THE CANCER LETTER

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Minority Based CCOP RFA Generates Wide Interest; 44 Letters Of Intent Received For Eight Awards

NCI's new minority based Community Clinical Oncology Program has generated 44 letters of intent from potential applicants, indicating that there is substantial interest in and

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In Brief

Holleb Named Memorial Distinguished Alumnus; Hankey Appointed DCPC Statistics Branch Chief

ARTHUR HOLLEB, who retired last year from the American Cancer Society as senior vice president for medical affairs, has been selected by the Memorial Hospital Alumni Society as its "Distinguished Alumnus for 1988." Holleb took his surgical training at Memorial Sloan-Kettering and became an attending surgeon in the Breast Service and associate chief medical officer of Memorial Hospital. After retiring from ACS, he has continued with the Society as a consultant and as editor in chief of "Ca-A Cancer Journal for Clinicians". . . . **BENJAMIN HANKEY**, who has been acting chief of the Cancer Statistics Branch in the Surveillance Program of NCI's Div. of Cancer Prevention & Control, has been appointed permanent chief of the branch. Hankey has been with NCI 21 years. His responsibilities include supervision of the Surveillance, Epidemiology & End Results (SEER) Program, as well as a variety of other survey and analytic work related to cancer surveillance. . . . **FRANK MEYSKENS**, director of the Univ. of California (Irvine) Cancer Center, has been named chairman of the Div. of Cancer Prevention & Control Board of Scientific Counselors. He replaces **Paul Engstrom**, whose term on the board has expired. Meyskens will serve as chairman for one year, when his term on the board will end. . . . **POSTER ABSTRACT** deadline for the 15th International Cancer Congress in Hamburg Aug. 16-22, 1990, is Nov. 30. For instructions on abstract submissions and other information contact 15th International Cancer Congress, Secretariat of the Program Committee, Letzter Hasenpfad 61, D-6000 Frankfurt 70, Federal Republic of Germany. . . . **DIFFERENTIATING YOUR** Program" through advanced cancer technologies is the theme of a seminar Oct. 5-6 in Hilton Head, SC, sponsored by CDP Services Inc. Topics include advantages of academic affiliation in offering advanced cancer technologies, advanced technologies in community hospitals, marketing strategies, and reimbursement issues. Contact CDP, 1050 Crown Pointe Parkway, #210, Atlanta, GA 30338, phone 404/391-9872.

Minority Based CCOP Generates Wide Interest; 44 To Apply For 8 Awards

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competition for the program's eight awards.

The program, based on the highly successful model of the regular CCOPs, is aimed at bringing both academic and community based oncologists with large minority populations into the clinical trials network.

If the minority based CCOP thrives as well as its parent, which this spring was "institutionalized" as an ongoing extramural NCI program, more minority patients and their physicians will have access to clinical trials and new treatment will be available more quickly and effectively to all cancer patients being treated in those settings.

The large amount of interest in the minority based CCOP and the relative inexperience of many of the applicants prompted the Div. of Cancer Prevention & Control's Community Oncology & Rehabilitation Branch to sponsor a workshop to answer questions from applicants.

This program will differ from the other CCOPs in that it will accept applications from university hospitals of major teaching institutions if they serve large minority populations. Applicants must show that 50 percent or more of their new cancer patients are minorities.

The estimated budget for minority CCOPs is $1.2 million for FY 1990, increasing to $1.3 million in 1992. Awards are for three years.

Carrie Hunter, CCOP program director, said that if there are strong applications beyond the eight awardees, "we will go for more funds."

Budgetary questions were prominent at the workshop for applicants last week, in which some current CCOPs offered advice.

Charles Cobau, principal investigator of the Toledo CCOP, in Toledo, OH, pointed out that applicants should have full support from their institutions.

"This is a research program, not a service program," Cobau said. "NCI will not reimburse you for all of your costs." In Toledo, the NCI grant covers only half the costs of running the program, he said.

Robert Frelick, medical director of the chronic disease program of the Delaware State Tumor Registry and former CCOP coordinator when the program first began, noted that CCOPs "are not going to make a financial killing."

But the reasons for getting involved in the program outweigh the costs, he said. "I think most of the current CCOPs have found the returns, in the sense of the added value of the institution, worth it," he said. "It is going to be difficult and costly, but ultimately it is worth it."

One potential applicant said that his institution may have records that only 48 percent of new cancer patients are minorities. "Should I tell my board that we can't apply?" he asked.

"Give us a call and let us assess (eligibility)," Hunter said.

NCI staff developed a paper with suggestions for organizing the information needed to fill out the minority based CCOP application. The main points are reprinted here, but for a complete copy of the suggestions, including suggested forms in which the information could be listed, applicants may contact Hunter at 301/496-8541.

Applicants were instructed to integrate the following suggestions into the standard application form PHS-398. These suggestions do not take the place of that form.

Minority based CCOP applications are due by 5 p.m. Oct. 13.

Resources and environment. Describe the proposed patient catchment or service area in four pages or less:

--Include a map of the patient catchment area, designating counties or Zip codes from which approximately 80 percent of the cancer patients will be drawn.

--Describe the geographical area from which patients will be drawn. Include the demographics of the new cancer patient population available to the minority based CCOP applicant organization and to the participating physicians.

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--Estimate the percent of oncologists in the service area who will be participating in the minority based CCOP.

--Describe cancer care resources available in the service area (hospitals, clinics, physicians, cancer centers, medical schools, Cooperative Group Outreach Program satellite hospitals) which are not part of the minority based CCOP application.

--Describe the unique characteristics and resources of the patient/subject population and how participation in the minority based CCOP will benefit them.

--Estimate the percent of the catchment area population that participates in HMOs or PPOs.

Previous relationships. Is there a history of previous working relationships among some or all of the proposed participating physicians? If so, describe:

--Previous patient practice relationships (referral, group practice, cross coverage).

--Previous experience of some or all of the investigators working together as a group in clinical trials (common research base, IRB, data management).

--Previous experience working together on other cancer related programs (cancer screening clinics, educational programs).

Cancer treatment research participation. Describe your experience in cancer treatment research and related programs. Indicate whether the research was funded or sponsored by NCI, cooperative groups, cancer centers, public health departments, the American College of Surgeons, drug companies, local hospitals, or other sources. Include a description of other treatment studies as appropriate. Limit to three pages.

Cancer control research participation. Describe your experience in cancer control research and related activities. Indicate whether the research was funded or sponsored by NCI, cooperative groups, cancer centers, public health departments, the American Cancer Society, or others. Also include a description of other cancer control activities (hospice, screening, other self help programs). Limit to three pages.

Experimental design and methods: Operational plan. Limit to three pages.

1. If the minority based CCOP has more than one component or affiliate, provide a diagram of the components, indicating distances between components or affiliates including administrative office and shared resources and location of proposed personnel.

2. Describe the relationship of components/affiliates to each other and to the minority based CCOP headquarters.

3. Provide information on how the minority based CCOP will be organized and directed (physician and staff) to facilitate clinical treatment and cancer control research. Include an organizational chart of how the group will function. Describe procedures for assuring implementation of the organizational plan.

4. Describe plans for communication among physicians and components/affiliates, and incentives for participation.

5. Describe the level and type of component contributions to the minority based CCOP.

Proposed data management. Limit to four pages.

1. Describe the proposed data management plan, including:

--Who will have overall responsibility for data management.

--The source of records (hospital, office, clinic, registry).

--Who will be responsible for registering patients on study.

--How the information will flow; provide flow chart.

--Who will be responsible for information entry on primary patient record and on protocol forms (R.N., M.D., data manager, secretary).

--Who will be responsible for collecting and sending materials (pathology slides, port films, etc.) to the research based if required by a protocol.

--What records, if any, will be placed on patient charts.

2. Describe the proposed quality assurance mechanisms for treatment and cancer control protocols. Who will have overall responsibility for quality control?

3. Describe in detail the data management operations within and between components/affiliates, investigators, and the central minority based CCOP administrative office (if applicable).

4. Will data be transmitted in batch form or as acquired to an intermediary institution or central office of the research base? Will this submission procedure be the same for each research base?

5. Are computers to be used for data management (data file, reminder system, protocol data entry, transmittal to research base computers)?

6. How will NCI and FDA requirements for

control of investigational drugs be met?

7. If applicable, describe the involvement in protocol studies of oncology nurses or data personnel not funded by the proposed minority based CCOP award.

Proposed research base affiliations. Describe previous working relationships with proposed research bases, if applicable. If one or more components participated at CGOP satellite hospitals, specify the years. Limit to two pages.

Cancer control protocols proposed for use by participants. In addition to the cancer control protocols listed, describe in detail two examples (see minority based CCOP RFA, section VII.B). If appropriate, include plans for involving primary care physicians, other professional disciplines and volunteer or community organizations.

NCAB Shows Lack Of Understanding Of Bypass Budget Purpose, History

Recent discussion at a meeting of the National Cancer Advisory Board shows that some of the newer board members lack understanding of the purpose of NCI's bypass budget.

The bypass budget, unique to NCI among all of the National Institutes of Health, provides a potentially powerful mechanism for publicizing the scientific financial needs of the institute.

Some NCAB members have expressed the belief that the bypass budget, because it is much larger than recent actual budgets requested by the President and appropriated by Congress, represents a "pie in the sky" figure that cannot be justified politically.

At the May NCAB meeting, board member Howard Temin took the lead in expressing this view, in discussion of the FY 1991 bypass budget, which is 50 percent greater than the 1990 President's budget request. Other board members and board Chairman David Korn also expressed concern about the bypass request.

"While (the bypass budget) is a realistic professional judgement in a world of infinite money what could usefully be spent on cancer research by the National Cancer Institute, it is so removed from the fiscal reality in this country, that it becomes unrealistic," Temin said. "I find it hard to approve--it is as if there is no other problem in the U.S."

Korn noted that the 50 percent difference between the bypass budget and the actual budget didn't happen "all of a sudden."

"Each year as the actual budget has fallen more and more short of the earlier projection (in the bypass budget) that gap is also getting wider and wider," he said. Korn said the board should think about "whether or not to set the thermostat at some lower level, so that the gap isn't quite as shocking."

Korn said he raised the issue with NCI Director Samuel Broder.

"I said, you know, you get to a point where the request is so out of line with reality that we will lose any kind of political credibility at all, and no one will take it seriously," Korn said.

Broder, who came in after Korn's comments, took issue with that view.

"Once we start adopting the political consideration, once we start saying, well, now we have a professional needs but this is unrealistic, you are putting on a different dimension than what we are supposed to do," Broder said. "I don't believe the Cancer Act says something about what is politically feasible, or what is realistic in a political context. It is supposed to be our professional judgment."

Broder said the board is "acting as though the bypass budget is of value only if it were to become enacted in its total. I think it is really important that it is a statement for the record, permissible, statutorily required statement which would permit people, the public or Congress or other individuals to essentially have a sense of our priorities, in case they chose not to give the total bypass, but to give a partial increment."

No agency in the federal government has the authority to go public with its own budget requests and send them directly to the President without interference or changes by the intervening hierarchy. That authority was granted NCI by the National Cancer Act of 1971 as part of the compromise which kept NCI within NIH and the Dept. of Health & Human Services.

Cancer program advocates who lobbied for an independent NCI accepted the compromise in the belief that the bypass budget would be the budget submitted to Congress, perhaps with some reductions by the President. President Nixon encouraged that belief when he signed the Act, promising that cancer research "will get all the money it needs."

Neither Nixon nor his successors have kept that promise, and the bypass budget has been ignored by the Office of Management & Budget. Instead, a budget developed within NIH

and HHS is the budget that is sent to Congress.

However, the bypass budget has been useful because it provides a figure to Congress of NCI's actual needs as determined professionally, not politically. The bypass budget spells out the resources that are needed to build and maintain the most effective cancer research and control program possible.

Enrico Mihich, associate director of Roswell Park Memorial Institute and an NCAB member, emerged as a leader in urging scientists to use the bypass budget in discussions with members of Congress.

"I think (the bypass budget) is realistic, but it is realistic because it reflects needs, Mihich said. "To become politically realistic, which is what Howard is talking about, I think it needs to be tightly justified, not only in reference to the actual (needs), but also in reference to missed opportunities of the past two, three, four years and how this represents the possibility of trying to recapture the lost ground.

"This squeeze we are in, that is as unrealistic as the increment requested," Mihich said.

Board member Helene Brown also came to the defense of the bypass request. "Since 1980, excluding inflation, NCI has been asked to stay at a flat level....I know in our institution, we have people sitting in each other's laps, because we have not have any construction money in the last 10 to 12 years. And yet, the research is expanding to such a degree, and our ability to attract people has expanded, that we have not been able to give them the space and the other resources they need."

The discussion of the "unrealistic" bypass budget was reminiscent of the early 1980s, when former NCI Director Vincent DeVita decided that the bypass budget should be more "realistic." That culminated in the 1984 bypass budget request of $1.075 billion--almost exactly what Congress eventually appropriated.

Despite getting the bypass budget request, NCI still was able to fund only 33 percent of approved RO1 and PO1 grants, down from 34 percent the previous year. Previous bypass budgets (and subsequent ones) have included enough to fund from 40 to 50 percent of approved competing grants.

The 1984 total also resulted in cutting the cooperative groups to an average of 80 percent of their recommended levels. Little money was available for new initiatives, and DeVita admitted that the attempt to present a "realistic" bypass budget was a mistake (**The Cancer Letter,** Oct. 21, 1983).

From then on, NCI tied the bypass request to the Year 2000 goals, with an "optimal" total request. That's what the authors of the National Cancer Act had intended--the bypass budget should be NCI and NCAB's best estimate of that needed to fund the best effort research and cancer control programs, and that is what the recent bypass budgets have done.

Cancer Letter Moves Into Capitol Hill Office; No Issues Next Two Weeks

The headquarters of **The Cancer Letter** has been moved to our Capitol Hill office, in Washington D.C., effective Sept. 1. All communications and inquiries, for both news and subscriptions, should be directed to that office.

The new mailing address is **P.O. Box 15189, Washington, D.C. 20003.** The phone number is **202/543-7665.** For those calling from outside the D.C. metropolitan area who must dial the area code, please note it is area 202.

The new office has a 24 hour FAX machine. That number is **202/543-6879.**

For those sending material by delivery services which must use a street address, that is **230 Eighth St. SE, Washington D.C. 20003.**

Editor Jerry Boyd may still be contacted at the Reston, VA office, phone number 703/620-4646. The new office, however, will be staffed regularly, 9 a.m. to 5 p.m., Monday-Friday. Messages may be left there for Boyd if he is out of the Reston office. Answering machines will be operating in both offices when they are closed and will be checked regularly.

The Cancer Letter will not be published during the next two weeks while some of the staff goes on vacation. The new office will remain open; daytime calls will be answered live, electronically at other times.

The next issue, Vol. 15 No. 36, will be published Sept. 22.

NCI Staff Evaluating Evaluation Of PDQ; Physician Use Growing

Staff members of NCI's International Cancer Information Center are in the process of evaluating the evaluation of PDQ, which had found that--at least by mid-1987 when evaluation figures were compiled--the system was used more by the public than by physicians (**The Cancer Letter,** Aug. 18).

The evaluation report was obtained by ICIC about the same time it was made available to

The Cancer Letter, in mid-August. The staff intends to develop an NCI response to the evaluation, but that probably will require several weeks.

The evaluation, performed under an NCI contract by Survey Research Laboratory of the Univ. of Illinois, offered five pages of recommendations for improving PDQ, most of which already have been implemented, are in the process of being implemented, or will be implemented as time and ICIC staff limits permit.

Most of the recommendations dealt with technical and management matters required to improve vendor accountability, accessibility, interfaces, clarity of display, clarification of information that is available, training and education, and marketing and publicity.

One recommendation that apparently will not be carried out is the suggestion that NCI "give serious consideration to the value of discontinuing MDC as a channel for the dissemination of PDQ."

MDC is Mead Data Central, which with BRS/Saunders was one of the first two vendors to add PDQ to its database. The evaluators were critical of "MDC's failure to even mention PDQ in its documentation, its failure to update the PDQ files on two consecutive months, and its unwillingness to cooperate in parts of this evaluation." That is "evidence of a lack of interest in or support for PDQ," the report said.

MDC primarily serves the legal profession, and the company soon found little interest in PDQ among its clients. MDC rates are considerably higher than those of the National Library of Medicine and other vendors offering PDQ, and the company determined it would not be cost effective to spend money promoting it. However, ICIC staff said that frequent checks have found that MDC is regularly updating its PDQ files, and they see no harm in allowing the company to retain PDQ as long as it is kept current.

The evaluation process included an "access demonstration study (ADS) which was designed as a quasi-experiment in which physicians were randomly assigned to one of two groups: easy access or multiple exposure. The impact of the intervention is examined separately for oncologists and nononcologists and by demonstration group.

Overall, ADS increased both awareness and use of PDQ among this sample of physicians. Among oncologists, 42% initiated calls with requests for PDQ information, 65% reported use of PDQ in the final interview, and 84% said that they planned to use PDQ in the six months after that interview. Among nononcologists, 21% initiated request calls during ADS, 37% reported use in the final interview, and 56% said that they planned to use PDQ in the six months following that interview.

ICIC staff believes that ADS demonstrated that efforts to acquaint physicians with PDQ will increase their use of it. In fact, ICIC is being deluged with requests from various organizations and companies who want to provide PDQ through their services.

Oncologists interviewed in the ADS had a much higher proportion of users at baseline that did nononcologists. This early use was found to be associated with existing participation in and interaction with other components of the National Cancer Program, regardless of any other characteristic of these physicians. For physicians who participated in the ADS, use and plans to use PDQ were no longer associated with these factors. Plans to use in the future were fairly uniform across oncologists and only slightly greater among those referring cancer patients than among those not providing this service. By demonstration group, the multiple exposure strategy provided little or no additional benefit among oncologists, and results are inconsistent across outcome measures. The small sample sizes in the two demonstration groups for oncologists hampers the interpretation of these results, the report said.

Among nononcologists, the increases in both the use of PDQ and in reported plans to use PDQ following the demonstration are large and consistently significant. The increase in use is larger than what could be expected over time without the demonstration, as estimated based on the increase between 1985 and 1986. Although the nononcologists' plans to use PDQ following the ADS is still much lower than that of the oncologists, it shows a proportionately much larger increase over use at baseline, changing from almost 0% to sizeable proportions. This suggests that their extremely low level of use prior to the intervention may be due to lack of familiarity with the system rather than a rejection of it.

Among oncologists, ADS expanded use of PDQ to physicians beyond those who were early users, that is, beyond those who are already involved with clinical trials or other components of the National Cancer Program. Physicians who said that they planned to use

PDQ in the future do not differ significantly from those who do not plan to use it in number of cancer patients seen, age, or specialty, although those who refer cancer patients are more likely to be users than those who do not. Thus, ADS was effective in extending use of PDQ to all types of oncologists.

Similar analyses for the nononcologists indicated that the users of PDQ during the ADS were more likely than nonusers to be surgeons, to be younger, and to see more cancer patients. Surgeons were also more likely to plan to use PDQ in the future, as were physicians who referred or provided primary care to cancer patients or who had prior direct involvement in clinical trials.

How does a physician's assessment of PDQ affect his/her adoption of the system?

ADS physicians were asked several questions concerning their assessment of PDQ. The majority said that the printouts did not contain too much irrelevant information, the labels were clear, and the type was easy to read. The nononcologists were more likely than the oncologists to have found information that was new to them; among nononcologists, physicians in the multiple exposure group were more likely than those in the easy access group to say that they found new information.

ADS physicians came from colleague networks in which there is at least some awareness of PDQ; 81% of the oncologists and 46% of the nononcologists reported that they have colleagues who are aware of the database. These are much higher rates of awareness than those found in a previous sample. It is possible that participation in the study increased physicians' perception that their colleagues are aware of PDQ. It is also likely that they themselves contributed to that awareness by talking about the demonstration or by sharing with colleagues the searches that they received. Thus, the impact of ADS on awareness of PDQ might indirectly extend to the participants' colleagues.

The majority intend to use PDQ again, with 84% of the oncologists and 56% of the nononcologists saying in the ADS final interview that they would use it in the next six months. Among nononcologists, the multiple exposure physicians were more likely than those in the easy access group to say that they planned to use it, and these differences are statistically significant. Among oncologists, the opposite is true, and the differences are not statistically significant.

RFAs Available

RFA 89-CA-15
Title: Intervention research in Hispanic populations
Application receipt date: Dec. 1

The Special Populations Studies Branch of NCI's Div. of Cancer Prevention & Control invites applications for cooperative agreements to support investigators conducting studies to determine the effectiveness of cancer prevention and control intervention strategies in Hispanic populations.

The subjects for the studies will be Mexican Americans, Puerto Ricans, Cuban Americans, or Central and South Americans residing in the United States. The research will involve studies which address the effectiveness of existing cancer prevention and control intervention strategies, or the development of new intervention strategies. The range of research is not limited to any particular aspect of cancer prevention and control but must be multidisciplinary and may include, for example:

* Methods for circumventing barriers to health system utilization.
* Strategies to increase early detection of cancer.
* Prevention strategies including smoking cessation and dietary modification.

The intervention research will advance through two stages. A methods development or strategies modification, i.e., developmental stage, stage 1 (cancer control phase 2 research studies) followed by an intervention implementation and evaluation stage, stage 2 (cancer control phase 3 research studies). Investigators submitting evidence of intervention methods/strategies already pilot tested in Hispanic communities may opt for studies focusing solely on the intervention implementation/evaluation stage.

Intervention research in Hispanics is to be characterized by methods which will circumvent or reduce barriers to cancer prevention and control programs and services; and, as in the case of smoking prevention and cessation or dietary change, by methods which are used to modify existing behavior or prevent the development of cancer risk behaviors. Barriers include but are not limited to (1) behavioral/cultural barriers, i.e., language differences, social psychological considerations, particular cultural beliefs which may affect accessing cancer control services, lack of knowledge and understanding of cancer prevention and control opportunities; and (2) health system/structural barriers, i.e., availability of cancer control services, financial limitations, transportation barriers and limited bilingual and cultural health care providers. Smoking prevention and cessation as well as dietary change programs are also appropriate intervention areas which may be considered.

Two elements are critical for obtaining support for a study. Respondents must demonstrate the ability to access and obtain the participation of the Hispanic population in which the cancer intervention study will be conducted, and to develop and evaluate a culturally compatible intervention in the target population.

Requests for copies of the RFA should be addressed to Elva Ruiz, Special Population Studies Branch, DCPC, NCI, NIH, Executive Plaza North Rm 240, Bethesda, MD 20892, phone 301/496-8589.

RFA 89-CA-16
Title: Public health approaches to breast and cervix screening
Letter of intent receipt date: Oct. 1
Application receipt date: Dec. 11

NCI's Div. of Cancer Prevention & Control invites grant applications from a consortium of public health agencies or institutions to develop, implement, and evaluate programs designed to increase breast and cervical cancer screening of older, low income, low education level and minority women.

The primary objectives of this reserch are to demonstrate how a consortium of community agencies can:

1. Characterize utilization patterns for mammography, clinical breast examination, breast self examination and cervical cytology screening in the target population through baseline surveys. These data will establish frequency of screening, as well as

assess barriers to utilization.

2. Design and pilot test interventions to recruit women in need of breast and cervical screening regimens that can be integrated with other health services used by these women, and can affect the behavior of nonhealth agency clients.

3. Evaluate the effectiveness of specific interventions to reach the target population for breast and cervical cancer screening.

4. Assure compliance with followup recommendations for women with anything but completely normal mammograms (ie.e., indeterminate or suspicious findings) and smears (i.e., further action recommended).

5. Describe prospectively the screening behavior of the targeted women in view of current NCI recommendations (i.e., establish that women are coming back at recommended intervals for screening).

Grants may be awarded to profit and nonprofit organizations and institutions, and governments and their agencies within the U.S. However, it should be noted that this RFA is primarily targeted at demonstrating a consortium approach, involving public agencies or institutions, such as health departments, community health centers or public hospitals with established linkages to the target population (e.g., the health department may have experience with providing or contracting for the health services, an area agency on aging may have established networks with elderly women, and the American Cancer Society may have experience with providing public education campaigns). This approach seeks to address the problem in a coordinated fashion while taking advantage of the public agency's role as a noncompetitive collaborator, stimulator, convenor, and facilitator of existing resources to increase mammography and pap smear utilization in women least likely to be screened. The lead agency must demonstrate experience with disease control, but does not necessarily have to be the direct provider of the screening services. In many communities, the lead agency is likely to be the health department; however, other public agencies could fill this role. Among the team of applicants or consortium, one institution must be proposed as the lead institution to serve as the applicant and assume responsibility for the project.

Applicants will be responsible for the planning, direction, and execution of the proposed project. Allowable direct costs for the intervention will not include funds to pay for mammograms or pap smears. However, expenses incurred in developing and promoting the utilization of these services, such as baseline and followup surveys, design of materials, and public and professional education are considered allowable costs.

Approximately $1 million in total costs per year for five years will be committed to specifically fund applications submitted in response to this RFA. The total project period for applications should not exceed five years. The earliest feasible start date for the initial awards will be Aug. 1, 1990. The award of grants pursuant to this RFA also is contingent upon the availability of funds for this purpose.

Copies of the complete RFA and additional information may be obtained from Lawrence Bergner, MD, Program Director, Cancer Control Applications Branch, NCI, EPN Rm 233C, Bethesda, MD 20892, phone 301/496-8584.

RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-05619-56
Title: Resource to support the information needs of the Div. of
Deadline: Nov. 12

NCI's Div. of Cancer Etiology is recompeting a mechanism for the development of information in the areas of environmental and occupational cancer which consists of four tasks.

Task 1--Support of the chemical selection and nomination process. This consists of two class studies per year, for a total of 10, during this five year acquisition. The contractor shall review classes (structural or use) of chemical substances, as directed by the project officer, and prepare a report for review by the Chemical Selection Planning Group (CSPG) and the Chemical Selection Working Group (CSWG).

One of the reasons for conducting class studies is the selection of candidate chemicals on which summary sheets shall be prepared for consideration by the CSWG for ultimate nomination to the National Toxicology Program. Suitable class studies shall be published in the open literature. Summary sheets will be prepared in accordance with a specific format. Thirty summary sheets per year are planned, for an approximate total of 150, during this five year period. The contractor will plan, support, attend, and prepare minutes of three to four CSWG meetings and eight Chemical Selection Planning Group meetings per year; prepare and submit data packages containing the summary sheets and CSWG recommendations for those chemicals selected for nomination for carcinogenicity bioassay; support the nomination of approximately 25-30 chemicals to the DCE short term testing program; continue maintenance and updating of NCI's chemical tracking file which is a computerized file that tracks the status of all chemicals considered for nomination for carcinogenesis bioassay.

Task 2--Support of the chemical information needs of the International Agency for Research on Cancer. This entails coordinating activities with IARC staff and the NCI project officer. For the five year period of this contract, 15 IARC working group meetings are expected requiring submission of information for Section 1 (chemical and physical data) and Section 2 (production, use, occurrence, and analysis) of the IARC monographs on the evaluation of carcinogenic risks to humans on 250-300 chemicals. Material is furnished to IARC no later than 90 days prior to each working group meeting. A contractor representative (professional chemist or toxicologist to be approved by NCI) shall attend up to three IARC meetings per year. The contractor is expected to be familiar with chemical industry economics with emphasis on patterns of production, including chemical process flow distribution, intermediate use and end products, on a world wide basis (with emphasis on the Unite States, Eastern and Western Europe, and Japan), and have access to reliable national and international reference sources.

Task 3--Chemical carcinogenesis research information system (CCRIS). This consists of maintaining and enhancing the CCRIS data base which resides in and may be searched at the NIH National Library of Medicine's TOXNET system. The contractor shall survey pertinent sources and evaluate data in accordance with the evaluation criteria furnished by NCI.

After final review by a senior toxicologist and project officer, the contractor shall enter suitable studies on chemicals into the CCRIS data base. For the five year period of this acquisition, accrual of studies on approximately 250-300 discrete chemicals per year, or a total of 1250-1500 chemicals, may be anticipated with some overlap on data for carcinogenicity, mutagenicity, cocarcinogenicity, etc.

Task 4--Special studies. This entails the continued updating of the NCI bioassay report summary handbook by preparing summaries, following the established format, of NCI/NTP carcinogenesis bioassay technical reports. There will be an average of between 20-25 summaries per year. The contractor will respond to ad hoc inquiries, at the direction of the project officer, at the rate of approximately five per month.

The proposed acquisition is 100 percent set aside for small business concerns. The small business size standard is 500 employees and the standard industrial classification code is 8731.

anticipated that a cost
awarded for a period of

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