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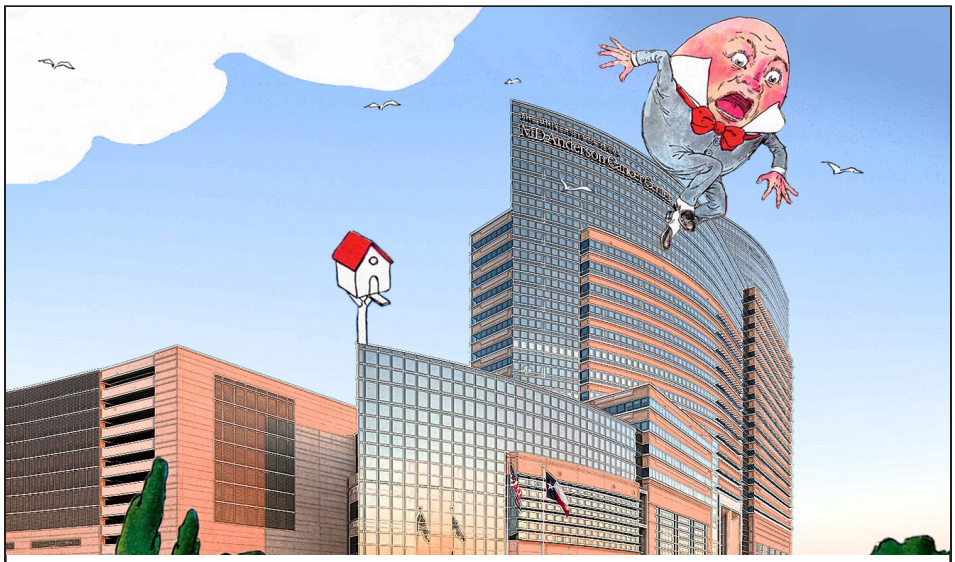

Former MD Anderson Faculty Chairs: "We are Disheartened and Dismayed At the Precipitous Decline in Faculty Morale"

By Paul Goldberg

A group of eight past chairs of the MD Anderson Cancer Center Faculty Senate have weighed into the controversy over leadership and morale at the Houston-based hospital.

"As former chairs, we are disheartened and dismayed at the precipitous decline in faculty morale that has occurred at MDACC under the current executive leadership," the past chairs wrote in an email distributed to the faculty on Feb. 26. "We are further troubled by the continuing loss of outstanding long-term senior faculty from MDACC, an exodus that many have attributed to current administrative policies."

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Guest Editorial

NCCS CEO Applauds Oncology Care Model

By Shelley Fuld Nasso

The recent announcement by the Innovation Center at the Center for Medicare and Medicaid Services regarding the launch of an Oncology Care Model is an important step toward patient-centered cancer care.

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In Brief

Hwu to Lead MD Anderson Cancer Medicine

PATRICK HWU was named division head of Cancer Medicine at **MD Anderson Cancer Center**, effective March 4. Hwu joined MD Anderson in 2003 as the first chair of Melanoma Medical Oncology. He is also currently chair of Sarcoma Medical Oncology.

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Chancellor McRaven to Address MD Anderson Faculty Mar. 18

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The group's letter suggests that discussion of morale at the cancer center is becoming more open at a time when its current president, Ronald DePinho, is on notice to improve his relationship with the faculty.

With this latest salvo from the eight past chairs, peace between DePinho and the faculty is slipping further from the embattled president's grasp. No commander wants open conflict with his troops. Yet, open conflict appears to be exactly what DePinho has on his hands.

There has been a call for the UT System to march in, a petition from DePinho loyalists, and a letter from luminaries disgusted by what they describe as demands for a "loyalty oath." Worse, the people DePinho reports to made their wishes clear late last year: solve the problem (The Cancer Letter, Nov. 7, 2014).

And that was before former Adm. William McRaven became the UT System chancellor. McRaven hasn't made any public statements on morale at MD Anderson, but it's a safe guess that being the four-star admiral who coordinated the baddest of badass operations of America's military—including the raid that offed Osama bin Laden—he treats leadership and troop morale with greater urgency than an academic bureaucrat.

Conflicts at MD Anderson—measured by nearly identical results from four surveys over two years and hostilities that are getting worse by the day—are now squarely before McRaven's nose.

In fact, earlier this week, McRaven made a visit to MD Anderson to speak to faculty leaders and the administration.

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In an email to the faculty, DePinho said the chancellor will return to campus on March 18.

"As follow-up to his brief visit to MD Anderson this week to meet with various institutional leaders and faculty groups, UT System Chancellor Bill McRaven expressed interest in returning soon to meet with all faculty," DePinho wrote. "I am pleased to report Chancellor McRaven will be on campus for a faculty-only meeting Wednesday, March 18, at noon in Hickey Auditorium.

"Please make every effort to attend and to take advantage of this excellent opportunity to directly engage our new Chancellor, who clearly has a strong interest in MD Anderson and our ongoing efforts to collaboratively move this great institution forward in support of our mission."

Here is how the current outburst of hostilities developed:

• On Nov. 20, 2014, the Faculty Senate unanimously passed a resolution seeking an intervention by the UT System. The resolution, passed unanimously by the 154 members present, stopped short of a no-confidence vote, but asked the UT System to establish "milestones and timelines to implement measures to improve the morale of the faculty and the general health of the institution."

• The resolution wasn't announced or conveyed to the UT System in expectation of McRaven's arrival. On Feb. 6, 2015, the resolution was sent to the UT System Board of Regents in advance of their meeting Feb. 11-12. The document was subsequently released (The Cancer Letter, Feb. 20).

• The MD Anderson administration responded with two letters, one from division chairs, dated Feb. 17; and one from the administration and the division chairs, dated Feb. 19. The latter response amounted to an assertion that the situation is under control. "We were surprised to learn of the Faculty Senate's resolution of November 20, 2014, since goals have been established and milestones reached in response to faculty concerns," officials wrote. (The Cancer Letter, Feb. 20).

• On Feb. 20, three past chairs of the Faculty Senate—who now hold administrative positions—started a petition in support of the administration. An email that accompanied the petition stated that the previous unanimous vote of the Faculty Senate didn't represent the views of the faculty.

"After speaking with many faculty senators as well as faculty at large, we, as past chairs of the faculty senate, believe that a broader perspective of the faculty should be heard," the three past chairs wrote. "It was conveyed to us that a number of senators believe that the Executive Committee of the Faculty Senate (ECFS)

actions did not accurately reflect what they understood to have occurred in November 2014. We also heard from many faculty members at large who believe it does not fully represent their true sentiments nor is it a comprehensive depiction of the current environment."

The letter included the following phrase: "We cannot guarantee your anonymity but will not proactively share the list of signatories without prior notice."

The petition was launched by:

- **JB Durand**, Faculty Senate Chair from 2012-2013
- **J. Jack Lee**, Faculty Senate Chair, 2004-2005
- **Paul Mansfield**, Faculty Senate Chair, 2003-2004

The petition is active through March 6, and it's not publicly known how many signatures have been received.

A Loyalty Oath?

On Feb. 26, MD Anderson's faculty members received the following email:

From: Farquhar, David
Sent: Thursday, February 26, 2015 4:33 PM
Subject: Statement From 8 Former Senate Chairs re Petition

At the November 2014 meeting of the M.D. Anderson Cancer Center (MDACC) Faculty Senate, a resolution of concern regarding the executive leadership of the Institution was passed by unanimous vote of 154 Senators who attended the meeting. It was sent by the Executive Committee of the Faculty Senate (ECFS), together with an explanatory cover letter, to the University of Texas System Board of Regents. All MDACC faculty were copied on these documents.

The resolution was introduced in the wake of four satisfaction surveys conducted over the past two years, all of which reflected low morale and major dissatisfaction with executive leadership on a broad range of issues.

The most recent survey was developed by the UT System. It was sent to 1,578 faculty members during September, 2014 and returned by 966 for a participation rate of 61%. Among the significant findings, announced in November, 2014, were that a majority of faculty disagreed or strongly disagreed with the following statements: Overall morale has improved as a result of recent changes made by executive leadership; executive leadership is open to faculty ideas and recommendations; executive leadership is appropriately responding to important internal issues; there is faculty engagement in decision making; and there is sufficient time for clinical faculty to pursue academic responsibilities. In an accompanying cover letter, Raymond Greenberg, UT System Executive Vice President for Health Affairs, stated that "the survey provides a valid and unbiased sampling of faculty opinion."

Recently, three former chairs of the Faculty Senate, who now hold faculty administrative appointments, have expressed "deep concern" at the above actions of the ECFS. They have formulated an online petition inviting support for their views. While we, as former Chairs of the Faculty Senate, acknowledge their right to express their opinions, we deplore their effort to undermine the deliberations and actions of the Faculty Senate, the duly constituted faculty governance body of MDACC, as approved by UT System.

The petition and associated preamble are replete with sweeping anecdotal statements, none of which are supported by evidence. Many of the views expressed are emotional in nature and others are irrelevant to the issues at hand. The authors do not currently participate in Senate activities and none are conversant with recent extensive ECFS discussions with executive administration regarding the areas of concern identified in the resolution.

Furthermore, unlike the satisfaction surveys, the petition is not scientific and is largely self-serving. An implicit promise of administrative favor exists for those who sign it with the specter of potential retribution for those who do not.

Faculty with administrative appointments, who serve at the pleasure of the president, will feel a compelling pressure to sign, as may some non-administrative faculty who seek to be viewed in a positive light.

As such, the petition may be seen as a "loyalty oath," a circumstance that is anathema to academic freedom, to principles of shared governance, and to a campus free of fear and retaliation. Far from constructively addressing the problems identified in the resolution, the petition potentially exacerbates them by pitting faculty against faculty and undermining the team cohesion that is vital to the core mission of MDACC.

As former chairs, we are disheartened and dismayed at the precipitous decline in faculty morale that has occurred at MDACC under the current executive leadership. We are further troubled by the continuing loss of outstanding long-term senior faculty from MDACC, an exodus that many have attributed to current administrative policies. In this context, the fact that 154 out of 154 Faculty Senators attending the Senate meeting of November 20, 2014 voted to support the resolution of concern speaks for itself. Given these circumstances, we deplore the misguided action of the

three former Senate Chairs, now holding administrative faculty appointments, and strongly support the ECFS and Senate in their aforementioned actions.

Signed (alphabetically).

Borje Andersson, Faculty Senate Chair, 2005-2006

Joel Dunnington, Faculty Senate Chair, 1996-1997; 2007-2008; [University of Texas System Faculty Advisory Council] Chair 1998-1999

Carol Etzel, Faculty Senate Chair, 2011-2012

David Farquhar, Faculty Senate Chair, 1998-1999

Emil Freireich, Faculty Senate Chair, 1993-1995

Jim Klostergaard, Faculty Senate Chair, 1998-1999; 2008-2009

Susan O'Brien, Faculty Senate Chair, 2001-2002

Michael Siciliano, Faculty Senate Chair, 1995-1996; [University of Texas System Faculty Advisory Council] Chair 1997-1998

Executive Committee Defends its Role

Similarly responding to the petition, the executive committee sent out this email to the faculty.

The statement basically reaffirms that the executive committee intends to play a pivotal role in resolving the situation:

Dear Faculty members:

The Executive Committee of the Faculty Senate (ECFS) would like to clarify the role of the Faculty Senate in its duty as the institutional shared governance body, and provide an update on recent events.

The purpose of the Faculty Senate of The University of Texas MD Anderson Cancer Center is to provide a forum for elected representatives to address all issues that impact the faculty. The Faculty Senate and its leadership are committed to representing all faculty members in the institution and maintaining open communication channels with its constituents.

The Faculty Senate draws information about faculty opinions, problems, and solutions from numerous sources. These include four faculty surveys—two released by the Senate, one released by the UT System, and one released by the institution (the BIG Survey); direct communication with senators, both within Senate meetings and ad hoc; and senate leadership visits to multiple departments.

The November 2014 resolution of concern, developed in response to the University of Texas System Survey of October 2014, was sent to the Chancellor, the Executive Vice Chancellor for Health Affairs, and the Board of Regents to establish timelines and milestones to improve faculty morale and the health of the institution.

Because of impending changes that were to occur in the Chancellor position and in the Board of Regents, we delayed submission until mid-February.

The Faculty Senate and the ECFS care deeply about the institution and our faculty, and remain committed to being the faculty voice on critical issues as well as a constructive body to form creative solutions together with the administration.

Following the UT System survey, the executive leadership of the institution has engaged division heads, department chairs, the ECFS, and the faculty, and together we are collaboratively working to address a number of issues affecting faculty morale.

We remain committed to working collegially and collaboratively with the UT System, the administration, the division heads, the department chairs, and the faculty in full transparency for the best interests of the faculty and the institution.

Guest Editorial

NCCS CEO Applauds CMS Oncology Care Model

(Continued from page 1)

In 2013, the Institute of Medicine released its report, "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis." According to the IOM, the American cancer care system is in crisis due to three failings: it is often not patient-centered, does not provide well-coordinated care, and does not always encourage evidence-based treatment decisions. One of the IOM's recommendations is that CMS and other payers should design and evaluate innovative payment models to improve care delivery.

Although only a step in the payment and delivery reform process, the OCM holds significant promise of boosting patient satisfaction and improving the overall quality of care. Participation in the Oncology Care Model, or OCM, is voluntary for oncology practices. Those volunteering practices will be required to refine their care processes to focus on the needs of patients who are undergoing chemotherapy.

On Feb. 12, the CMS Innovation Center announced a "new multi-payer payment and care delivery model to support better care coordination for cancer care." The OCM is the second specialty care model the Innovation Center has developed and launched. The Innovation Center was established by the Affordable Care Act and given the charge of testing innovative health care

payment and delivery models that will improve care quality and reduce CMS spending.

The National Coalition for Cancer Survivorship immediately applauded the Innovation Center announcement of the OCM, which detailed the Medicare payment streams that physicians participating in the demonstration project will receive. What did we see in the announcement of a new payment system that holds promise for changing patient care?

For NCCS, the most important elements of the OCM are structuring care into six-month episodes, reimbursing physicians through a per beneficiary per month payment of $160 (for each month of the six-month episode) to help them address the complex needs of patients receiving chemotherapy, and defining with specificity several patient-centered changes that practices must undertake.

• Physician practices that choose to participate in the OCM must do these things to change their procedures and processes:

• Provide patient navigation services;

• Document a care plan that meets the standards outlined by the Institute of Medicine;

• Provide 24/7 patient access to a clinician with access to the patient's medical records;

• Treat patients according to nationally recognized clinical guidelines;

• Engage in continuous quality improvement; and

• Use electronic health records and meet certain meaningful use standards by the third year of the demonstration.

NCCS has, for a decade, sought a modest reform of the traditional fee-for-service Medicare payment system: the establishment of a reimbursable cancer care planning and coordination service. We endorsed and championed legislation to establish the Medicare cancer care planning and coordination service, which was defined in legislative language in a manner consistent with the standards of the Institute of Medicine definition. We believed that a written care plan would trigger a shared decision-making process and foster better coordination of cancer care.

We are pleased to see the cancer care planning and coordination service among those services that a physician practice must provide to patients in order to participate in the OCM. Just as we saw the discrete cancer care planning service/code as a first step in reform of fee-for-service payment and promotion of quality care, so we see it as one of the core practice reforms in the OCM.

In addition to paying those practices that participate in the OCM a per beneficiary per month fee, the demonstration project would reimburse all Part A, Part B, and certain Part D services that a chemotherapy patient receives on a fee-for-service basis. The demonstration project would also hold the potential for performance-based payments, which are intended to incentivize practices to improve care and lower the total cost of care provided in the six-month period. CMS has indicated that reductions in cost of care will result from avoiding hospitalizations and emergency department visits.

These two elements of the demonstration project—the continuation of fee-for-service payments and the potential for performance-based payments—have stimulated criticism. Some have criticized the OCM for relying on the fee-for-service payment system, which they say is broken. Others say that performance-based payments hold the potential to encourage "stinting" on care.

NCCS believes that the keys to the success of the OCM and to delivery of patient-centered care are: 1) achieving cancer care practice transformation by successful adoption of the six core practice standards of the OCM, and 2) performance according to the quality measures identified in the OCM. We have heard it suggested that oncology practices may choose to participate in the demonstration in order to receive the per beneficiary per month payments and that the practice transformation outlined in the OCM will be easily achieved.

We are gratified that the CMS Innovation Center has included in the OCM implementation plan several reporting and monitoring efforts such as tracking of claims to detect possible systematic stinting on care, patient surveys, reporting of the use of model funds (through the per beneficiary per month payments) for infrastructure enhancements to achieve practice transformation, and time-and-motion studies to document practice staff time dedicated to such activities as care coordination.

Through our work as patient advocate advisors to practices that are developing and implementing patient-centered oncology medical homes, we have had the pleasure of collaborating with oncology practices that have a keen interest in transforming their practices and honoring principles of patient-centeredness.

These oncologists are truly committed to the delivery of the right treatment to the right patient at the right time. We believe that these practices, which are admittedly leaders in the transformation process, are also representative of practices in general. There is strong interest in patient-centered practice, and we do not anticipate that practices will enroll in the demonstration simply to receive per beneficiary per month payments. However, the Innovation Center monitoring plan will protect against such enrollments.

Reform of Medicare delivery and payment often occurs in incremental fashion, and the OCM is consistent with that tradition. However, the standards for reform that

are articulated in the OCM are decidedly patient-focused.

We encourage additional payers to join Medicare in the OCM, and we encourage oncology practices to participate. The OCM will provide practices important resources to improve the processes and procedures they employ to care for patients undergoing chemotherapy. Patients are relying on their physicians to embrace this opportunity for change and for ongoing quality improvement.

The author is the CEO of the National Coalition for Cancer Survivorship.

ORIEN Big Data Collaboration Adds Four Cancer Centers

The Oncology Research Information Exchange Network, a precision cancer research collaboration founded by Moffitt Cancer Center and The Ohio State University Comprehensive Cancer Center, announced the addition of four cancer centers Feb. 23, bringing its membership to six.

The new members of ORIEN include City of Hope, University of Virginia Cancer Center, University of Colorado Cancer Center, and the University of New Mexico Cancer Center.

The addition of the new ORIEN members is expected to exponentially increase the number of patients consenting to donate their tissue and clinical data—including corresponding genomic data—for research to understand cancer at the molecular level, with the goal of developing more targeted cancer treatments.

Additional nationally designated cancer centers are in the process of joining ORIEN, where partners share de-identified data to accelerate the development of targeted treatments, allowing researchers and clinicians to more quickly match eligible patients to clinical trials and conduct larger and richer analyses.

According to a statement from Ohio State, ORIEN personifies "big data"—extensive databases with cancer patient information (medical history, cancer tissue, and DNA) that can be used for basic research and clinical trials—that puts cancer genomics on the leading edge of precision medicine.

ORIEN is expanding just as the national spotlight is focused on the promise of precision medicine. President Barack Obama revealed his plans to invest in precision medicine during his State of the Union address, and on Jan. 30 unveiled the $215 million initiative.

"The growth of ORIEN coincides with President Obama's announcement and the recognition that molecularly targeted medicine holds tremendous promise for all disease, particularly cancer," said Michael Caligiuri, director of The Ohio State University Comprehensive Cancer Center and CEO of the James Cancer Hospital and Solove Research Institute. "We believe ORIEN illustrates a collaborative pathway to operationalize personalized medicine to help discover cures for more patients."

The new members will adopt Total Cancer Care, the protocol created by Moffitt in 2006 and now in use at OSUCCC-James. The protocol creates a standard system for tracking patient molecular, clinical and epidemiological data.

Consented patients are followed throughout their lifetime and agree to be contacted for future studies, playing an active role in the study of their cancer and improving care for future generations.

"With the addition of City of Hope, UVA Cancer Center, the CU Cancer Center and UNM Cancer Center, more than 50,000 new patients each year will have the opportunity to consent to donate their tissue and clinical data to the ORIEN network, and potentially be matched with ongoing clinical research with the most potential to help them," said Thomas Sellers, center director and executive vice president of Moffitt. "Each of these renowned National Cancer Institute-designated cancer centers will enhance our collaborative model, which greatly reduces the amount of time required to conduct clinical trials."

PCORI Approves $64 Million For Five 2015 Grant Awards

The Patient-Centered Outcomes Research Institute approved awards totaling more than $64 million to fund five large patient-centered comparative effectiveness research studies concentrating on cancer, back pain and stroke.

These are the first awards made through the institute's Pragmatic Clinical Studies Initiative, an effort to produce results that can be more quickly taken up in routine clinical practice. The grants range from $7.75 million to $14.5 million each.

The three studies focusing on cancer are detailed below. The other two studies will explore: primary care versus prompt referral to physical therapy combined with cognitive behavioral therapy to see which more effectively prevents acute low back pain from progressing to chronic pain; and also whether

a comprehensive package of transitional care and in-home support services is more effective than usual care at improving stroke survivors' functional abilities and preventing hospital readmissions.

The five studies were selected from proposals submitted to PCORI's first funding announcement issued last February. PCORI has issued three funding announcements through this initiative to date, seeking proposals that focus on a series of key CER topics identified by PCORI's advisory panels, the Institute of Medicine, and the Agency for Healthcare Research and Quality.

These clinical studies will test a care option's effectiveness in real-life practice situations, such as typical hospital and outpatient care settings, and will involve more diverse patient populations, according to the institute.

The three studies focused on cancer are:

"Enabling a Paradigm Shift: A Preference-Tolerant RCT of Personalized vs. Annual Screening for Breast Cancer."

The grant includes $14,009,998 for a five-year project headquartered at the University of California, San Francisco. The project summary follows:

We believe that it is time to test a more targeted approach to breast cancer screening in which those at higher risk are screened more often and those at lower risk are screened less often. Our proposal compares annual screening with a personalized schedule of breast cancer screening that is based on each woman's own personal risk. We will compare the two strategies to determine whether personalized screening is as safe as annual screening and whether it will reduce false-positive results and over-diagnosis. We will also determine whether women readily accept personalized screening and if knowledge of their own risks, and the reasons for less-frequent screening, will reduce—or at least not increase—anxiety about breast cancer. Finally, we will determine whether our personalized approach will lead to more of the highest-risk women deciding to use strategies that can prevent breast cancer.

Participants in the personalized screening arm will receive a risk assessment that includes family and medical history, breast density measurement, and tests for genes (mutations and variations) linked to the development of breast cancer. Women who have the highest personal risk of developing breast cancer will receive recommendations to begin screening at an earlier age, receive mammograms more often, and continue screenings until a later age. Women with the lowest personal risk will begin screening later, screen less frequently, and stop screening earlier. No woman will be screened less frequently than is recommended by US Preventive Services Task Force guidelines. Ours goals are to maximize the chances of detecting a cancer early and to reduce false-positive results and the chance of detecting lesions that do not need to be treated.

This study has been planned in partnership with the people it was designed to help—our patients, their families, and their primary care providers. We have also worked tirelessly to gain the support of healthcare payers and insurance companies to ensure that they cover the expense of the personalized approach. Thus, if proved successful, personalized screening can be readily implemented across the United States.

If our study is successful, the benefits to women of screening age will be enormous. Fewer women will suffer from the anxiety of false-positive mammograms and unnecessary biopsies. It will help women gain a realistic understanding of their personal risk of breast cancer, which may reduce general worry about breast cancer. On the other hand, there are many women in America—perhaps 2 million—who have a high risk of breast cancer and who, because they are unaware of their risks, are not being screened appropriately or being offered strategies to reduce their chances of developing the disease. Routine comprehensive risk assessment not only would alert them to their risks but also would allow them to take advantage of the well-studied and proven options we now have available to help prevent breast cancer.

"A Pragmatic Trial of More versus Less Intensive Strategies for Active Surveillance of Patients with Small Pulmonary Nodules."

The grant includes $14,458,936 over five years for the Kaiser Foundation Research Institute in California. The project summary follows:

Background: Guidelines now recommend that smokers and former smokers undergo lung cancer screening, which can identify small growths. These pulmonary nodules are typically then monitored with serial CT scans that look for changes suggesting the nodules are cancerous. However, the optimal frequency of such scans has not been determined. The proposed research will compare more intensive versus less intensive protocols for CT surveillance.

Objectives: Among individuals with small pulmonary nodules that progress beyond the most curable stage of lung cancer, we will compare two protocols for CT surveillance, both of which are supported by existing guidelines from professional societies and are

consistent with current standards of care. We consider patient-reported outcomes of emotional distress, anxiety, general health status, and satisfaction with the evaluation process; resource utilization and exposure to diagnostic radiation; adherence to the recommended protocols for surveillance; and adherence to use of low-radiation-dose techniques.

Methods: Using automated methods for identification, notification, and registration into the study, we will enroll eligible patients at each of 26 hospitals within 14 healthcare systems. We estimate that almost 47,000 patients will be passively enrolled over 20 months and followed for two years. We will perform analyses to determine which protocol works best for specific subgroups of patients.

Patient Outcomes: Lung cancer tumor stage T1a, the most curable stage of cancer; timeliness of lung cancer treatment; survival from lung cancer; emotional distress, anxiety, and general health status during surveillance; overall satisfaction with evaluation; number of tests and procedures performed during the surveillance period; number of procedure-related complications during the surveillance period; adherence to recommended surveillance, for both patients and providers; and exposure to potentially harmful radiation.

Patient and Stakeholder Engagement: We have assembled a team of researchers, patients, clinicians, and stakeholders from health systems, advocacy groups, purchasers, and professional societies to help design and execute the study, and to help interpret and disseminate the results.

Anticipated Impact: Surveillance imaging and downstream invasive testing can be inconvenient, costly, and potentially harmful. By comparing two existing options for surveillance in the context of routine clinical practice, our trial will have a large and immediate impact on clinical care. By collaborating with stakeholders from health systems, professional societies, and advocacy groups, we will disseminate our findings widely and facilitate implementation in diverse practice settings.

"A Pragmatic Trial to Improve Colony Stimulating Factor Use in Cancer."

The grant includes $7,750,999 over four years for researchers at the Fred Hutchinson Cancer Research Center. The project summary follows:

In patients receiving chemotherapy that carries a high risk (more than 20 percent) of febrile neutropenia (FN), a serious infection resulting from loss of white blood cells, clinical practice guidelines recommend use of primary prophylactic colony-stimulating factors (PP-CSF) during the first cycle of chemotherapy to maintain white blood cell count. Guidelines suggest only "consideration" of PP-CSF in conjunction with chemotherapy carrying an intermediate FN risk (10–20 percent), and it is not recommended for patients receiving low-risk chemotherapy (less than 10 percent risk of FN). Studies show that PP-CSF is both underused and overused, resulting in serious adverse outcomes (FN, interruption of chemotherapy, or reduced dose intensity of chemotherapy) and wasted resources.

We propose a pragmatic trial evaluating a guidelines-based, standing-order entry system for PP-CSF use versus usual care among breast, colorectal, and lung cancer patients receiving chemotherapy, along with a prospective randomized study of PP-CSF versus no PP-CSF for patients receiving intermediate-risk chemotherapy. The primary outcomes are rates of FN, FN-related emergency room (ER) visits and hospitalizations, health-related quality of life (HRQOL), mortality, and adherence to guidelines. A third aim is to examine CSF use and outcomes among clinics that have already implemented standing CSF order systems. We address two key questions: First, does a guidelines-based, standing PP-CSF order entry system improve prescribing of CSF in accordance with clinical practice guidelines and reduce the risk of FN, compared with usual care in patients receiving chemotherapy? Second, what are the risks and benefits of PP-CSF among patients receiving intermediate-risk chemotherapy?

We will enroll men and women aged 21 and over with breast, non-small-cell lung, and colorectal cancer who are receiving chemotherapy. Clinics are first randomized to either standing CSF order entry intervention or usual care. Within the intervention arm, clinics will be randomized again to either PP-CSF or no PP-CSF for all intermediate-risk patients.

Patient outcomes to be assessed are PP-CSF prescribing, chemotherapy regimens, adverse events, blood counts, PP-CSF use that is consistent with guidelines, FN events and related ER visits and hospitalizations, and mortality. Patient surveys will

assess HRQOL, out-of-pocket costs, and knowledge of the risks, benefits, and costs of CSF.

The research questions, study design, recruitment procedures, and study outcomes were designed in consultation with patients, patient advocates, an ethicist, oncologists, insurance plan leaders, policy makers, and leaders of the community clinics where the study will be implemented. Stakeholders will continue to participate in study development, monitoring of progress, and dissemination of results.

The study will improve the evidence on the benefits and risks of PP-CSF for commonly prescribed intermediate-risk chemotherapy regimens.

Obituary

Meir Wetzler, 60, Roswell Park Hematologic Oncologist

Meir Wetzler, 60, chief of the Leukemia Section at the Roswell Park Cancer Institute, died Feb. 23, nearly two weeks after a skiing accident in Denver, Colo.

Remembered as a brilliant and compassionate physician, he worked with cooperative groups and pharmaceutical companies to make clinical trials available to leukemia patients at Roswell Park. At the time of his death, he was principal investigator at the institute for clinical trials for CML, acute myeloid leukemia, multiple myeloma and myelofibrosis.

His research focused on autocrine and paracrine growth factor regulatory loops in the pathogenesis of leukemia, and signal transducer and activator of transcription proteins in leukemogenesis.

During his tenure at Roswell Park, he was named numerous times to the Castle Connolly Medical Ltd. list of America's Top Doctors, most recently this year.

Colleagues remember him as someone who often appeared serious but had a playful side, evidenced every year when he and members of his team dressed in themed costumes and slid into a pool of gelatin to raise money for the Leukemia and Lymphoma Society of Western New York.

Often the team paraded through the Roswell Park inpatient rooms in costume, "because it was good for the patients' morale to do something fun," recalled pathology resource technician Linda Lutgen-Dunckley.

"He oversaw clinical activities departmentally and co-chaired the Ambulatory Services Executive Committee," said Alex Adjei, chair of the Department of Medicine and senior vice-president for clinical research.

"He co-chaired the Scientific Review Committee and chaired the Pharmacy & Therapeutics Committee. Meir also oversaw the leukemia tissue bio-repository and ran a research laboratory. In addition to doing all of this, he carried a full clinical load and took outstanding care of his patients," he said. "Meir touched us all in so many different ways; Roswell Park has lost a dedicated son."

"He gave a piece of himself in everything he did, from his research to his care for patients to his interactions with his team of colleagues," said Kara Eaton-Weaver, executive director for Patient and Family Experience. "Meir was a transformational leader who built a culture of empathy, compassion and integrity and innovation. His character is an inspiration to us all."

Wetzler was also an accomplished athlete, passionate about snowboarding, skiing, and running, and participated in many triathlons, including several Ironman triathlons. He motivated friends and colleagues to exercise for better health.

Originally from Israel, Wetzler earned his medical degree in 1980 from Hebrew University's Hadassah Medical School in Jerusalem and served his residency at Kaplan Hospital in Rehovot. From 1988-1992 he completed fellowships in clinical immunology/biologic therapy and medical oncology at MD Anderson Cancer Center. He was board-certified in both internal medicine and medical oncology.

Wetzler joined the Leukemia Division at Roswell Park Cancer Institute in 1994.

At the time of his death, he held additional posts as assistant research professor in the Immunology Program of Roswell Park's Graduate Division; professor of medicine in the School of Medicine & Biomedical Sciences of the State University of New York at Buffalo; and adjunct faculty member in the Physician Assistant Department of D'Youville College in Buffalo.

Wetzler was the author or co-author of more than 100 journal articles, book chapters, and abstracts, and served as a referee for Blood, Cancer, Stem Cells, Leukemia Research, and American Journal of Hematology.

He was a member of the Chronic Myelogenous Leukemia Treatment Committee of the National Comprehensive Cancer Network; a member of the Leukemia Core Committee of the Alliance for Clinical Trials in Oncology (formerly the Cancer and Leukemia Group B); and a member of the American Society of Clinical Oncology, American Association for Cancer Research, American Society of Hematology, and Israel Medical Association.

Wetzler is survived by his wife, Chana, and their four children: daughters Mor and Shira, and sons Adam and Modi.

In Brief

Hwu Named Cancer Medicine Division Head at MD Anderson

(Continued from page 1)

Hwu's selection came after a national search to fill the position currently being served by Richard Champlin on an interim basis. Champlin will continue to serve as chair of Stem Cell Transplantation and Cellular Therapy.

"[Hwu is] a seasoned leader and has successfully chaired two departments and served as co-director of MD Anderson's Center for Cancer Immunology Research and its immunotherapy platform," said Ethan Dmitrovsky, MD Anderson provost and executive vice president. "He has also held endowed positions, including the Sheikh Mohamed Bin Zayed Al Nahyan Distinguished University Chair in Cancer Research."

Hwu has helped launch the field of gene modified T cells, publishing research on the first chimeric antigen receptor directed against cancer. Clinical trials using CAR-transduced T cells now are being studied in many types of cancers, and MD Anderson has established an adoptive T cell therapy program.

In addition, Hwu has produced a study of combination T cell and dendritic cell therapy and a study of T cells modified with chemokine receptor genes to enhance their migration to the tumor. His most recent preclinical studies have focused on combinations of immune checkpoint blockade and T cell therapy, as well as rational combinations of targeted therapies and immunotherapies.

During Hwu's 11 years as Melanoma Medical Oncology chair, the department evolved from a purely clinical group to an NIH-funded academic program. The department has grown from 40 faculty and staff to more than 120, and its peer-reviewed grant funding has increased from $200,000 to more than $6 million.

Hwu also serves on the advisory board for a number of institutions, including the Moffitt Cancer Center and the University of Chicago Medicine Comprehensive Cancer Center.

WILLIAM NELSON will serve as the editor-in-chief of **Cancer Today**, the American Association for Cancer Research's consumer magazine.

Nelson is the Marion I. Knott professor of oncology and director of the Sidney Kimmel Comprehensive Cancer Center. He has been a member of the magazine's editorial board since 2012.

Cancer Today is published quarterly and has a circulation of approximately 200,000. As editor-in-chief, Nelson will serve a term of five years, which is renewable for an additional term.

At Johns Hopkins, Nelson has held the position of director of the cancer center since 2008. In addition to being professor of oncology, he is also professor of urology, pharmacology, medicine, pathology, and radiation oncology. He specializes in the research and treatment of prostate cancer.

Nelson served on the AACR Board of Directors from 2000 to 2003. He is a senior editor of two AACR journals, Cancer Research and Cancer Prevention Research, and is a member of the editorial board of Clinical Cancer Research. He serves as vice chair of the scientific advisory committee of Stand Up To Cancer and as a member of the scientific advisory board for the Prostate Cancer Foundation. He was also one of three co-chairs of the NCI's Translational Research Working Group.

BEAUMONT HOSPITAL'S Cancer Institute in Royal Oak has begun construction of a proton therapy center. This will be the first single-room proton treatment center of its kind in Michigan.

When completed, the two-story Proton Therapy building will be 25,200-square-feet, including a basement. The first floor will house the Proton Therapy Center. This 10,000-square-foot space will include a cyclotron and a single-room treatment area. The hospital plans to complete the project in two years, at a cost of $40 million, with first patients receiving treatment in the spring of 2017.

The 8,000-square-foot second floor will house the Beaumont Children's Hospital Pediatric Oncology and Hematology program.

Beaumont has chosen Ion Beam Applications of Belgium, also known as IBA, to install and maintain the proton system.

Drugs and Targets

Accelerated Approval Granted To Farydak in Multiple Myeloma

FDA granted accelerated approval to Farydak (panobinostat) for the treatment of multiple myeloma. The FDA had previously granted Farydak priority review and an orphan product designation.

Farydak inhibits the activity of histone deacetylases. This process may slow the over-development of plasma cells in multiple myeloma patients or cause these cells to die.

Farydak is the first HDAC inhibitor approved to treat multiple myeloma. It is intended for patients who have received at least two prior standard therapies, including bortezomib and an immunomodulatory agent. Farydak is to be used in combination with bortezomib and dexamethasone.

In November 2014, the FDA's Oncologic Drugs Advisory Committee advised the agency that, based on the data reviewed, the drug's benefits did not outweigh its risks for patients with relapsed multiple myeloma. After the meeting, the company submitted additional information supporting Farydak's use for a different indication: patients with multiple myeloma who have received at least two prior standard therapies, including bortezomib and an immunomodulatory agent.

The safety and efficacy of Farydak in combination with bortezomib and dexamethasone was demonstrated in 193 clinical trial participants with multiple myeloma who received at least two prior treatments that included bortezomib and an immunomodulatory agent. Participants were randomly assigned to receive a combination of Farydak, bortezomib and dexamethasone, or bortezomib and dexamethasone alone.

Study results showed participants receiving the Farydak combination saw a delay in their disease progression for about 10.6 months, compared to 5.8 months in participants treated with bortezomib and dexamethasone alone. Additionally, 59 percent of Farydak-treated participants saw their cancer shrink or disappear after treatment, versus 41 percent in those receiving bortezomib and dexamethasone.

Farydak carries a Boxed Warning alerting patients and health care professionals that severe diarrhea and severe and fatal cardiac events, arrhythmias and electrocardiogram changes have occurred in patients receiving Farydak.

Because of these risks, Farydak is being approved with a Risk Evaluation and Mitigation Strategy consisting of a communication plan to inform health care professionals of these risks and how to minimize them.

An improvement in survival or disease-related symptoms has not yet been established for Farydak. As part of the accelerated approval program, the company is now required to conduct confirmatory trials to verify and describe the clinical benefit of Farydak. Farydak is marketed by Novartis Pharmaceuticals.

FDA granted Rintega (rindopepimut) a Breakthrough Therapy Designation for the treatment of adult patients with EGFRvIII-positive glioblastoma.

This application was based on data from the phase II ReACT study in recurrent GBM, the phase II ACT III study in newly diagnosed GBM and additional supportive phase II studies.

An international phase III study of rindopepimut, called ACT IV, in newly diagnosed GBM completed enrollment of 745 patients in December 2014.

Rindopepimut is an investigational immunotherapy that targets the tumor specific oncogene EGFRvIII. Patients with EGFRvIII-positive glioblastoma typically have a worse prognosis than the overall glioblastoma population, including poor long term survival. Rindopepimut is developed by Celldex Therapeutics Inc.

Bristol-Myers Squibb Company and Rigel Pharmaceuticals Inc. entered into a collaboration agreement for the discovery, development and commercialization of cancer immunotherapies based on Rigel's portfolio of small molecule TGF beta receptor kinase inhibitors.

TGF beta can promote tumor growth, broadly suppress the immune system and increase the ability of tumors to spread in the body. The collaboration will focus on developing a new class of therapeutics aimed at increasing the immune system's activity against various cancers either as monotherapy or in combination with immune checkpoint inhibitors, including Bristol-Myers Squibb's Opdivo (nivolumab) and Yervoy (ipilimumab).

Under the terms of the agreement, Bristol-Myers Squibb will obtain exclusive, worldwide rights to develop and commercialize small molecule therapeutics derived from Rigel's TGF beta library, including, but not limited to, those approved to treat cancer.

Bristol-Myers Squibb will pay $30 million upfront and Rigel will be eligible to receive development and regulatory milestones that could total more than $309 million for a successful compound approved

in multiple indications. Rigel will also be eligible to receive tiered royalties on the net sales of any products from the collaboration.

FDA approved the marketing of 23andMe's Bloom Syndrome carrier test, a direct-to-consumer genetic test to determine whether a healthy person has a variant in a gene that could lead to their offspring inheriting the disorder.

Along with this authorization, the FDA is also classifying carrier screening tests as class II. In addition, the FDA intends to exempt these devices from FDA premarket review.

The agency plans to issue a notice that announces the intent to exempt these tests and that provides a 30-day period for public comment. This action creates the least burdensome regulatory path for autosomal recessive carrier screening tests with similar uses to enter the market.

"The FDA believes that in many circumstances it is not necessary for consumers to go through a licensed practitioner to have direct access to their personal genetic information. Today's authorization and accompanying classification, along with FDA's intent to exempt these devices from FDA premarket review, supports innovation and will ultimately benefit consumers," said Alberto Gutierrez, director of the Office of In Vitro Diagnostics and Radiological Health in the FDA's Center for Devices and Radiological Health. "These tests have the potential to provide people with information about possible mutations in their genes that could be passed on to their children."

Like other home-use tests for medical purposes, the FDA requires the results to be conveyed in a way that consumers can understand and use. This is the same approach the FDA has taken with other over-the-counter consumer products such as pregnancy, cholesterol and HIV tests for home use.

If sold over the counter, the FDA is also requiring 23andMe to provide information to consumers about how to obtain access to a board-certified clinical molecular geneticist or equivalent to assist in pre- and post-test counseling.

The test is intended only for post-natal carrier screening in adults of reproductive age, and the results should be used in conjunction with other available laboratory and clinical information for any medical purposes.

The FDA issued a safety alert regarding the design of endoscopic retrograde cholangiopancreatography duodenoscopes, and how it may impede effective cleaning of the reusable device.

The FDA says that the complex design of ERCP endoscopes (also called duodenoscopes) may impede effective disinfection or sterilization. "Recent medical publications and adverse event reports associate multidrug-resistant bacterial infections in patients who have undergone ERCP with reprocessed duodenoscopes, even when manufacturer reprocessing instructions are followed correctly," the FDA said. "Meticulously cleaning duodenoscopes prior to high-level disinfection should reduce the risk of transmitting infection, but may not entirely eliminate it."

More than 500,000 ERCP procedures using duodenoscopes are performed in the U.S. annually. Unlike most other endoscopes, duodenoscopes also have a movable "elevator" mechanism at the tip. The elevator mechanism changes the angle of the accessory exiting the accessory channel, which allows the instrument to access the ducts to treat problems with fluid drainage.

Although the complex design of duodenoscopes improves the efficiency and effectiveness of ERCP, it causes challenges for cleaning and high-level disinfection. Some parts of the scopes may be extremely difficult to access and effective cleaning of all areas of the duodenoscope may not be possible.

In addition, a recent FDA engineering assessment and a growing body of literature have identified design issues in duodenoscopes that complicate reprocessing of these devices. For example, one step of the manual cleaning instructions in device labeling is to brush the elevator area. However, the moving parts of the elevator mechanism contain microscopic crevices that may not be reached with a brush.

Residual body fluids and organic debris may remain in these crevices after cleaning and disinfection. If these fluids contain microbial contamination, subsequent patients may be exposed to serious infections.

In total, from January 2013 through December 2014, the FDA received 75 Medical Device Reports encompassing approximately 135 patients relating to possible microbial transmission from reprocessed duodenoscopes. It is possible that not all cases have been reported to the FDA.