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Working Group Considering Formal Cap On Size Of Cancer Center Support Grants

An advisory committee formed to assess the NCI Cancer Centers Program is being asked to consider the appropriateness of placing a formal limit on the size of cancer center support grants.

Cancer Center Support Grants, also known as "core" grants, are

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In Brief

Children's Hospital Of Boston Names Pizzo Physician-In-Chief; Lynch Wins Bristol Award

PHILIP PIZZO, chief of the NCI Pediatric Branch, has been named physician-in-chief and chairman of the Department of Medicine at Children's Hospital of Boston. Pizzo came to NCI in 1973 as a clinical associate. He was appointed head of the infectious disease section of the Pediatric Branch in 1980, and became branch chief in 1982. Since 1995, he has been acting scientific director of the Division of Clinical Sciences. He plans to move to Boston in July. . . . **HENRY LYNCH**, professor and chairman of preventive medicine and public health, Creighton University School of Medicine, was selected to receive the $50,000 Bristol-Myers Squibb Award for Distinguished Achievement in Cancer Research. Lynch's work helped establish the hereditary basis of certain gastrointestinal, breast and ovarian cancers. He manages a database of family pedigrees, and last year established Creighton's Hereditary Cancer Prevention Clinic. Lynch first encountered a family with a high incidence of colon cancer in 1961. He tracked athology records of the family, and identified hundreds of other families with hereditary non-polyposis colon cancer, also known as Lynch Syndrome. . . . **TWO CANCER CENTERS** have received $500,000 unrestricted cancer research grants from Bristol-Myers Squibb Co.: **Aichi Cancer Center** in Nagoya, Japan, acting president, **Makoto Ogawa**; and **University of Chicago Medical Center**, Cancer Research Center, director, **Richard Schilsky**. . . . **CHILDREN'S MEMORIAL** Institute of Education and Research has established the **Sharon B. Murphy** and **Steven T. Rosen** Endowed Chair in Cancer Biology, a faculty position to direct the institute's cancer biology program. The chair was endowed by a $1.5 million donation from the Ann and Robert H. Lurie Family Foundation. Murphy is a professor of pediatrics at Northwestern University Medical School and head of the division of hematology/oncology at Children's Memorial. She is also chairman of the Pediatric Oncology Group. Rosen is director of Northwestern's Robert H. Lurie Cancer Center. CMIER is a freestanding research institute dedicated exclusively to pediatrics.

NCAB Advice On 20% Cap Never Formally Implemented

(Continued from page 1)

awarded to the nation's top cancer centers to pay for pilot studies, equipment, shared resources, and some administrative costs. During the 1980s, critics charged that the sizes of grants were skewed in favor of the centers that have been in the program the longest.

In fact, in 1992, the National Cancer Advisory Board recommended that NCI limit the support grants to 20 percent of the amount of a cancer center's NCI- and American Cancer Society-funded research. Thus, a center that held $5 million in NCI and ACS research grants could receive a support grant of no more than $1 million.

Though the NCAB recommendation never became the Institute's policy, peer reviewers use the 20 percent ratio as a guideline for determining the size of support grants, said Brian Kimes, director of the NCI Centers, Training and Resources Program.

"Our recommendation is to implement the 20 percent ratio cap on support grants, allowing the NCI Executive Committee to make exceptions," Kimes said to the Cancer Centers Program Working Group at its meeting March 12.

"Also, we recommend that no center receive a support grant that amounts to more than 5 percent of the Cancer Centers Program budget," Kimes said.

In 1992, Samuel Broder, then the NCI director, did not carry out the NCAB recommendation, Kimes said. "This policy was passed by the NCAB, but Broder decided he didn't want to use any caps on anything, so he just did not take the advice of the NCAB," Kimes said.

This year, NCI funded 55 support grants for basic, clinical and comprehensive cancer centers. The grants averaged $2.4 million each.

Group To Assess $166 Million Program

The cancer centers working group is the first of the advisory committees that are being convened by NCI Director Richard Klausner to evaluate the Institute's major programs. Altogether, seven such committees are expected to be formed. The cancer centers group was asked to study all aspects of the Institute's $142 million Cancer Centers Program, as well as the $24 million Specialized Programs of Research Excellence, and make specific recommendations.

"What we want is a reconsideration of the entire program; nothing is off-limits," Robert Wittes, director of the Division of Cancer Treatment, Diagnosis and Centers said. "However, there is no implication that the program is deeply flawed in some way."

Joseph Simone, working group chairman and physician-in-chief at Memorial Sloan-Kettering Cancer Center, said the group intends to complete its work by June and send a draft report to the NCI Board of Scientific Advisors. Following the BSA review, the report would be presented to Klausner and, subsequently, to the NCAB.

Klausner has said he hopes the advisory group will help NCI simplify and, potentially, expand, the centers program. "I think we will have some fundamental changes in the hoops that we force institutions to go through in order to be called an NCI cancer center," he said in remarks to the annual meeting of the Association of Community Cancer Centers last week.

"We need to open those processes up," he continued. "One of my goals is to make sure that to a much greater extent the practice of oncology is integrated with the national enterprise of discovery and research."

The NCI Cancer Centers Program Working Group plans to meet on April 24-25, May 23-24, and June 20-21.

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More Equitable Distribution

The ratio cap would more fairly distribute support grant money among centers and allow NCI to fund new support grants, Kimes said to the working group. "The larger centers lose money over time, the smaller centers gain money, and it leaves us room to fund new centers," he said. "The ratio cap is unique. It doesn't prevent you from getting a cost-of-living increase."

Funds would not automatically be redistributed, Kimes said. Funding adjustments would be recommended by peer reviewers.

After Broder decided not to implement the cap, the centers program developed materials to provide peer reviewers with general budgetary guidelines. Those guidelines suggested that a 20 percent ratio be used to determine the size of support grants.

"In the absence of a cap, we had to use other methods for drawing the attention of the peer review group to how the budget is distributed," Kimes said. "In R01 study sections, you review 70 to 100 applications in a round and you get a good idea of the relative value of the science. The Cancer Center Support Grant review committee gets only 10 or 14 grants in a year."

The centers program gave the review committee a one-page statement urging reviewers to "apply consistent relative standards" to budget recommendations.

"While the NCI chooses not to establish formal 'policy caps' for its large grants, it is reasonable to consider some ratio of the size of the CCSG to the size of the research base as a trigger point for examining overall budgets more carefully...." the statement said. "For example, a 20 percent ratio of the size of the CCSG to the peer reviewed cancer research base was one model examined carefully by the Cancer Centers Subcommittee of the NCAB and was considered a reasonable way to effect more equitable distribution and effective use of the NCI's budget for CCSGs."

Reviewers Look At Ratio

NCI also gave reviewers a table with average costs per peer reviewed project for basic, clinical and comprehensive cancer centers, and the ratio of the core grant to NCI-funded research at those types of centers, Kimes said.

"This was their guide for making determinations whether a center was on the high end and they should look at the budget carefully, or the low end, and whether they should consider an increase," Kimes said.

Max Wicha, a working group member and the former chairman of the support grant review committee, said the NCI guidelines had a significant effect. "The committee looks at that ratio before starting the grant review," said Wicha, director of the University of Michigan Comprehensive Cancer Center.

"Centers that are below the cap tended to get a higher percentage of the levels they asked for than those above the cap, although it wasn't an absolute rule," Wicha said.

Some basic science centers might consider the 20 percent cap too restrictive, because their base of NCI-funded research could be smaller than that of clinical and comprehensive centers, Kimes said. In those cases, the Executive Committee could make exceptions, he said.

According to NCI documents Kimes provided to the committee, 26 cancer centers hold support grants that exceed the 20 percent ratio, while 22 others fall below the 20 percent cap. The remaining five are close to 20 percent, documents said.

Responding to a question by Robert Young, a member of the working group and president of Fox Chase Cancer Center, Kimes said basing the cap solely on a center's NCI-funded research, excluding other NIH support and grants from organizations such as ACS, provides greater accuracy to the figures. Also, he said, adding in the other grants made little difference in the calculation.

"There is no logic for what number you use in the denominator," Kimes said. "It seemed a little more logical for us for to say institutes should work on their NCI support. It says that if your NCI research base grows, your cancer center support grant grows."

Restraining "Unlimited Growth"

Two other types of limits were placed on center support grants in 1992, Kimes said.

A "growth cap" limits a center from applying for more than a 50 percent increase over its previous year's support grant budget. Another rule limits new centers from applying for more than $800,000 in direct funds.

"Before 1989, there didn't seem to be any logic to how the [centers program] budget was distributed relative to the strength of the science base at any of

NCI Cancer Center Support Grants, 1989 vs. 1995

Institution	1989 Award	1995 Award	FY95 in real 1989$
Sloan-Kettering Institute for Cancer Research	$8,169,394	$6,133,391	$4,557,110
Institute for Cancer Research (Fox Chase)	7,142,632	5,995,805	4,454,883
University of Wisconsin (combined-see below)	4,486,750	5,530,328	4,109,034
Fred Hutchinson Cancer Research Center	4,106,014	5,338,297	3,966,355
Dana-Farber Cancer Institute	3,560,416	3,351,800	2,490,387
Johns Hopkins University	3,159,354	4,487,349	3,334,100
University of Alabama	3,059,870	3,983,562	2,959,787
Yeshiva University--Albert Einstein	3,017,868	3,653,731	2,714,722
Duke University	3,017,857	3,773,620	2,803,800
American Health Foundation	2,941,233	2,830,588	2,103,127
University of Southern California	2,851,005	3,500,973	2,601,223
University of Rochester	2,703,969	1,189,384	883,712
Jonsson Comprehensive Ca Center (UCLA)	2,648,953	3,239,719	2,407,111
Columbia University	2,598,624	3,004,917	2,232,653
St. Jude Children's Research Hospital	2,529,723	3,622,658	2,691,635
University of Wisconsin (Clinical Center)	2,260,451	2,812,175	2,089,446
University of Wisconsin (McArdle Lab)	2,236,299	2,718,153	2,019,588
Wistar Institute of Anatomy and Biology	2,222,536	3,127,483	2,323,720
Massachusetts Institute of Technology	1,954,549	1,501,615	1,115,700
University of Miami	1,862,962	1,039,249	772,162
Cold Spring Harbor Laboratory	1,794,054	2,669,134	1,983,167
Mayo Foundation	1,733,496	2,290,106	1,701,549
New York University Medical Cntr (combined)	1,668,575	3,352,755	2,491,097
University of Pennsylvania	1,658,500	2,991,069	2,222,364
Roswell Park Memorial Institute (combined)	1,621,347	1,969,183	1,463,103
University of Chicago	1,396,197	1,847,505	1,372,696
University of Michigan at Ann Arbor	1,340,276	1,890,883	1,404,926
University of Colorado Health Sciences Cntr	1,331,450	2,109,279	1,567,194
Salk Institute for Biological Studies	1,301,221	1,842,009	1,368,613
Univ. of Texas M.D. Anderson Cancer Cntr	1,235,416	2,297,806	1,707,270
University of North Carolina	1,234,382	2,324,033	1,726,757
Roger Williams General Hospital	1,211,627		
Worcester Foundation for Exper Biology	1,150,455		
Yale University	1,118,338	1,597,918	1,187,253
University of Pittsburgh	1,117,960	1,651,014	1,226,703
Dartmouth College (Norris Cotton Cancer Cntr)	1,016,037	1,662,995	1,235,605
Wake Forest U/Bowman Gray Sch of Medicine	1,004,234	1,595,469	1,185,433
Howard University	996,881		
Temple University Fels Institute	978,265		
University of Arizona	933,371	1,703,593	1,265,770
Drew University (w/Meharry/Morehouse)	915,481	700,00	520,100
Case Western Reserve University	908,607	648,653	481,949
Jackson Laboratory	869,079	1,240,543	921,717
University of California San Diego	864,535	1,394,994	1,036,481
Roswell Park (Grace Cancer Drug Cntr)	856,593		
New York University (Environmental)	853,147		
Beckman Research Institute/City of Hope	839,006	1,857,839	1,393,748
Wayne State University	786,936	1,570,552	1,166,920
California Institute of Technology	728,692		
Univ. Comm. VA, Massey Cancer Center	724,404	881,048	654,619
La Jolla Cancer Research Foundation	707,937	1,488,389	1,105,873
Ohio State University	705,357	1,951,420	1,449,905
University of Virginia, Charlottesville	702,576	950,122	705,941
University of Utah	688,955	1,310,321	973,569
Illinois Cancer Council	663,547		
University of Nebraska (Eppley Institute)	590,841	971,673	721,953
University of Vermont Regional Ca Center	480,784	1,043,599	775,394
Purdue University	391,742	662,577	492,295
Northern California Cancer Center	223,542		
University of Kentucky	40,662		
Vanderbilt		1,129,775	839,423
Irvine		1,112,659	826,706
Northwestern University		1,211,108	899,853
Jefferson		1,125,927	836,564
Cancer Therapy & Research Center		1,604,400	1,192,069
Average	$1,765,416	$2,400,962	$1,491,470
Median	1,234,899	1,951,420	1,265,770
Maximum	8,169,394	6,133,391	4,557,110

Source: NCI Cancer Centers Branch

our cancer centers," Kimes said to the working group.

"There was this unlimited growth concept: We can always add another shared resource, and another shared resource, and another shared resource," Kimes said.

"Our experience from peer review is that if centers were given flexibility to form any resource without close peer review, there is no assurance that these resources would all be of high quality," Kimes said.

"Likewise, the scientists who rely on the high quality of these resources do not want the quality of their research compromised by a poor quality resource."

Working Group Members

Members of the Cancer Centers Program Working Group are: Chairman, Joseph Simone, physician-in-chief, Memorial Sloan-Kettering Cancer Center; Michael Brown, director, Jonsson Center for Medical Genetics; Deborah Collyar, managing director, Clinical Trials Information Project; Virginia Ernster, professor, Dept. of Epidemiology and Biostatistics, School of Medicine, University of California, San Francisco; Judy Garber, assistant professor of medicine, Dana Farber Cancer Institute; Judith Gasson, director, Jonsson Comprehensive Cancer Center, UCLA; Edward Harlow, Massachusetts General Hospital Cancer Center; Waun Ki Hong, professor of medicine, M.D. Anderson Cancer Center; Richard Hynes, director, Center for Cancer Research; Joseph Pagano, director, UNC Lineberger Comprehensive Cancer Center; Franklyn Prendergast, acting cancer center director, Mayo Clinic; Philip Sharp, head, Dept. of Biology, Massachusetts Institute of Technology Center for Cancer Research; Richard Schilsky, director, University of Chicago Cancer Research Center; Ralph Snyderman, chancellor for health affairs, Duke University Medical Center; James Watson, president, Cold Spring Harbor Laboratories; Max Wicha, director, University of Michigan Comprehensive Cancer Center; and Robert Young, president, Fox Chase Cancer Center.

Three NCAB members serve as liaisons to the working group: Michael Bishop, director, the George Williams Hooper Research Foundation, University of California, San Francisco; Robert Day, president and director, Fred Hutchinson Cancer Research Center; and Sydney Salmon, director, Arizona Cancer Center.

Administration's FY97 Budget Requests $12.4 Billion For NIH

President Clinton has requested $12.406 billion for NIH in fiscal year 1997, an increase of $467 million, or 3.9 percent, over the fiscal 1996 budget of $11.939 billion.

The budget request, submitted to Congress on March 19, includes $310 million for construction of the new 250-bed NIH Clinical Center (**The Cancer Letter**, March 8, 1995).

In the Administration's budget request, $11.986 billion is intended for NIH program costs, an increase of $193 million, or 1.9 percent above the current year's budget.

NIH plans to support 6,827 competing investigator-initiated research project grants, an increase of 207 grants over the current year's estimate, the institutes said. Support for all research project grants, including Small Business Innovation Research and Small Business Technology Transfer awards, would increase by 3.2 percent.

The Administration request includes $2.28 billion for NCI, an increase of $29 million over FY96.

Funding for AIDS-related research in NCI would decrease from $225 million this year to $220 million in FY97, while funds for all other NCI activities would increase from $2.025 billion to $2.06 billion.

NCI To Ask HCFA To Launch Pilot Clinical Trials Program

NCI Director Richard Klausner said a meeting was being arranged to request that the Health Care Financing Administration launch a pilot program that would reimburse medical care costs for Medicaid and Medicare patients enrolled in cancer clinical trials.

"I will be meeting with [HHS Undersecretary for Health Philip] Lee and the head of HCFA," Klausner said last week at a meeting of the Association of Community Cancer Centers. Klausner said the proposal would be similar to a recently announced three-year demonstration project between NCI and the Department of Defense.

Under that deal, DOD will reimburse patient care costs for the military and their dependents eligible to participate in cancer clinical trials.

"Personally, I hope that HCFA would be willing to enter into a similar broad agreement about all cancer therapy trials," Klausner said. The date for

the meeting remains to be set, sources said.

If HCFA, the agency that administers the Medicare and Medicaid programs, agrees, the result would amount to a breakthrough for clinical trials. Moreover, it would make it less likely that other major payors would continue to deny coverage for patient care costs involved in clinical trials.

"Taking DOD Agreement On The Road"

NCI is using the DOD model agreement to seek cooperation of private insurers as well, Klausner said.

"We are taking [the DOD agreement] on the road," Klausner said. "This agreement has been a wake-up call to a large number of payors and providers that we are actively negotiating with that such agreements can be made, that we can move the conversation about where patients are and what payors pay for to issues of quality and responsibility to advance medicine."

The possibility that HCFA would be asked to launch a program similar to that of DOD was first brought up by Lee at a press conference announcing the signing of the interagency agreement (**The Cancer Letter**, March 8).

The excerpted text of Klausner's remarks to ACCC follows:

"We need to reach out and make sure that to a much greater extent the practice of oncology is integrated with the national enterprise of discovery and research. We need to re-examine our clinical trials system. We need to look at disincentives for both providers and for patients to enter and stay in clinical trials.

"We need to take a fresh look at different models for large-scale and simple clinical trials. We need to make sure that we learn efficiently and we learn quickly. As many members of practice community as possible should be part of this process.

"The changing health care system is going to continue to place challenges, barriers and problems for the conduct of clinical research, be it prevention trials or treatment trials.

"While we are not a medical practice institution, we must address the infrastructure that allows our discoveries to benefit patients.

"So we have embarked on a very aggressive set of negotiations with most—and, soon, hopefully, all—of the major payors and providers in the US to talk about the possibility of entering into a partnership with NCI for the express purpose of having partnerships with the patients throughout the country have available to them ready access to clinical research and clinical trials.

"We have completed what we believe is the first of what we hope will be many of these agreements, and that is an agreement of the Department of Defense.

"[The agreement] represents what many of us have been talking about: the need to talk not just about cost and bottom line, but quality and commitment to quality.

"Because it's a partnership, we have set up an office that will make sure that we are working to provide useful, user-friendly, accessible information and educational materials directed both at the providers and the participants. We need to improve that, and we will invest in improving our production and distribution of materials that are user-friendly and accessible in multiple media.

"We will also do something very important in this partnership in this office—we will use it to study how well this is working.

"The assumption that accruing and maintaining individuals on clinical trials will increase the clinical costs associated with cancer treatment has not been shown.

"I doubt it's significant. But we will follow it."

RFP Available

RFP NCI-CM-67247-08

Title: **Computer Based Searches For Chemical Structures**

Deadline: Approximately April 1

One cost-reimbursement contract is expected to be awarded to assist the NCI Developmental Therapeutics Program, NCI Div. of Cancer Treatment, Diagnosis and Centers. There is a need to perform high volume computerized full and substructure chemical searches of the DTP database in support of various segments of the Program. The contractor shall support the DTP through the described substructure and full structure chemical searches as well as data item searches. Bibliographic searches shall be performed utilizing databases such as NLM/MEDLARS, STN, DIALOG, and other systems. The contractor shall analyze each request, develop an appropriate search strategy, phrase the search question, process the query interactively, check and review the output, and generate the output report. The contractor shall generate systematic nomenclature for selected compounds. The principal investigator shall have a masters degree in organic chemistry or equivalent experience. An additional chemist for 4-8 hours a week is also preferable. The contractor shall perform the work on-site at DTP offices. Space and equipment will be

provided. The contract is 100% set-aside for small business with a SIC code of $7 million.

Inqiries: Todd Cole, tel: 301/496-8620, NCI RCBTCS, 6120 Executive Blvd, EPS/Rm 603, MSC 7220, Bethesda MD 20892-7220.

RFAs Available

RFA CA-96-009

Title: **Immunobiology Of AIDS Lymphoma**

Letter of Intent Receipt Date: April 25

Application Receipt Date: May 24

The intent of this initiative is to stimulate research on biologic and immunologic mechanisms involved in the development of lymphomas in AIDS patients. Specifically, this initiative will encourage development and testing of hypotheses about the mechanisms of lymphomagenesis in the unique immune environment induced by HIV infection. This environment is characterized by defects in immune regulation, loss of specific immune cell subsets, presence of abnormal cytokine levels, changes in the architecture of germinal centers and other lymphoid tissues and an apparent loss of immune surveillance. Any or all of these factors may play a role in the high incidence and distinctive characteristics of AIDS-associated lymphoma. This dysregulation may lead to an increase in the rate of generation of transformed lymphocytes and/or to enhanced capacity of these cells to escape surveillance and cause disease. Before effective therapies can be designed, it is necessary to understand the basic mechanism of lymphomagenesis in AIDS. Approximately $1,000,000 in total costs per year for four years will be committed to fund applications submitted in response to this RFA. Approximately six research project grant (R01) awards will be made.

Inquiries: Dr. John Finerty, NCI Division of Cancer Biology, 6130 Executive Blvd Rm 501, Rockville, MD 20892-9904, tel: 301/496-7815, fax: 301/496-8656, e-mail: fin@nih.gov

RFA HS-96-004

Title: **Expansion Of Quality Measures (Q-SPAN)**

Letter of Intent Receipt Date: April 26

Application Receipt Date: June 12

The Agency for Health Care Policy and Research announces the availability of cooperative agreements (U18) to develop and test quality of care measures. To complement current efforts underway in the field, development of measures for clinical conditions and populations where measures are lacking will have a high priority. Applicants are encouraged to form consortia that provide (1) the technical capabilities to develop quality of care measures, and (2) access to delivery settings in which to test the utility of these measures. Potential consortia participants include: health care plans, purchasers, State health agencies (particularly those involved with Medicaid managed care), Peer Review Organizations (PROs), horizontally and vertically integrated delivery systems, and academic health science centers. Consortia participants should include appropriate multidisciplinary expertise in clinical, scientific, information systems, and administrative areas. Both consortia members and project staff should include individuals from academic and delivery settings with expertise in research and evaluation. AHCPR expects to award up to $3 million in FY96 for several short term (one to three years) and long term (three to five years) projects.

Inquiries: Joann Genovich-Richards, Q-SPAN Project Officer, AHCPR, 2101 East Jefferson St, Suite 502, Rockville, MD 20852-4908, tel: 301/594-1352 ext. 114, fax: 301/594-2155, e-mail: jrichard@po3.ahcpr.gov

RFA HS-96-006

Title: **Referrals From Primary To Specialty Care**

Letter of Intent Receipt Date: April 22

Application Receipt Date: June 12

The Agency for Health Care Policy and Research invites applications to conduct research related to patient referrals from primary to specialty care. Applications are sought for studies that (1) describe how changes in health care organization affect referral practices, and/or (2) measure quality of care, economic and other outcomes resulting from decisions by primary care providers (PCPs) who refer, or do not refer, patients to specialty providers. Research should address issues related to referrals in the ambulatory care setting. AHCPR has a particular interest in studies that evaluate outcomes of "discretionary" referrals within public and/or private health care plans as well as studies focusing on provider supply and decisionmaking by referring providers (including nonphysician PCPs). Outcomes of interest reflect quality of care and include measures of patient health status, well-being, and satisfaction as well as the financial consequences of referral or non-referral. A "referral" is defined as transfer of all or part of the responsibility for patient care; a "specialist" is defined as a provider with recognized knowledge and skills in a specific area of health care; and "discretionary" referrals are defined as those associated with nonemergent conditions, for which there is considerable variation in practice among referring providers and/or differences in expert opinion concerning the timing or indications for referral. The RFA will use the R01 mechanism. AHCPR expects to award up to $1.5 million for the first year of projects.

Inquiries: Dr. David Lanier, Center for Primary Care Research, AHCPR, 2101 East Jefferson Street, Suite 502, Rockville, MD 20852-4908, tel: 301/594-1357, e-mail: dlanier@po3.ahcpr.gov

Program Announcement

PA-96-034

Title: **Aging Women And Breast Cancer**

The National Institute on Aging, NCI, and the National Institute of Nursing Research invite research project grant (R01) and First Independent Research Support and Transition (R29) award applications that focus on the unique problems of older women with breast cancer. Breast cancer affecting elderly women is a major problem for cancer control. The purpose of this broad based program announcement is to inform the scientific community of the interests of NIA and NCI, and to expand the knowledge base on breast cancer in older women through studies in the fields of biology, clinical medicine, epidemiology, and the behavioral and social sciences.

Inquiries: Rosemary Yancik, Geriatrics Program, National Institute on Aging, Bldg 31 Rm 5C05, Bethesda, MD 20892, tel: 301/496-5278, fax: 301/496-2793, e-mail: YancikR@31.nia.nih.gov

Claudette Varicchio, NCI Division of Cancer Prevention and Control, EPN Suite 300, Bethesda, MD 20892, tel: 301/496-8541, fax: 301/496-8667, e-mail: Varricci@DOPCEPN.nci.nih.gov

June Lunney, Scientific Program Administrator, National Institute of Nursing Research, Bldg 45 Rm 3AN12, Bethesda, MD 20892-6908, tel: 301/594-6908, fax: 301/480-8260, e-mail: Jlunney@EP. NINR.NIH.GOV

Agencies Seek Small Business Research Grant Applicants

Title: **Small Business Innovation Research Program**

Application Receipt Dates: April 15, Aug. 15, Dec. 15

The Small Business Innovation Research program provides support for research and development of new technologies and methodologies which have the potential to succeed as commercial products.

The applicant organization must be a small business concern, and the primary employment of the principal investigator must be with the small business at the time of award and during the conduct of the proposed project.

In accord with the intent of the SBIR program to increase private sector commercialization of innovations derived from federal R&D, scientists at research institutions can play an important role in an SBIR project by serving as consultants and/or subcontractors to the small business concern.

Normally, up to one-third of the Phase I budget may be spent on consultant and/or contractual costs, and up to one-half of the Phase II budget may be spent on such costs. In this manner, a small business concern with limited expertise and/or research facilities may benefit from teaming with a scientist at a research institution; for the scientist at a research institution, this team effort provides support for R&D not otherwise obtained.

Public Law 102-564 requires NIH, the Centers for Disease Control and Prevention and the Food and Drug Administration to reserve a specified amount of their extramural research or R&D budgets for an SBIR program. In fiscal year 1996, 2 percent of the extramural budget is reserved for the SBIR program, amounting to nearly $184 million at NIH alone; in fiscal years 1997 and beyond, the SBIR set aside requirement becomes 2.5 percent of the extramural budget.

The SBIR program consists of the following three phases:

Phase I: The objective of this phase is to determine the scientific and technical merit and feasibility and potential for commercialization of the proposed project and the quality of performance of the small business concern, before consideration of further federal support in Phase II.

Awards should not exceed $100,000 for direct costs, indirect costs, and negotiated fixed fee for a period normally not to exceed six months.

Phase II: The objective of this phase is to continue the research or R&D efforts initiated in Phase I. Funding shall be based on the results of Phase I and the scientific and technical merit and commercial potential of the Phase II application.

Awards should not exceed $750,000 for direct costs, indirect costs, and negotiated fixed fee for a period normally not to exceed two years, that is, generally, a 2-year project should not cost more than $750,000 for that project. A Phase I award must have been received in order to obtain a Phase II award.

Phase III: The objective of this phase, where appropriate, is for the small business concern to pursue, with non-SBIR funds, commercialization of the results of the research or R&D funded in Phases I and II.

Several NIH awarding components are inaugurating a “fast-track” pilot initiative to expedite the decision and award of SBIR Phase II funding for scientifically meritorious applications for projects that have a high potential for commercialization.

Fast-Track offers concurrent peer review of both Phase I and Phase II projects and minimal or no funding gap between Phase I and Phase II.

Inquiries: Eligibility requirements, definitions, application procedures, review considerations, application forms and instructions, and other pertinent information are contained in the Omnibus Solicitation Of The National Institutes Of Health, Centers For Disease Control And Prevention, And Food And Drug Administration For Small Business Innovation Research (Sbir) Grant Applications, available in hard-copy from MTL Inc., 13687 Baltimore Ave., Laurel, MD 20707-5096, tel: 301/206-9385, fax: 301/206-9722, e-mail: a2y@cu.nih.gov