THE CANCER LETTER

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Oncology Faces Cuts In CMS Revamp Of Physician Payments Under Part B

By Paul Goldberg

The physician payment policy proposed by the Centers for Medicare and Medicaid Services would dramatically alter federal payments for cancer treatment.

For medical oncologists and hematologists, the total drop proposed by Medicare would add up to 6 percent next year. Of this margin, the practice expense component would drop by 5 percent and the allotment for malpractice insurance would drop by a percentage point.

The American Society of Clinical Oncology characterized the proposal as "a serious threat to the cancer community" and pledged to oppose it vigorously.

According to ASCO's analysis, the CMS proposal would have

(Continued to page 2)

NIH News:

Francis Collins Nominated For NIH Director Two Days After Final Stem Cell Guidelines

By Kirsten Boyd Goldberg

President Barack Obama said July 8 that he intends to nominate geneticist Francis Collins as NIH director.

Collins, 59, served as director of the National Human Genome Research Institute at NIH for 15 years, stepping down last year to pursue other projects, including working with the Obama campaign.

Collins' nomination for NIH director had been rumored for months, and came two days after the administration released final regulations governing stem cell research, allowing many older stem cell lines to be eligible for federally financed research. The guidelines are posted at http://stemcells.nih.gov/policy/2009guidelines.htm.

"The National Institutes of Health stands as a model when it comes to science and research," Obama said in a statement released by the White House. "My administration is committed to promoting scientific integrity and pioneering scientific research and I am confident that Dr. Francis Collins will lead the NIH to achieve these goals. Dr. Collins is one of the top scientists in the world, and his groundbreaking work has changed the very ways we consider our health and examine disease. I look forward to working with him in the months and years ahead."

Collins helped found the BioLogos Foundation, formed by a group of

(Continued to page 4)

Radiation Oncologists, Radiologists Also Face Cuts

(Continued from page 1)

particularly dramatic impact on administration of chemotherapy. Core chemotherapy administration services, including infusion of chemotherapy, would be cut by more than 20 percen.

Medical oncology is not the only specialty to face cuts, and some are cut even more dramatically. Radiation oncologists would get a 19 percent cut, radiologists would see an 11 percent drop, and urologists would get a 7 percent cut. Diagnostic testing facilities would drop by 24 percent. Cardiology—Medicare's second biggest ticket item after internal medicine—would get an 11 percent cut.

On top of that, payments to physicians are scheduled to drop by 21.5 percent as part of the federal government's long-standing efforts to use a "conversion factor" to reduce the physician component of Medicare. Between 2004 and 2009, Congressional action has spared physicians these cuts and even produced small increases.

These last-minute reprieves notwithstanding, the cuts remain on the books, and the threat of their cumulative impact looms. Should Congress fail to come to the doctors' rescue during the calendar year 2010, medical oncologists and hematologists would face a 27.5 percent decrease in overall reimbursement, and radiation oncologists would see their practice payments shrink by 40.5 percent.

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With compounded conversion factor cuts hanging over all doctors like the sword of Damocles, Congress and the administration have considerable leverage over physician lobbies as they pursue healthcare reform. At the same time, most professional societies expect to be approached by the administration and Congress with requests to accept additional cuts in order to pay for universal healthcare.

"A 21.5 percent plus six percent to a community that cares for one of the top two killers of Medicare patients in the country doesn't seem like a way to ensure access to care," said Deborah Kamin, ASCO's senior director for cancer policy and clinical affairs. "And cardiologists, who care for patients suffering from the leading cause of death in the U.S., are taking an 11 percent cut on top of the projected 21.5 percent SGR reduction."

Another cancer organization, Community Oncology Alliance, is advocating a legislative proposal to consider oncology separately from the rest of healthcare reform.

AMA Survey Triggers Redistribution

The proposed 6 percent cut for oncologists is the result of a survey of practice costs.

The survey, called Physician Practice Information Survey, or PPIS, was designed and conducted by the AMA. The survey results were used to reapportion funds within the $77.7 billion Medicare has budgeted for physician charges under Part B.

Clear winners in this reallocation were primary care physicians. Family practitioners are slated to get an 8 percent raise, internists, with a 6 percent raise, general practitioners who get 6 percent, optometrists (12 percent), and opthalmologists, (11 percent).

CMS also proposed increasing the payment rates for the "initial preventive physical exam," also called the "welcome to Medicare" visit. The initial visit was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and is conducted within one year of the beneficiary's enrollment in Part B.

Physician groups that benefit from the redistribution would be unlikely to join oncologists, radiologists and cardiologists as they take their grievances to Capitol Hill.

In another significant change that would affect oncology, the CMS proposal separates physician-administered drugs from the payment formula.

In a statement accompanying the 1,128-page proposed rule, the agency said that the decision to

remove drugs from the payment formula was an intermediate step toward fundamental revision of payment rules.

"While working with Congress to develop a more appropriate mechanism for updating physician payment rates, CMS is proposing to remove physician-administered drugs from the definition of 'physician services' for purposes of computing the physician update formula in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments," the agency said.

The proposal also attempts to alter the "competitive acquisition program," created in 2005 to enable oncology practices to get out of the business of selling drug they administer. CAP was designed as an alternative to reimbursement based on "average sale price" of drugs. A physician taking part in CAP would receive drugs from a Medicare contractor.

Though it existed on paper, the competitive acquisition program hasn't been financial viable and is currently not offered by any contractor.

In another change, the agency proposed eliminating payment for consultation codes, which are paid at a higher rate than equivalent evaluation and management services.

Though it takes longer for a specialist to evaluate a new case for consultation, some insiders said higher reimbursement led to excessive reliance on such consults. Now, practitioners will be paid the same amount regardless of whether they are evaluating their current patient or consulting on a new case.

The agency said the redistribution of payments is also intended to curb what it described as rapid growth in high-cost imaging services.

The proposal recalibrates the utilization rates on physician-owned computed tomography, magnetic resonance imaging and positron emission tomography equipment. "The current payment rates assume that a physician who owns this type of equipment will use it about 50 percent of the time, but recent survey data suggest this expensive equipment is being used more frequently," the agency said.

The new calculation assumes 90 percent utilization, which lowers per-treatment reimbursement rates. In a related move, the agency would require accreditation of advanced imaging services by 2012

Professional Societies React

"We are certain that your practice expenses have not dropped since 2005, given the high level of the care and treatment that oncologists currently provide people with cancer," ASCO said in an alert to its members. "In fact, we believe that expenses have more likely increased substantially for many practices."

ASCO and several other societies conducted their own surveys of practice expenses, but this time, they were told by CMS that it would rely on the AMA survey that would compare expenses across specialty groups.

Now, ASCO argues that the CMS survey, which collected on physician practice expenses per hour at 50 oncology practices, was inaccurate.

"This sample grossly under-represents practicing oncologists and in no way reflects the true costs to practices," the society said in a communication to its members. "ASCO promptly communicated with CMS on this point and will continue to advocate that this survey provides an unbalanced perspective on the full cost of providing quality care to people with cancer."

CMS hasn't been transparent in its redistribution of resources, ASCO's Kamin said. "If you look at the fee schedule, it is not at all clear what their thinking was, how they rationalized basing payment amount on 50 responses," Kamin said. "We don't even know where these practices are, what states they are in, what settings they are in. We are not sure these 50 responses represent the spectrum of practices and settings."

The American College of Radiology, which represents the specialties most severely impacted by proposed change, disputed the CMS premise that utilization of radiology services is unacceptably high.

"One could argue that the growth rate for imaging may actually be too low," said Shawn Farley, a spokesman for the American College of Radiology. "Medical imaging procedures are replacing more invasive (and ultimately more costly) techniques. They allow patients to return to activity more quickly with less productivity lost. This is an area where growth is good. Driving down utilization too far may stifle research and development of technologies to benefit patients and deny patients access to life saving and life extending imaging care."

According to an ACR analysis, Medicare Payment Advisory Commission (MedPAC) and GAO statistics show that utilization, especially of the high end modalities, has flattened and is going lower. MedPAC data shows that the imaging growth rate, per Medicare beneficiary, for 2006-2007 was 2 percent.

Alsso, ACR argues that the 90 percent figure springs from a MedPAC report based on a survey of facilities in six large urban areas. MedPAC has stated and the Centers for Medicare and Medicaid services agreed that the urban survey was not sufficient to drive

national reimbursement policy.

"A recent national sampling of facilities by the Radiology Business Management Association found that the national median utilization rate for facilities is actually 54 percent," Farley said. "In rural areas, the median utilization rate is 48 percent. The 90 percent utilization assumption is grossly over-inflated and has no medical basis. Arbitrary assumptions should not dictate medical policy."

CMS Proposed Rule Consistent With Advisors

The proposed rule seem to be largely consistent with the recommendations of the AMA Specialty Society RVS Update Committee, commonly abbreviated as RUC.

Commenting on the 2008 physician payment schedule, the advisory group that represents a spectrum of specialties, wrote that CMS should reallocate payments based on a surveys that would compare expenses across specialty groups.

Also, the committee recommended that CMS change its assumptions about utilization of radiology equipment and other accounting assumptions.

Excerpts from the RUC recommendations to CMS follow:

The survey: "CMS currently utilizes practice expense data and physician hours from the 1995-999 AMA Socioeconomic Monitoring System survey to calculate 'practice expense per hour' estimation for each specialty. At several meetings, the RUC has recognized that these data are outdated and that there is a significant need for new survey data. On March 24, 2006, a multi-specialty sign-on letter (signed by more than 70 organizations) was sent to CMS with the following recommendation:

"'We are all in agreement… that moving forward, it is imperative that a multi-specialty practice expense survey be conducted to collect recent, reliable, consistent practice expense data for all specialties and health care professionals. We urge CMS to work with AMA and other physician and health professions organizations to achieve this goal.'"

ASCO and ACR are not among groups that signed the letter, documents show. At that time, the survey was expected to be completed in 2008 and implemented during the current year.

Equipment Utilization Data: "The RUC reiterates its recommendation that the existing 50 percent standard utilization rate for all equipment is not an accurate measure. SMS should consider using a higher rate for all equipment, providing an opportunity to specialty societies to provide date to support lower utilization rates, if appropriate, based on clinical or geographic considerations. An increase in the utilization rate should redistribute practice expense relative values to all services within the RBRVS."

The committee didn't propose an alternative utilization rate.

Cost of Capital Assumptions: "CMS currently utilizes an interest rate of 11 percent in pricing medical equipment. CMS had previously requested comments regarding the appropriate interest rate. In 2006 and early 2007, the RUC suggested that an 11 percent interest rate assumption is too high and should be adjusted to market conditions." The current proposed rule includes the 11 percent interest rate assumption. The comments on equipment utilization and interest rates also figure in the 2008 recommendations from the RUC.

The proposed CMS rule is posted at www.federalregister.gov/inspection.aspx#special Comments would be accepted through Aug. 31, and the final rule is scheduled to be published Nov. 1. The text of the RUC 2007 recommendation is posted at http://www.cancerletter.com/publications/special-reports.

NIH News:

Collins, Known For Genome Project, Nominated For NIH

(Continued from page 1)

scientists to bridge gaps between science and religion. He wrote a 2006 book on science and religion, "The Language of God: A Scientist Presents Evidence for Belief." In talks and interviews, he has described his conversion to Christianity as a medical student. He has just completed a new book on personalized medicine, "The Language of Life: DNA and the Revolution in Personalized Medicine," to be published early next year by HarperCollins.

Collins stepped into a role as a science communicator as head of the Human Genome Project, which had become beset with administrative problems before he took over. Some members of Congress questioned NIH's spending on the project, and advocated stopping the public effort to let a competing private firm finish the job. Collins forged relationships with legislators, public officials, the press, scientific and medical societies, and disease advocacy groups to save the public project, which puts all its data into the public domain.

The Human Genome Project met projected milestones ahead of schedule and under budget, cumulating in April 2003 with the completion of a

finished sequence of the human DNA.

However, some advocates for medical research say Collins and others involved in the project oversold its promise. The hope that the elucidation of human DNA would quickly lead to advances in medical treatment has diminished in recent years as it has become clear that translating genetic risk factors to the development of actual therapies is a long and difficult process.

Collins also is known for his guitar-playing and singing, performing at science-related events and university commencements. Many of his performances are posted on YouTube.

According to the White House statement, Collins has been involved in the discovery of genes for cystic fibrosis, neurofibromatosis, Huntington's disease, a familial endocrine cancer syndrome, and most recently, genes for adult onset (type 2) diabetes and the gene that causes Hutchinson-Gilford progeria syndrome.

Collins received a B.S. in chemistry from the University of Virginia, a Ph.D. in physical chemistry from Yale University, and an M.D. from the University of North Carolina. Prior to joining NIH in 1993, he spent nine years on the faculty of the University of Michigan, where he was an investigator of the Howard Hughes Medical Institute. He has been elected to the Institute of Medicine and the National Academy of Sciences, and was awarded the Presidential Medal of Freedom in November 2007.

NCI Programs:

NCI Advisors Approve $5M Contract Program For Reagents

Advisors to NCI unanimously approved the institute's plans to set aside $5 million over two years to support contracts to develop reagents and assays from data derived from two large genetics projects funded by the institute.

The NCI Board of Scientific Advisors also overwhelmingly approved the reissuance of five other Requests for Applications to continue several large programs, in AIDS-related malignancies, cancer health disparities, obesity and cancer, and environmental causes of breast cancer.

Excerpts from the concept statements follow:

Developing Necessary Reagents to Enable Translation of TCGA and TARGET Discoveries. Concept for a new RFP, four to seven awards, estimated first year set-aside $2.5 million, total $5 million over two years.

The Cancer Genome Atlas (TCGA) and Therapeutically Applicable Research to Generate Effective Treatments (TARGET) projects, Center for Strategic Scientific Initiatives, Office of Cancer Genomics are leading extramural efforts to provide a comprehensive characterization and sequence analysis of adult and pediatric cancer genomics. To leverage data from TCGA and TARGET requires broad engagement of the cancer research communities to conduct the in vitro and in vivo studies needed to understand the correlation with these genomic aberrations with the cancer biology. Currently, this progress is blocked by a critical lack of specialized reagents and assays to bridge genomic data and clinically relevant biomarkers. This concept proposes to address this barrier through the development of the tools needed and pipeline that will ultimately connect the data from these projects with cancer biology and ultimately drive biomarker discovery.

Two general classes of reagents will be generated in this project:

Nucleic Acid Reagents and Assays: The comprehensive nature of TCGA and TARGET will make it possible to identify novel targets that may have potential utility as biomarkers. A few examples of potential activities that could be funded in this project include, but are not limited to:

—Development of complex genomic characterization assays for the detection of homozygous deletions and amplifications in patient samples (paraffin embedded tissue, flash frozen samples, etc.).

—Development of complex genomic characterization assays for quantitative real-time PCR measurement of somatic mutations, gene expression alterations or DNA methylation changes.

—Development of micro-array or sequence-based methods for the simultaneous detection of many genetic alterations, gene expression variations or DNA methylation changes.

Protein-Based Reagents: Examples of potential activities for the generation of protein focused reagents include:

—Generation of protein capture reagents: Monoclonal antibodies directed to recognize TCGA or TARGET derived gene aberration targets that are specific to that mutation will be generated. Evidence for such specificity needs to be demonstrated (e.g. Western blotting, immunofluorescence analysis, immunohistochemistry, epitope mapping).

—Generation of peptide capture reagents: A novel and powerful new quantitative mass spectrometry technology uses novel anti-peptide monoclonal

antibodies that enable individual researchers to measure a defined set of low abundance human proteins in biological samples with sensitivity and specificity, high-throughput and cost levels that enable study of meaningfully large biological populations. This approach is also useful when the isolation of the antigen is difficult or time consuming, or when the antigen is a member of a large protein family. Therefore, to enhance application of these assay platforms, anti-peptide mAbs specific to proteotypic peptides derived from target protein and specific to the TCGA derived gene aberration will be produced. Additional monoclonal antibody characterizations should also be demonstrated.

Deliverables of this concept include:

1. The identification of nucleic acid and protein potential biomarker targets from TCGA and TARGET data that merit further exploration.

2. Generation and qualification of reagents and assays which can then be validated by the research community as potential biomarkers.

3. Generation of an accessible, transparent catalogue of credentialed reagents to the research community.

4. Deposition of all information developed in a publicly accessible website designated and supported by NCI.

AIDS Malignancy Consortium. Concept for a reissued RFA, cooperative agreement, one award, first year set-aside $4.68 million, estimated total $26.75 million over five years.

The AMC was established in 1995. The total estimated incidence of AIDS-related cancers in the U.S. per year is unlikely to be more than 5,000. More than 50% of these individuals are indigent and lack insurance, and the patients are often affected by multiple complex medical problems. AMC manages two life-threatening diseases simultaneously, AIDS and diverse cancers, which require wider expertise and tend to drive up the cost of trials. AMC conducts its own study monitoring, auditing, and performance evaluation through a subcontract paid by the grant, and supports its own correlative studies. In part, for these reasons, the cost of these trials is understandably high. Another challenge is that as the AIDS epidemic evolves and new treatments for HIV are developed, there are changes in the epidemiologic patterns of AIDS malignancies, often over the span of a few years. Yet another challenge, is that in recent years there has been little interest from the pharmaceutical companies or other for-profit groups in AIDS malignancies. There is little support for research in this population outside the government.

Since its competitive renewal in 2006, the AMC has developed 17 new protocols and has completed enrollment of six. Currently, it has 11 protocols that are actively enrolling and three that are in review. During this time period, a total of 279 patients have been accrued to AMC protocols. By the end of February 2009, the cumulative number of patients accrued on AMC trials since its creation in 1995 exceeded 1,200 patients. More than 40% of trial patients were of African-American and Hispanic origin.

The purpose of the proposed RFA concept is to continue to provide support to stimulate cooperative efforts in the 1) design, development, and evaluation of clinical interventions for the prevention and treatment of malignancies in patients with HIV infection, 2) development of more effective management and therapeutics for HIV-associated malignancies, 3) investigation of the biology of HIV malignancies within the context of clinical trials, 4) management of issues of international importance in HIV-associated malignancies, and 5) distribution of excess tumor tissue and other relevant biologic fluids to the AIDS and Cancer Specimen Resource for ongoing or future investigations. The mission and objectives of the AMC are of substantial interest to the Office of AIDS Research and are part of the Trans-NIH Strategic Plan for HIV-Related Research.

It is proposed that the RFA will be reissued and the AMC will re-compete within the context of its current structure. The project will use the cooperative agreement (U01) mechanism to fund one application under the guidance of the AMC Chair and Executive Committee. This award will provide for subcontracts to EMMES, core sites, affiliate sites, network laboratory and the Statistical Center. Funds for patient care costs will be available for approximately 8-12 core sites and 20-25 affiliate sites. Sites will receive patient care costs on a capitation basis and for laboratory correlative studies, clinical pharmacology and international studies. The group will have at least four scientific disease-oriented working groups: KS, lymphoma, HPV-associated cancers, and non AIDS-Defining Cancers. The network laboratory will be responsible for routine clinical trial support activities, pathogenesis-driven correlative studies, and clinical pharmacology and pharmacokinetics studies of anticancer/antiviral interactions. All trials conducted by the AMC will be available to subjects of all racial/ethnic groups. It is expected that the AMC will work closely with local patient advocacy groups and institutional Community

Advisory Boards, and that CAB members will serve on the various AMC committees.

Community Networks Program: Reducing Disparities Through Outreach, Research and Training (CNP-II) (U54). Concept for a reissued RFA, cooperative agreement, 24 awards, first year set-aside $20.7 million, estimated total cost $103.5 million over five years.

In 2005, the Center to Reduce Cancer Health Disparities launched the CNP and 25 institutions were funded under this program. The purpose of CNP is to reduce cancer disparities in racial/ethnic minorities and underserved populations by increasing access to and use of beneficial biomedical procedures in primary and secondary prevention and to develop a cadre of well-trained researchers who will continue to reduce disparities in communities. The underlying scientific approach is Community-Based Participatory Research. CBPR is a research approach that mandates a partnership between traditionally trained experts and members of a community, with all parties interested in addressing a common research problem. CBPR is characterized by substantial community input in the development and implementation of a research proposal.

Through the work of CNP, over 330 new investigators have been trained in cancer health disparities research. Small pilot research grants were awarded to 53 new investigators to conduct small research projects and support training.

The purpose of this concept is to continue building upon NCI's efforts to address the cancer burden in racial/ethnic minorities and other underserved populations by using CBPR. The overall goal of the CNP-II is to further increase knowledge of, access to and utilization of beneficial biomedical procedures across the health care continuum from prevention to early detection, diagnosis, treatment and survivorship in racial/ethnic minorities and other underserved populations.

Based on findings from the CNP along with needs assessments and pilot projects, CNP-II would further develop the infrastructure, outreach, research and training activities needed to continue NCI's efforts towards a reduction in cancer disparities and other co-morbid conditions affecting racial/ethnic minorities and other underserved populations.

Comprehensive Minority Institution/Cancer Center Partnership. Concept for a reissued RFA, cooperative agreement, four to five awards, first year set-aside $5 million, estimated total cost $25 million over five years.

The purpose of the U54 MI/CCP is to foster and support intensive and mutually beneficial collaborations among the Minority-Serving Institutions and cancer centers for the development of strong national cancer programs aimed at understanding reasons behind the significant cancer disparities and related impacts on racial and ethnic minority and socioeconomically disadvantaged populations. The MI/CCP U54 targets four areas: cancer research, cancer training, cancer outreach, and cancer education. Each grant must address the first three target areas; cancer education is optional.

This initiative is intended to support planning, development and/or implementation of collaborations and partnerships between MSIs and NCI-designated cancer centers that will achieve the following general objectives:

—Build and stabilize independent, competitive research and research training capabilities at MSIs.

—Improve effectiveness of cancer centers in conducting activities specifically designed to address cancer disparities in underserved racial and ethnic minority populations and socioeconomically disadvantaged.

—Create a stable, long-term collaborative relationship between MSIs and NCI-designated cancer centers in the areas of research, training, career development and mentorship, education and outreach.

Transdisciplinary Research on Energetics and Cancer. Concept for a reissued RFA, cooperative agreement, six U54 research centers and one U01 coordinating center, first year set-aside $15 million, estimated total cost $85 million over five years.

This concept frames the renewal of the TREC cooperative agreement grant mechanism (U54) in nutrition, physical activity, energy balance, obesity, and cancer. The initiative fosters collaboration across multiple disciplines and encompasses projects that cover the biology, genomics, and genetics of energy balance to behavioral, socio-cultural, and environmental influences upon nutrition, physical activity, weight, energetics, and cancer risk.

Competitive renewal of the initiative will enable NCI to expand this research model in energetics and cancer with renewed emphasis on testing and integrating health theories, challenges in survivor populations, systems analysis, accelerating capacity using animal and human studies in diverse research designs, and expansion of the application of biological markers to

inform behavioral based research.

Breast Cancer and the Environment Research Program. Concept for a reissued RFA, cooperative agreement, nine to 10 awards. First year set-aside $3 million from NCI, $4.1 million from NIEHS. Estimated total cost over five years $15 million from NCI, $22.5 million from NIEHS (six years).

This proposal is to renew the BCERP, a partnership between NCI and the National Institute of Environmental Health Sciences. This initiative was developed to support a network of teams comprising scientists, clinicians, and breast cancer advocates who work collaboratively on questions related to environmental and genetic factors that may predispose a woman to breast cancer throughout the life span.

The next phase of the program is intended to complete the initial population study, to expand upon the recent findings across the program, and to continue efforts to include and inform the breast cancer community. In addition, efforts will be made to stimulate novel dimensions in basic and applied research to exploit the latest concepts in breast cancer ontology and environmental health.

Cancer Control:

DOD, VA, Congress Should End Military Tobacco Use, IOM Says

Because tobacco use impairs military readiness, harms the health of soldiers and veterans, and imposes a substantial financial burden on the departments of Defense and Veterans Affairs, these agencies should implement a comprehensive strategy to achieve the Defense Department's stated goal of a tobacco-free military, a report from the Institute of Medicine said.

DOD should gradually phase in a ban on tobacco use in the military, starting at military academies and officer training programs and among new recruits, the report said. DOD should also stop selling tobacco products in Army and Air Force commissaries—Navy and Marine Corps commissaries already do not sell them—and should stop selling them at a discount in military exchanges and other stores. Also, Congress should allow VA to establish tobacco-free medical centers.

The report was requested by DOD and VA.

Tobacco use reduces soldiers' physical fitness and endurance and is linked to higher rates of absenteeism and lost productivity, the report said. In 2005, 32 percent of active-duty personnel and 22 percent of veterans were smokers; rates among active-duty personnel have recently increased, possibly because of growing tobacco use by deployed troops.

"We found that the adverse effects of tobacco use on military readiness, the health of both smokers and nonsmokers, and the financial cost of the medical care of smoking-related illness in military and veteran populations are a sound basis for moving systematically toward a tobacco-free military," said Stuart Bondurant, professor of medicine and dean emeritus of the School of Medicine at the University of North Carolina, Chapel Hill, and chairman of the committee that wrote the report. "The state of the art in tobacco control is such that with well-managed programs, DOD and VA could eventually be tobacco-free with minimal disruption, and with substantial benefit to military personnel and veterans."

DOD and VA should ensure that all personnel have quick and easy access to comprehensive, evidence-based tobacco-cessation services, the report said. All DOD and VA health care providers should be able to provide brief counseling and nicotine-replacement therapy to patients. The committee recommended that VA and DOD develop toll-free "quitlines" to provide military personnel and veterans with counseling on quitting tobacco. Quitline counselors should be trained to deal with issues related to these populations, such as post-traumatic stress disorder.

The Defense Department should set a date by which the military will be tobacco-free and require each of the four services to develop and enforce a timeline for achieving this goal, the report said.

Eventually, all military installations and active-duty personnel should be required to be tobacco-free—a goal that could realistically be achieved in 20 years or even sooner, if the plan's initial phase for military academies and new recruits starts within a year, the report said.

The report, "Combating Tobacco Use In Military And Veteran Populations," is available at www.nap.edu.

Funding Opportunities:

NIH Guidelines for Human Stem Cell Research http://grants.nih.gov/grants/guide/notice-files/NOT-OD-09-116.html

Mechanisms Underlying the Links between Psychosocial Stress, Aging, the Brain and the Body (R01) (PA-09-216) http://grants.nih.gov/grants/guide/pa-files/PA-09-216.html

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