

THE

CANCER LETTER

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Vol. 39 No. 29
July 19, 2013

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Who is Number One?

A "Screw-Up" Worked in MD Anderson's Favor In Seven-Year Stint as Top-Ranked Center

By Paul Goldberg

Systematic misclassification of emergency patients at MD Anderson Cancer Center has enhanced that institution's rating by U.S. News & World Report for the past seven years, The Cancer Letter has learned.

The miscounting, which led to exclusion of nearly 40 percent of admissions, was discovered and corrected in mid-2009, but no reliable way could be found to adjust the results to reflect the missing data, officials at U.S. News and MD Anderson confirmed.

Since U.S. News averages data over three years, the results of the MD Anderson top rating by the magazine [released July 16](#) are still partially based on tainted data.

The top spot in U.S. News rating of cancer hospitals represents the ultimate bragging rights in oncology. The ranking—particularly the top spot—is of vital significance to the cancer centers as they compete for patients both locally and worldwide. Also, the No. 1 rating strengthens a center's ability to raise funds.

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Conversation with The Cancer Letter

Correcting the Error: What U.S. News Could and Couldn't Do to Fix the Problem

The Cancer Letter asked Avery Comarow, health rankings editor at U.S. News & World Report, to explain the problem that occurred when MD Anderson Cancer Center submitted erroneous data to a government database which the magazine uses to help rank cancer hospitals.

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In Brief

Zwelling Moves to Legacy Community Health

LEONARD ZWELLING is joining **Legacy Community Health**, the largest federally-qualified health clinic in Houston, as the vice president of Medical Support Services.

Zwelling, a vocal critic of the administration of MD Anderson Cancer Center, will retire from that institution after 29 years in scientific, clinical and administrative positions.

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A Long-Unnoticed Coding Error Distorted Data Used by U.S. News

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Hospitals that are recognized as “high-performing” have the option to license the use of the U.S. News logo to promote their ranking. U.S. News officials declined to reveal how much this costs.

MD Anderson has been rated No. 1 for the seven years since the error first started to distort its results, relegating Memorial Sloan-Kettering Cancer Center to the position of a perpetual runner-up.

Avery Comarow, health rankings editor at U.S. News described the omission as a massive “screw-up” in MD Anderson’s collection of data submitted to Centers for Medicare and Medicaid Services.

U.S. News doesn’t ask hospitals to provide data directly, relying instead on government databases, which are less prone to tampering.

“It’s hard to imagine that if so many patients had not been excluded that it would not have changed the rankings,” Comarow said to The Cancer Letter. “It would have made a clear difference. If you are taking that many patients out of the picture, it changes your performance—unless you assume, and I cannot assume this, that the medical status of all of those excluded patients was identical to the overall patient profile of those who were not excluded.

“That just stretches the bounds of plausibility.”

A conversation with Comarow appears on page 1.

The problem runs so deep that it cannot be fixed by

re-tabulating existing data posted by [RTI International](#), the U.S. News contractor on the hospital rankings project. The miscounting would confound the “survival” metric used in the ranking. Moreover, with patient volume misstated, the nurse staffing per patient ratio could be thrown off.

Since the top place is given the score of 100 and the rest of the scores normalized, all the scores would be affected.

The error occurred in mid-2004 and was corrected in mid-2009. The scores and rankings announced earlier this week pool data from 2009, 2010 and 2011.

Prior to the error, the top prize went to either MSKCC or MD Anderson.

Nobody is asking for a recount, though sources said that MSKCC has asked for a re-examination in the past.

“We, like many hospitals in the U.S., were curious about methodology U.S. News adopts, and, over the years, we had numerous conversations with U.S. News, because there is high consumer interest in those rankings,” acknowledged Avice Meehan, MSKCC vice president and chief communications officer.

This year, the two institutions were seven points apart.

The Genesis of a Screw-Up

The error occurred in the measurement of what U.S. News calls survival, which the magazine defines as “risk-adjusted mortality.”

These data aren’t supplied by hospitals, and instead come from the Medicare Provider Analysis and Review (MedPAR) database, maintained for the Centers for Medicare & Medicaid Services. MedPAR records include the patient’s diagnosis, medical procedure, age, sex and discharge destination.

At MD Anderson, the error occurred in creating mapping classification of patients as transfers from other hospitals or emergency center patients.

“CMS routinely changes the parameters of the MedPAR file,” said Victoria Jordan, MD Anderson director of quality measurement and engineering in the Office of Performance Improvement.

Starting in 2007—the year when the U.S. News survival metric was based on pooled data from 2003, 2004 and 2005—the magazine decided to exclude patients transferred into the hospitals from mortality calculations.

According to [the methodology report](#) for that year, the change was made in order to adjust for the practice called “dumping,” which occurs when community

THE CANCER LETTER

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202-362-1809 Fax: 202-379-1787

PO Box 9905, Washington DC 20016

General Information: www.cancerletter.com

Subscription \$405 per year worldwide. ISSN 0096-3917.

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hospitals transfer their complicated cases to tertiary hospitals.

The U.S. News methodology report explains:

“This change in methodology means that patients legitimately transferred for appropriate care are lost, but it is more important to ensure that each hospital’s mortality numbers are not affected by transfers of very sick patients from hospitals unable to properly care for them. Transfers were identified using the claim source of inpatient admission variable on the MedPAR files. Variable values of ‘4’ (transfer from a hospital) or ‘A’ (transfer from a critical access hospital) were used to identify transfers from acute hospitals or critical access hospitals.”

When the mapping of the MedPAR file was created at MD Anderson, the error occurred, Jordan said.

“We had no reason to go back and check that, because it doesn’t impact payment, it doesn’t impact anything,” she said. “We don’t even really see the MedPAR file. We don’t purchase the MedPAR file, and CMS never asked us about it.

“We really had no reason to know about that error,” Jordan said. “It’s not like somebody was coding it incorrectly over and over again. From what the people at MD Anderson saw, they were marking ‘this patient came from the Emergency Center; this patient came from a transfer,’ but behind the scenes, the computer mapping error was there. That’s why it went unnoticed and took a lot of digging for us to figure it out when [it was] brought to our attention.”

The identity of the individual who made the mapping error is unknown, said Thomas Feeley, former MD Anderson vice president for medical operations, who now heads the Institute for Cancer Care Innovation and the Division of Anesthesiology and Critical Care.

The problem was apparently noticed by MSKCC officials.

Sometime in 2009, MSKCC officials informed U.S. News that MD Anderson had 41 percent of its 8,482 inpatient admissions in the 2005-2007 MedPAR dataset coded as transfers from another facility. This is about ten times the average transfer rate of 3.9 percent found at other inpatient facilities.

With these cases excluded from the mortality analysis, MD Anderson’s Mortality Index was based on only 59 percent of their admissions.

At the time MSKCC officials made this startling discovery, it’s unlikely in the extreme that they could have known about the coding error.

The fact that the error resulted in exclusion of the sickest patients who were admitted through the

emergency room would have bolstered a case for recounting—or, for that matter, voiding—the results.

MD Anderson’s Feeley first learned about the problem around September 2009, when he received a call from RTI.

An RTI official asked: “Do you have a large number of transfers?”

Feeley said: “No.”

“And they said, ‘That’s very interesting. It seems that in the database that we use for the U.S. News & World Report calculations MD Anderson has a large number of transfers,’” Feeley recalled.



From the MD Anderson website: the U.S. News & World Report shield is used to help the cancer center attract patients.

“So we looked into the transfer issue, and we saw what they saw, and that is that we had a large number of patient that looked like they were transfers from other hospitals,” Feeley said. “It didn’t make any sense to us, because we don’t have that many.”

Ultimately, MD Anderson officials zeroed in on the mapping error.

“I use the term ‘error,’” Feeley said. “But it wasn’t an intentional error. It was an inadvertent miscoding. It appeared that, for all intents and purposes, every patient who was admitted to MD Anderson through the Emergency Center looked like they were a transfer.”

As soon as MD Anderson officials found the problem, they informed RTI and U.S. News and offered to try to correct the data.

“They said no,” Feeley said. “I remember this vividly, because I thought that’s very interesting. We asked, ‘Why don’t you want it?’ and they said ‘We have a system, and our system is to use the [MedPAR] data, however it comes, flawed or not, and we don’t want to get into taking hospitals’ corrected data.’

“So, we offered, and they said ‘No.’ If you had

a bank error, and the bank put \$100,000 in your account, and you went and said, 'It's not my \$100,000,' if they said, 'Okay, keep it,' it's a bank error in your favor."

It wouldn't have been easy to correct the dataset well enough for U.S. News to use, and the MedPAR file would have been impossible to construct retroactively, Feeley said.

"We don't know what the mortality was for those patients," Feeley said. "We would have attempted to [calculate it]. Anything can be done with enough people and enough time, but there was no reason to do it."

At the same time, officials contacted the institution's compliance and finance departments. The two departments said MD Anderson's payments from CMS weren't affected.

"We asked whether we should do anything to change that with what had been historically reported, and everyone agreed that there was no reason to change that, because, number one, it wouldn't affect what U.S. News & World Report did, because they had already used the data, and, number two, there was no reason to change that for the CMS perspective, because it [didn't impact] billing," Feeley said. "The only thing that was coded [incorrectly] was where the patient came from. It had nothing to do with the claim that was submitted for their hospitalization."

The person who made the error was never identified, Feeley said.

"We have no idea," he said. "By that time, they probably didn't even work here anymore. It clearly wasn't intentional. This could have been a simple keystroke."

Feeley said he presented the data to MD Anderson President Ronald DePinho, who instructed him to inform the department chairs and faculty. The slides from his Nov. 14, 2012 presentation to a working group are posted [on The Cancer Letter website](#).

The ranking announced earlier this week is minimally affected by the tainted data, Feeley said.

"I don't want this to tarnish this year's rankings," he said. "By this point, having made that correction in 2009, as of this year, at a minimum, 75 percent of the

Impact of Transfers on Outcome

- Major problem for our future outcome scoring
- Transfer patients have been excluded from USNWR mortality index calculation since 2007
- Error in our data discovered by USNWR in 2009
 - We incorrectly coded Emergency Center patients as transfer patients since mid-2004
 - Incorrectly coded patients account for 40% of admissions
- Mortality rate higher for admitted Emergency Center patients (which were inappropriately excluded) leading to a lower mortality ratio
- Error corrected in 2009 resulting in incremental increases in our mortality ratio that will progressively worsen our outcome score through 2014

5

A presentation given to an MD Anderson working group lists the problems created by incorrect data reporting. The presentation is available on [The Cancer Letter website](#). MD Anderson overcame these problems and was named number one for the seventh year in a row earlier this week.

data that goes into that mortality score is absolutely correct. So the fact that our mortality score is the same as Memorial's again this year suggests that this year, for sure, there is no question that this is deserved."

The problem is probably anything but exotic, Feeley said.

"When you are relying on administrative datasets like this, that is the risk that you take," he said. "And a lot of health services research is done [based] on these administrative datasets that are keyed in by clerical and technical help who are not devious or scheming—they are just doing a clerical job."

Challenging Metrics

Any effort to distinguish between cancer centers is all the more challenging and problematic, because in the aggregate no one can say with certainty that cancer centers provide better outcomes than community doctors.

With this big question unanswered—and perhaps unanswerable—it's unclear how reliable an effort to split academic and centers and rank them can be.

Comarow said the rating system isn't designed for readers to say that MD Anderson is better because it's number one, and that MSKCC is worse because it is number two.

“We’ve never claimed that anybody should look at a number one or two or three hospital in a specialty ranking and say, ‘Well, since these are one and two and three, I have to go there. I have to go to one of these hospitals and I really should go to number one,’” Comarow said. “That’s ridiculous.”

The rankings are a “first screen,” Comarow said.

“You look at the cancer rankings and you say, ‘This is a cancer hospital that does really tough things routinely, so maybe this would be a good place for me for whatever it is I’ve been diagnosed with,’” he said.

Nonetheless, directors of cancer centers say that they feel the pressure to increase their U.S. News rankings. To accomplish this, some centers place ads in airline magazines at a time when oncologists travel to the annual meeting of the American Society of Clinical Oncology. Others send out email blasts containing what amounts to campaign letters to all oncologists in the U.S., or offer their experts as guests on television talk shows.

Primarily, these efforts are intended to influence the 200 cancer specialists chosen to award the “reputation” score, which is worth 32.5 percent of the total grade. These doctors are chosen at random from the American Medical Association Physician Masterfile. They are asked to choose up to five institutions in their field “irrespective of expense or location,” that they regard as the best for patients with “serious or difficult conditions.” These scores are then averaged over three years.

This year, 57 of the 200 cancer specialists invited responded to the survey.

MD Anderson’s reputational score in the current rating was 67.7 percent. Last year, it was 69.5 percent. Memorial’s current score was 62 percent—last year it was 61.

In a move that may affect its ranking in the future, MSKCC is applying for a “nurse magnet” designation from the American Nurses Credentialing Center, Meehan said.

“We are doing it because we think it’s the right think to do,” she said to *The Cancer Letter*.

U.S. News’s Comarow happily takes credit.

“I applaud them,” he said. “That’s the rankings driving clinical performance in a positive way.”

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Conversation with The Cancer Letter **Comarow: Error Likely Affected Rankings, Kept MSKCC No. 2**

(Continued from page 1)

The interview was conducted by Paul Goldberg, editor and publisher of The Cancer Letter.

Avery Comarow: Let’s go over two things you know already—one is that data screw-ups happen. They are not always malevolent or even deliberate. They are, as some famous person said, more often the result of incompetence or stupidity than malfeasance.

I can’t say for sure whether the exclusion of all these patients was deliberate. My own feeling is that excluding such a high percentage could not possibly be deliberate, because it’s so overt.

And we aren’t detectives. At U.S. News, our goal is simply to get things accurate and right. Our intent was to find out what could be done—to see, first of all, if there was in fact a problem. Just because Memorial Sloan-Kettering said there was didn’t necessarily mean there was. And once MD Anderson looked into it, and admitted to us that there was a big problem and that they had made an error—they’d been in touch with CMS, and we verified that they had—then the next step was to see what we could do about it.

And, obviously, we couldn’t retroactively rerun the cancer rankings, especially in the context of knowing that, out there in Hospital Land and in Data Land, X percent of the data is screwed up in some way, sometimes trivially and sometimes—very, very rarely I hope—massively. This was massively.

If it points to anything, to me, it was how could CMS have accepted the data submission without flags going up over the place. This wasn’t 2000 or 1990; this was well into sophisticated data collection and reimbursement—so all of these numbers mattered, and clearly there was a breakdown, both at MD Anderson and at CMS.

Paul Goldberg: *Would it have changed the rankings?*

AC: It’s hard to imagine that if so many patients had not been excluded that it would not have changed the rankings. It would have made a clear difference.

If you are taking that many patients out of the picture, it changes your performance—unless you assume, and I cannot assume this, that the medical status of all of those excluded patients was identical to the overall patient profile of those who were not excluded. That just stretches the bounds of plausibility.

PG: *So the rankings really could have changed?*

AC: We are talking about the numbers one and two cancer facilities for the most part.

PG: *So Memorial could have ended up on top?*

AC: Sure. It's barely possible that they wouldn't have. I don't have the numbers in front of me. What was the overall score difference?

PG: *It was 100 last year for MD Anderson, and Memorial was 93.8.*

AC: It's possible they could have flipped.

PG: *Why couldn't you rerun the rankings?*

AC: Because all hospital scores are relative to all other hospital scores. It would have changed everybody's. You can't just rerun one hospital's score because all of these are relative—they're all normalized.

The top hospital automatically gets a score of 100, and all other hospitals are scaled up to that 100. But really I'd like to back up for a second and ask you and your readers what difference it makes.

We're talking about a set of rankings that, in the first place, is not absolute. We've never claimed that anybody should look at a number one or two or three hospital in a specialty ranking and say, 'Well, since these are one and two and three, I have to go there. I have to go to one of these hospitals and I really should go to number one.' That's ridiculous.

The way we look at each of these specialties is across a whole range of conditions and procedures. And people don't have ranges of conditions and procedures—they usually have one. They have a diagnosis, or they have a particular surgery that they need.

So we're trying to identify hospitals that do very, very well—unusually well, under unusually demanding conditions: a pancreatic dissection, a glioma, or something that really takes an unusual degree of skill to deal with; a cancer that's not amenable, or late stage lung cancer, or whatever.

The problem is that there are relatively few of those cases. So we can't take those kinds of conditions and procedures and isolate them and say this hospital is better than others in late stage lung cancer, because so few hospitals see enough late stage lung cancers for the results to be statistically meaningful.

We have to, pardon the expression, lump them all together with other kinds of difficult and challenging conditions and procedures—so we get this mashup of hard patients; of really difficult patients.

So as a patient tool, it's a first screen. You look at the cancer rankings and you say, 'This is a cancer hospital that does really tough things routinely, so maybe this would be a good place for me for whatever it is I've been diagnosed with.'

So under those conditions, what the hell difference does it make whether you go to number one or number two or number three or number forty-seven—provided that you've done enough homework to verify that, whoever it is at that hospital who deals with patients like you, sees enough of them and has a good enough track record to matter for you to feel comfortable?

PG: *We are dealing with bragging rights.*

AC: As far as I'm concerned, yes.

PG: *Because you are comfortable with people going to Mayo, which is number three?*

AC: Look, I've had two bypass surgeries. In 1983, we didn't have the rankings so it didn't matter. There was nothing for me to look at. The last time I had one, in 1998, I went to a hospital that wasn't even ranked in cardiology and heart surgery. The reason I did that was because I was looking for a particular approach to that surgery.

That approach wasn't being executed by very many surgeons at the time. It was fairly new. So what I was looking for was a surgeon who had done enough of them that I was okay with having him or her do it, but at the same time knowing that it really was pretty new—it wasn't as if I was going to find anybody who had done 500 or 1,000 of them—and so I was really looking for someone who knew that procedure.

And I found that guy. I started by looking locally; I did my research. I found him at Washington Hospital Center, which at the time was not ranked in cardiology and heart surgery, and obviously he did a good job on me.

So this is about finding the right care for you. I don't care one damned bit whether someone uses our rankings or needs something that is so specific, so particular, that the rankings are almost irrelevant. For me, again, they are a very good first screen.

They are an alternative to someone sitting across from a doctor, and the doctor says 'Go here,' and most patients are too intimidated to say, 'Why are you sending me there?'

For those patients, well, here are some other options for you. And maybe there are some in your

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immediate area, so you won't have to travel, and maybe there are others after you do your homework and you discover that the best guy who does a trans-urethral prostatectomy is 250 or 500 miles away.

And you think about going there, and you factor in the hassle with your insurance company and everything else that's involved, and making your family travel.

It's all about options. We've never claimed that our rankings should be construed as a horserace.

PG: *Well here's the thing that's kind of fascinating—and this is sort of a very fancy way of agreeing with you on this—in oncology there is this big controversy whether community care is inferior to cancer centers, and no matter how hard you look, you're going to find nothing to suggest that.*

So here you are, with your metric—which actually changes over time, so that's also interesting—basically splitting this academic oncology piece further. And you are saying it provides a screen, but in the aggregate you can't make a case that the cancer centers are better than community care.

AC: But doesn't it depend on how you define care?

PG: *Oh, yes.*

AC: I'm talking about the kinds of conditions and the kinds of patients and the risks they come with, all the other factors that turn somebody from an everyday hysterectomy patient to a diabetic with high blood pressure and all sorts of other comorbidities and conditions and so on. You don't want high-risk patients at a community hospital.

PG: *Right, but that said, this big question of community care versus cancer centers is something that has been on the table for a really long time. It's still like the question of meaning of life; it's unsettled. And here you are essentially taking one chunk of it and splitting it up further.*

AC: Well, we are taking one chunk of the patients.

People lose sight of the fact that we are talking about cases that represent the most challenging there are.

We are not interested in taking a broad cross-section of cancer patients. That's not what Best Hospitals is all about. We are only interested in dealing with patients with a little bit of time to look around, but who need a much higher level of care than most hospitals can provide—because either their local hospital doesn't see many cases like theirs, or the patient represents some kind of seriously elevated risk, or both.

PG: *What is your take-home from MD Anderson versus Memorial?*

AC: My take-home is that it was a lesson to MD Anderson to be a lot more careful about their data. They

probably installed another layer or two of QA on top of whatever it is they had or had not been doing, and that's good.

The other lesson is that it's a war out there. There are hospitals that are extremely jealous of their positions and their prerogatives, and they don't like to not be number one. And if they are number two, they are looking for ways to become number one.

Sloan-Kettering has always been—well, both hospitals have always been very assertive about claiming their expertise and excellence. So when you have a couple of mega-cancer facilities like those, in a way I suppose this sort of thing every so often is inevitable.

PG: *Well, things are very controversial at MD Anderson right now, with leadership issues and so forth, and it's sort of interesting that in reputation with specialists, they're still number one—and that it's not really trickled down or it's viewed as irrelevant by the specialists.*

AC: That I can't tell you. Obviously there is a halo effect. I don't know if hospitals that routinely get high reputational scores always deserve them year after year. On the other hand, there's also an anti-halo effect.

Hospitals that deserve to do better reputationally have to go through a long lag period while the physician community catches up to the fact that, actually, they're pretty good. If you look at the cancer rankings, and if you look at all of our specialty rankings, one of the things that I find very encouraging is how many hospitals are ranked that have essentially negligible reputational scores: zero, 1 percent, 1.3 percent. Take a look and some of that discussion about how U.S. News lets reputation drive the rankings just vanishes.

Obviously if a hospital has a reputational score that's like 60 or 70 or 80 percent, it's going to pretty much automatically mean that it will be in the top half-dozen or so. But it's also the case that there are hospitals with very high reputational scores that are not rank-ordered with other hospitals with high reputational scores—they are one or two or three or four steps below.

I think of that as a triumph of good medicine. If you do the clinical stuff right, then you may not be number one or two or three or four, but you'll be among the top 50 hospitals out of the many hundreds of hospitals that were eligible for the rankings in the specialty. And certainly in the thousands of hospitals that do cancer care to some degree.

That's really the thing—the top 50 is about 3 percent out of all the ranking-eligible hospitals in the country, and it's less than 1 percent of all the hospitals in the country.

NCI News

BSA Approves Six Concepts At Joint Meeting With NCAB

The NCI Board of Scientific Advisors approved the following concepts at a meeting June 24-25:

The **NCI Community Oncology Research Program** aims to bring state-of-the-art cancer prevention, control, treatment, and imaging trials, as well as cancer care delivery research and disparities studies, to individuals in their own communities.

The new RFA was approved 19:2, with 3 abstentions.

Run by the Division of Cancer Prevention, NCORP would build on the clinical trial success of the Community Clinical Oncology Program and Minority-Based CCOP network, and capitalize on synergies between clinical trials, CCDR and disparities research questions.

The community participation in clinical trials will continue and a new research scope of cancer care delivery and disparities will be included. The CCDR research agenda would use observational studies and interventional studies to identify patterns of care and implement new technologies, and care models.

The funding for community participation in clinical trials will continue and the funding for the CCDR at the community level will include a fixed baseline funding, estimated at \$100,000 per award, to support the lead investigator, study coordinator and data system staff. Increased funding for awardees with substantial CCDR experience and capacity is estimated at \$300,000 per award.

The **PROSPR Initiative** (Population-Based Research Optimizing Screening Through Personalized Regimens) proposes to promote coordinated, multidisciplinary, and multi-level research to evaluate and improve the cervical, breast, and colorectal cancer screening processes in clinical practice.

The RFA was approved 23:0, with one abstention.

Competitive revisions to two existing PROSPR research centers, as proposed in the initiative, would capture cervical cancer screening process data, and submit these data to the central data repository housed at the statistical coordinating center, for use in collaborative projects comparing the cervical cancer screening process across different populations and health care systems. Only current PROSPR research centers are eligible to apply for these awards.

The initiative will be run out of the Division of Cancer Control and Population Sciences.

The total cost based on median annual budget for data collection core within funded PROSPR research centers is \$650,000 per center per year. The addition of the two cervical centers would cost \$1.3 million for the first year.

The **Sub-Saharan African Collaborative HIV and Cancer Research Consortia** proposes to conduct research projects that address high-priority research questions in HIV-associated cancer in partnering sub-Saharan African countries.

Now in its second phase, the consortia received unanimous approval. Studies can now leverage existing HIV infrastructure in Africa developed by NIH-supported programs and other U.S. programs such as

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the President's Emergency Plan for AIDS Relief.

The consortia would accelerate basic, translational, population and implementation research in HIV-associated malignancies in sub-Saharan Africa. The program will be run out of the Office of HIV and AIDS Malignancy in collaboration with the Fogarty International Center and the Center for Global Health.

In its first phase, the RFA focused on strengthening capacity for research for HIV-associated malignancies in Africa.

[The RFA](#) will be open to all qualified applicants. Applications can either be submitted by an institution in sub-Saharan Africa or by a U.S. institution. Each application must be based on collaborations between researchers in a U.S. institution and researchers in the sub-Saharan African country.

Applicants can request up to \$750,000 total cost per year for five years.

The **Cancer Detection, Diagnostic and Treatment Technologies for Global Health** program seeks to stimulate technology development and adaptation for low-cost use to detect, evaluate, diagnose and treat cancer in low resource settings.

The new RFA received unanimous approval.

These technologies, which include low-cost, portable devices, are designed to help address the need for early detection, diagnosis and treatment in low- and middle-income countries.

Run by the Center for Global Health, the RFA is issued over three years, with six phase I awards anticipated each year, with \$500,000 per award per year. Phase I would demonstrate clinical potential in a global health setting and phase II would validate devices, with \$1 million per grant per year. Nine phase I grants would advance to phase II.

[The program](#) will run for five years with a total cost of \$45 million.

The **NCI Cancer Genomics Cloud Pilot Concept** is a proposal designed to help resolve many of the issues associated with access to and use of large-scale genomics data that are currently being generated by projects such as the Cancer Genome Atlas and TARGET.

[The concept](#) was approved unanimously.

Under this concept, NCI will fund the development of up to three pilot computing environments that will provide co-located storage and compute capacity for pre-loaded TCGA data and provide an Application Programming Interface to allow scientists to run

custom analyses on these "clouds."

The concept envisions that each pilot will operate with 2.5 petabytes of core data; that is, scaled to the amount of data that TCGA will generate by its conclusion in late September of 2014.

The management of the three pilots will be coordinated by the NCI Center for Biomedical Informatics and Information Technology and the NCI Center for Cancer Genomics, in concert with the NCI Genomic Data Commons, the next phase of the TCGA Data Coordinating Center.

Each pilot will share a common core data set, but with each of the three pilots supporting at least one additional TCGA data type and a set of unique capabilities. When complete, these pilots will be made available for evaluation and use by biomedical research community, and, if successful, can be scaled to support the needs of this community for years to come.

The **NCI Outstanding Investigator Award** concept proposes to provide long-term support to experienced investigators with outstanding records of research productivity who are likely to continue to conduct seminal cancer research.

The proposed award was approved unanimously.

The award would encourage investigators to embark on innovative cancer research that breaks new ground or extends previous discoveries in new directions or applications.

To be eligible for the award, a PI has to demonstrate outstanding research productivity and the potential for continued high quality research, and has to have been funded by NCI for five or more years.

The award may fund a project for up to seven years—a commitment of at least 50 percent of research effort is required, and institutions would provide 20 percent salary support for the duration of the award.

The budget for [the award](#) is up to \$600,000 in direct costs.

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In Brief

Zwelling Moves to Legacy Health; Greenberg Named UT System Vice Chancellor for Health Affairs

(Continued from page 1)

In [his blog](#), which is widely read at MD Anderson, Zwelling said he would depart sometime in the fall.

“I have been a board member there for the past few years (unpaid but reported to the Conflict of Interest Committee) and have come to admire the work that Legacy does, providing health care for anyone who walks in the door, regardless of his or her ability to pay. (Remember when MD Anderson used to be like that?)” Zwelling wrote.

“It is time for me to put my money where my mouth is when it comes to improving the delivery of health care in Houston and working for the good of those less fortunate than I. I say my money in my mouth, because I am foregoing my final year of tenure and taking about a 50 percent reduction in pay.”

Zwelling said he would continue to write the blog.

RAYMOND GREENBERG was named the **UT System** vice chancellor for health affairs. He replaces Ken Shine, who is retiring after 10 years on the job.

Greenberg has been president of the Medical University of South Carolina for the past 13 years. Prior to that, he served for five years as vice president for academic affairs and provost of MUSC.

He served for 12 years at Emory University, holding several leadership positions, including chair of the medical school’s department of epidemiology and biostatistics, deputy director of the Winship Cancer Center and founding dean of the Rollins School of Public Health.

MARGARET OFFERMANN started her term as president of the **Federation of American Societies for Experimental Biology** July 1.

Offermann is a medical oncologist and biomedical researcher and is a managing partner at the Salutrained Group, a consulting firm that provides analysis and support for life science executives.

Offermann has been on the FASEB board of directors since 2008, and served as vice president for science policy in 2011 and 2012.

Offermann served on the faculty of Emory University School of Medicine from 1989 to 2007,

where she rose to the rank of professor of hematology and oncology and served as co-director of the MD-PhD training program, associate director of the postgraduate training program in hematology and oncology, and associate director of the Winship Cancer Institute.

From 2007 to 2010, she was deputy national vice president for research at the American Cancer Society, where she provided executive leadership for both intramural and extramural research programs.

Additional new FASEB officers include President-elect **Joseph Haywood**; Vice President for Science Policy **Peter Rubenstein**; and Vice President-elect for Science Policy **Hudson Freeze**.

Haywood is professor of pharmacology and toxicology and assistant vice president for regulatory affairs at Michigan State University. Rubenstein is a professor in the department of biochemistry in the University of Iowa Carver College of Medicine, where he has been faculty member since 1977. Freeze is a professor of glycobiology and director of the genetic disease program at the Sanford-Burnham Medical Research Institute in San Diego.

DAVID PENSON received a \$2 million research award from the **Patient-Centered Outcomes Research Institute** to study localized prostate cancer.

Penson is the Paul V. Hamilton, M.D. and Virginia E. Howd Professor of Urologic Oncology at Vanderbilt University Medical Center, and also directs the Vanderbilt Center for Surgical Quality and Outcomes Research.

Over the next three years, Penson will study patient-reported outcomes and compare the effectiveness of treatment of prostate cancer in 3,691 men diagnosed with prostate cancer in five states in 2011.

Penson will be working with Tatsuki Koyama, assistant professor of biostatistics, and Daniel Barocas, assistant professor of urologic surgery.

The study builds on Penson’s recent success in developing a network of tumor registries that collect patient data which may hold the key to more scientifically proven treatment plans that make the most sense for each patient.

Vanderbilt launched the network in 2010 through a \$7.6 million Agency for Healthcare Research and Quality grant. Penson’s Comparative Effectiveness Analysis of Surgery and Radiation study continues to collect data such as treatment, complications and short-term cancer rates by following nearly 4,000 men with prostate cancer.