scientists and administrators.

**Higher Salaries for Patient Care**

NIH this week received the authority to supplement the salaries of staff who are involved in patient care through Title 38, a provision provided to Veterans Administration hospitals and several other federal agencies.

The authority will allow physicians' salaries to rise to $200,000 annually.

NIH also is close to receiving approval to form a Senior Biomedical Research Service, which would replace the existing Senior Scientific Service. The new service will allow the creation of supplements for career track employees beginning at the GS-15 level, through Executive Level 1.

The new service should improve the ability of NIH to recruit high-level executives, Gottesman said.

The service still requires approval from the White House Office of Management and Budget.

However, there is still no relief in sight for the freeze on promotions of staff from GS-13 to GS-14, Gottesman said.

"That is the single biggest problem for the intramural program right now," Gottesman said to **The Cancer Letter**.

Of the 19 NIH scientists who have gone through the new tenure process established last summer, 14

have been approved for tenure, Gottesman said. Of the five not approved, most were considered too early in their careers and were placed on the tenure track, he said.

The institutes used to tenure 50 to 60 scientists per year, but have tenured only 14 in the past nine months. "This reflects the downsizing," Gottesman said.

The meeting of BSC chairmen was open to the public. The group is expected to meet about once a year.

## DCPC Advisors Approve New Program Project Grants

Advisors to the NCI Div. of Cancer Prevention and Control agreed to set aside $25 million over the next five years to fund program project grants in primary and secondary cancer prevention.

The DCPC Board of Scientific Counselors last week approved in concept a new Request for Applications for Cancer Prevention Research Unit program project grants. Up to four grants would be funded to stimulate cancer prevention, health promotion and prevention services research.

The board also approved in concept a new grants program for metabolic studies in humans of how cancer is prevented by dietary modification. Eight to 10 awards would be funded with a total of $8 million over four years.

After board approval, concepts require final sanction by NCI officials, after which they are issued as RFAs, RFPs, or program announcements.

Excerpts of the concept statements follow. For futher information, contact the program director or project officer listed.

**Cancer Prevention Research Unit Program Projects.** Concept for a new RFA for P01applications, ad hoc review, four awards, total $25 million over five years. Funds for each CPRU would be capped at $1.25 million total annual costs. Program director: Sherry Mills, Prevention and Control Extramural Research Branch.

The CPRU Program is a attempt to stimulate the rapid establishment of long-term programs in cancer primary and secondary prevention, health promotion and prevention services research.

These CPRUs must focus on problem or program oriented cancer prevention research studies, will require long-term support and involve multidisciplinary participation, and, for cancer control Phase IV ad V studies, need to have access to defined populations in order to measure the population impact of any cancer control activities.

The CPRU concept envisions a multidisciplinary environment of scientists interacting closely in the research program. These can include new as well as experienced investigators in relevant fields and disciplines, such as disease prevention and control, medicine, public health, health education, health promotion, epidemiology, nutrition, nutrition sciences, early detection, chemoprevention, health policy and economics, health services research, behavioral and social sciences, community organization, communications, and biostatistics. Linkages between occupoational and environmental exposure and cancer control will strongly be encouraged.

It is not necessarily the intent of this concept to create a CPRU in a location where a critical mass of resources and qualified investigators does not exist, but rather to redirect, focus, and recruit institutions such as cancer centers already having highly competent investigators into cancer prevention ad control research. At present, there exists a shortage of comparable research units which are devoted to cancer prevention.

The CPRU requires a major program theme to focus the research effort and form the basis for multidisciplinary and inter-institutional collaboration and synergism. Themes previously used in large cancer prevention and control program project grants have varied, from single cancer site (e.g. breast cancer prevention and control), to risk factor focus (e.g. tobacco reduction in an HMO), to intervention focus (e.g. adherence to cancer control regimens or improving early detection methods).

Peer-reviewed developmental, pilot, or feasibility projects are permitted and encouraged in the CPRU. These short-term projects (usually 1-2 years) are particularly appropriate in conjunction with long-term prevention intervention studies in communities or other settings as a means to continually test new ideas, improve procedures, ensure rapid integration into ongoing studies, and allow a means to endure successful and optimal completion of major program project objectives. Occasionally, projects may be for longer than two years with appropriate justification.

These projecus are analogous to the variety of short-term experiments that a laboratory scientist can conduct in following up new leads rapidly as findings emerge from in-vitro studies within the general program theme of the grant.

Investigators will be expected to present a developmental project budget for five years.

The first two years of such pilot projeces will be reviewed as part of the whole CPRU application, as well as the scope of potential projects for years 3-5, if possible,

and a method for intemal peer review and decision making. The actual number of projects approved, the funding level in the furst two years, and the arnount allowed for years 3-5 will be determined by the peer review group during the review of the CPRU application. Up to 15% of the CPRU total costs may be devoted to developmental projects.

**Human metabolic studies of mechanisms for prevention of cancer by dietary modification.** Concept for a new RFA, eight to 10 awards, ad hoc special review group by NCI, estimated total $8 million over four years. Program director: Susan Pilch, Diet & Cancer Branch.

Goals of this concept are to elucidate mechanisms and define biological functions by which various dietary patterns, foods, and/or nutrients may reduce risk for human cancers. The goal is to enhance understanding of *the relationship* between diet and cancer in order to refine dietary guidance for the population.

Applications for investigator-initiated research projects will be sought. Research topics of interest comprise human metabolic studies to clarify the effects of dietary patterns, foods (including foods compositionally enhanced by means of genetic engineering, biotechnology, etc.), and/or nutrients on molecular, cellular, metabolic, physiologic, or biochemical parameters relevant to the prevention of cancer. Proposed studies that include use of purified compounds should be designed to assess levels that can be obtained from foods in the diet, rather than nonphysiologic levels.

Some examples of relevant research areas follow:

•Conducting human metabolic studies of the effects of modifications in dietary patterns, consumption of specific foods, or intake of nutrients on: alterations in production and circulating levels of sex steroid hormones, metabolic activity and products of intestinal microflora, protection from lipid peroxidation or other oxidative damage, prostaglandin synthesis, immune function, DNA *damage and repair*, modulation of gene expression, cellular differentiation or proliferation, or metabolism of chemical carcinogens;

•Defining dose-response relationships in humans for nutrient effects on molecular and cellular events and alterations in metabolic pathways relevant to cancer prevention;

•Characterizing individual variability in metabolic responses to specific dietary constituents or eating patterns;

•Determining the bioavailability of nutrients relevant to cancer prevention at various intakes and from different food sources; and

•Identifying biochemical markers as quantitative measures of food or nutrient intake, digestion, absorption, and metabolism or individual nutritional status.

**Biomedical computing software services in support of the Biometry Branch.** Recompetition of a contract with Information Management Services, one award, $3.035 million over five years. Project officer: Donald Corle. Program director: Laurence Freedman.

The contractor will provide statistical progrnmming support for the research projects being conducted by the Biometry Branch. This includes the analysis of large sets of medical data often involving complex statistical analysis, sophisticated data handling and analytic techniques, and extensive computer graphics.

The facilities of the NIH Div. of Computer Research and Technology will be used for most of the computer processing, including the IBM mainframe and the UNIX-based CONVEX computer. Some applications will also be developed for UNIX-based Sun workstations and the PC environment. Computer programs will be generally written in SAS and Fortran, but other languages such as Visual C+ + for Windows, and PC data base management languages such as ACCESS may be required. When appropriate, the contractor will convert existing software or write new programs to run in the DOS-based PC and microcomputer environment such as the Sun workstation.

**Surveillance, Epidemiology and End Results Program.** Concept for RFP, continuation of 11 non-competitive collection contracts and competitive RFP for one quality control contract. Total $124.1 million over seven years. Project officer: Benjamin Hankey, Cancer Statistics Branch. Program director: Brenda Edwards.

Data will be collected on all cancers diagnosed in residents of 11geographic areas of the United States during the period 1997-2003. Populations of interest within the 11 areas will be surveyed periodically to obtain data on knowledge, attitudes, and practices related to cancer prevention and control. Special studies will be conducted to address cancer control issues of interest to the NCI. Support for quality control of data collected is also included.

**MINSCAN simulation program for colorectal cancer screening.** The board approved in concept a sole-source contract with Erasmus Univ. in Rotterdam for the development of this model as a tool for planning and evaluation for the Prostate, Lung, Colorectal and Ovarian Screening Trial. Total cost is $225,000 over two years. Project officer: Martin Brown, Applied Research Branch.

## In Brief

(Continued from page 1)

1980, Warren will oversee all cancer patient care services in the newly created position. . . . **ROBERT PERRY**, a molecular biologist at Fox Chase Cancer Center, received the center's Stanley P. Reimann Honor

Award and became the first to hold the new Reimann Endowed Chair in Research, the first endowed chair at Fox Chase. . . . **DONNA SALZMAN** has joined the Univ. of Alabama at Birmingham Bone Marrow Transplant Program as an assistant professor of internal medicine and has been named an associate scientist in the UAB Comprehensive Cancer Center. She was a faculty member at the Univ. of Texas Health Science Center. . . **THERESA STRONG** was appointed research assistant professor in the UAB Comprehensive Cancer Center's Gene Therapy Program. She was an investigator with the Univ. of Michigan.

## RFPs Available

**RFP NCI-CP-62601-13**

Title: **Mechanisms Of Chemical Carcinogens In Old World Monkeys**

Deadline: Approximately Feb. 8

NCI has a requirement for a contractor to provide continued studies of Old World Monkeys in support of the intramural research program of the Laboratory of Comparative Carcinogenesis. This contract will provide for animal facilities adequate to house approximately 150 monkeys, all patas (Erythrocebus patas), or up to approximately 30 cynomolgus monkeys (Macaca fascicularis) or up to 15 monkeys of another compatible species, in place of an equal number of patas. Caging shall be of a size and configuration to meet current government (USDA/APHIS) standards for primates. The contractor shall be responsible for recordkeeping, housing, care, collection of tissues, cesarean sections, and necropsies of the monkeys. The contractor must be within one hour of the NCI facility in Frederick, MD.

Contracting Officer: Sharon Miller, NCI, 6120 Executive Blvd MSC 7224, Executive Plaza South Rm 620, Bethesda, MD 20852-7224, FAX 301/480-0241, Tel: 301/496-8611.

**RFP NCI-CP-62602-13**

Title: **Resource for Procurement of Human Tissues from Donors with an Epidemiological Profile**

Deadline: Approximately March 13

The NCI Div. of Cancer Etiology has a requirement for a resource for procurement of human tissues from donors with an epidemiologic profile. This will include 1) providing human broncus, lung and colon specimens following surgeries, organ transplants, and immediate autopsies; 2) obtaining appropriate human subject and informed consent approvals; 3) performing pathological analysis (morphological, cytochemical and immunocytochemical characteristics) of collected tissues from the fresh, unfrozen, normal, premalignant and malignant tissues to define conditions of the specimens at "time 0" of collection; 4) delivery of tissues to NIH within 2 hours of availability; 5) obtaining participation from smoking and nonsmoking male and female adults; 6) collecting viable specimens of blood components; 7) delivering donor questionnaires to NIH.

Contracting Officer: Sharon Miller, NCI, 6120 Executive Blvd MSC 7224, Executive Plaza South Rm 620, Bethesda, MD 20852-7224, FAX 301/480-0241, Tel: 301/496-8611.

**RFP NCI-CN-55082-70**

Title: **Phase I Studies of New Chemopreventive Agents**

Deadline: Approximately March 15

The NCI Div. of Cancer Prevention and Control Chemoprevention Branch, in its annual requirement to seek new sources, is soliciting proposals for Master Agreement Holders for Phase I Studies of New Chemopreventive Agents. The objective of these studies is to determine the parameters and characteristic of toxicity in humans, the safely delivered dose and the basic clinical pharmacokinetics of agents emerging from the NCI chemoprevention agent development program so that subsequent Phase III risk reduction trials can be appropriately designed.

Contracting Officer: Erin Lange, NCI RCB, PCCS, Executive Plaza South Rm 635, MSC 7226, Bethesda, MD 20892-7226, Tel: 301/496-8603.

## Program Announcement

**PA-95-021**

Title: **Models For AIDS and AIDS-Related Malignancies**

This Program Announcement is a joint effort by NCI and the National Institute of Allergy and Infectious Diseases to encourage investigators to develop useful and predictive biochemical, cellular, and in vivo models that could be used for the preclinical evaluation of new therapies against HIV disease and AIDS-related malignancies. Support will be by the investigator-initiated research project grant (R01), FIRST (R29) award, or the Interactive Research Project Grants (IRPG) mechanisms. NCI has set aside $2 million total costs in FY95 for the first year of funding and NIAID will give special consideration for the support of applications received in response to this initiative.

The RFA may be obtained electronically through the NIH Grant Line (data line 301/402-2221) and the NIH GOPHER (gopher.nih.gov), and by mail and email from: Nava Sarver, Div. of AIDS, NIAID, Solar Bldg Rm 2C01, 6003 Executive Blvd MSC 7620, Bethesda MD 20892-7620, Tel: 301/496-8197, FAX: 301/402-3211, Email: ns18p@nih.gov; or Mary Wolpert, NCI Div. of Cancer Treatment, EPN Rm 832, 6130 Executive Blvd MSC 7450, Bethesda, MD 20892-7450, Tel: 301/496-8783, FAX: 301/496-8333, Email: mkwolper@helix.nih.gov.