THE CANCER LETTER

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In the Cancer Centers:

Las Vegas Cancer Center Cuts Staff, Seeks Lifelines in "Perfect Storm"

By Paul Goldberg

If the Las Vegas street map is an indication, the Nevada Cancer Institute stood poised for making great contributions to cancer medicine.

The center's address is One Breakthrough Way.

It's located off Discovery Drive.

Alas, scientific breakthroughs now seem less likely to come from the idyllic campus located beneath red cliffs in an area called Summerlin.

Last month, the center ousted its director and CEO John Ruckdeschel—along with 150 of its 330 employees. The center's board is seeking partners for the start-up institution.

(Continued to page 2)

In the Cancer Centers:

Harvard's DePinho Finalist at M.D. Anderson; St. Jude's Kastan to Lead Duke Cancer Institute

RONALD DePINHO was named the sole finalist for the presidency of **MD Anderson Cancer Center**.

The University of Texas Board of Regents announced the decision May 11, during a meeting in which candidates were interviewed for the post. Each candidate recently met several constituent groups within the cancer center's community as part of a series of campus visits.

DePinho is set to succeed John Mendelsohn, who announced last

(Continued to page 11)

Revamping Cooperative Groups:

Chairs of the Ten Cancer Cooperative Groups Propose Eight "Guiding Principles" for Change

The Coalition of Cancer Cooperative Groups submitted its "principles" for the overhaul of the NCI network of clinical trials cooperative groups.

The document was prepared by the chairs of the ten groups, who comprise the coalition board, and submitted to NCI in the form of public comment related to the Funding Opportunity Announcement by which the cooperative groups apply for NCI grants.

"Optimally, the new federal grant guidelines will strengthen our scientific programs, and optimize patient and physician access to publicly funded cancer clinical trials of the utmost scientific integrity and innovation," said Robert Comis, president and chairman of the Coalition. "We believe that the principles we've outlined will provide greater clarity for stakeholders

(Continued to page 6)

Center Has $100 Million Debt, Modest Clinical Revenues

(Continued from page 1)

The problems of the five-year-old center could be traced to the decisions take on debt without the benefit of substantial clinical revenue. The decline of Las Vegas economy exacerbated the center's problems, as money needed for operations disappeared.

"I do not know why I was let go," the center's former director Ruckdeschel said in an email, responding to questions from The Cancer Letter. "I and many others supported the dream of developing a new academic cancer center in Las Vegas, and it's tragic that this now appears unlikely."

Some observers say that the problems at NVCI would be encountered by anyone trying to create a free-standing cancer center worthy of the NCI comprehensive cancer center designation.

"A university cancer center already has a lot of resources that a cancer center needs," said Joseph Simone, a consultant who has advised the Nevada center. "If you are building de novo, you have to provide everything."

To start a cancer cancer tomorrow, hypothetically, you would need a war chest of $100 million—depleted over seven years or so—to hire people, pay salaries and buy equipment, Simone estimated. "It doesn't count the buildings," said Simone.

Buildings are something NVCI has.

The center's clinical component includes 14 exam rooms in medical oncology and another six in radiation oncology, which provide 24 chairs for infusion and radiation. The clinical care component of the center is smaller than the U.S. Oncology practice in Las Vegas. Also, there is a 13,000-square-foot clinic at the University Medical Center of Southern Nevada. It includes six exam rooms and 12 infusion chairs.

There is a 143,000-square-foot main building, a 99,000-square-foot administrative services building, a 185,000-square-foot research building, and a 600-car parking deck.

This construction was financed in part with a $100 million package of debt. The debt—incurred from a variety of sources, including a bond issue—is held by a syndicate of banks.

Zoning covenants prohibit construction of a hospital on cancer center's campus, but, if the money was found, a hospital could be built nearby. The project was never undertaken.

The absence of clinical revenues and crushing debt created a dependence on charitable donations as part of an operating budget.

And then the money stopped flowing.

"The free-standing centers that have been successful—like Farber, and the Hutch, and St. Jude, and MD Anderson—all of those places had somebody at the very beginning, oftentimes a physician working with a major philanthropist," Simone said.

In Las Vegas, the philanthropy component was handled by Heather Murren, a former Merrill Lynch analyst, who is married to Jim Murren, chief executive of MGM Resorts International.

Both Murrens have been active in running the center, and Heather has at various times served as its chairman of the board and an unpaid CEO. Heather was also a member of the Financial Crisis Inquiry Commission, a ten-member bipartisan board that examined the causes of the recent financial crisis and failure of financial institutions.

She continues to serve on the NVCI board of directors as the center adjusts its grand vision of an NCI comprehensive cancer center designation to more humble economic reality.

In an interview with The Cancer Letter, Murren described the setbacks as a "perfect storm."

"A lot of the fundamentals of the cancer community have changed," Murren said to The Cancer Letter. "One is the ability to seek out and gain federal funding through grants is much diminished today versus where it was back then [in 2005]. Philanthropy, obviously, has been affected by the economy as well. And the state of

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Nevada itself, as well as the federal government, has been affected by the economy.

"We find ourselves in this perfect storm of reduction in revenue in a time where we really should, in a perfect world, be growing, as a small enterprise that's seeking critical mass in its operation.

"With that in mind, and in recognition of where we are from a business standpoint, we've decided that it was better at this point in time to reduce our operation and reduce our overhead to the point where it was at a much more sustainable level, given the new operating environment."

The center is seeking partners and is considering options that include seeking bankruptcy protection.

"You don't want to leave it off the table just because it sounds bad," she said. "You want to make sure that the reality of it—if the reality could be helpful to the organization in moving it forward—then it certainly would be something that we would look at."

Over the past five years, the center has gone through three directors, most recently Ruckdeschel, a lung cancer expert and an administrator who has the expertise in building and reviving cancer centers.

Ruckdeschel led the H. Lee Moffitt Cancer Center to obtaining its NCI comprehensive cancer center designation, and later rescued the Karmanos Cancer Institute in Detroit, when that institution was placed on probation by NCI.

Ruckdeschel had advised the Murrens from the outset, and accepted the top job at the center in 2009.

"When I arrived, the institute had a major short-term debt burden and a significant operating deficit that was being met by philanthropy," he said in an email. "I was recruited by the Murrens to expand the business, as there was no way to solely cut costs that would lead to profitability and the ability to finance the development of an NCI Center.

"Although the financial situation was difficult at best, we had made significant progress in developing a plan to right the ship."

The center's first director was Nicholas Vogelzang, former director of the University of Chicago Cancer Research Center, who held the director's job until 2009, and has since joined U.S. Oncology.

Vogelzang was replaced briefly by Sandra Murdock, an administrator who had been recruited from the Winship Cancer Institute at Emory University. Ruckdeschel came to Nevada with the understanding that he would expand patient care capacity, which would include building a hospital.

Joseph Aisner, an oncologist at the Cancer Institute of New Jersey, recently conducted a site visit at NVCI on behalf of the Eastern Cooperative Oncology Group. The group recommended that the center be allowed to accrue patients on group trials. (NVCI had been put on probation by SWOG before Ruckdeschel arrived.)

"By the time we got there, Jack had been there a year-plus, had already identified a scientific director, had recruited a couple of very interesting people from SWOG and from City of Hope, and was building in a programmatic way, from my perspective, aimed at going toward a core grant," Aisner said. "I thought if anybody could carry it off, Jack could,

"Did he have the idea and the vision? The answer is yes. His accrual, actually, showed that he had corrected whatever that problem was for SWOG. I was convinced, as were the other members of the site visit, that he would be able to pull off the requirements necessary for membership."

In an interview, Murren acknowledged that there has been a lot of turnover, but said that this is "not uncommon in a startup enterprise."

Murren said that the center's board has been trying to merge the center with local and national cancer research and cancer care organizations, including the Cleveland Clinic.

In the interim, Ruckdeschel was replaced by Phillip Manno, chief of clinical oncology and hematology services at NVCI, who has practiced in Las Vegas since 1992.

It's not clear how long the interim would be.

Founder Says NVCI Needs Partner; Bankruptcy Protection an Option

Heather Murren, one of the founders of the Nevada Cancer Institute, who now serves on its board of directors, described the past and future of the troubled institution.

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

PG: What happened?

HM: The Nevada Cancer Institute is a cancer center in formation and creation that opened its doors to patients in 2005 and built three great facilities.

One is the clinical space and the flagship that includes the clinical space, the laboratories and the support structures for patients and families, as well as the laboratory building, and the support services building.

We also hired some terrific medical professionals and research professionals over the course of 2005

through last year.

But even though we have a very excellent core effort, a lot of the fundamentals of the cancer community have changed. One is the ability to seek out and gain federal funding through grants is much diminished today versus where it was back then. Philanthropy, obviously, has been affected by the economy as well.

And the state of Nevada itself, as well as the federal government, has been affected by the economy.

We find ourselves in this perfect storm of reduction in revenue in a time where we really should, in a perfect world, be growing, as a small enterprise that's seeking critical mass in its operation.

With that in mind, and in recognition of where we are from a business standpoint, we've decided that it was better at this point in time to reduce our operations and reduce our overhead to the point where it was at a much more sustainable level, given the new operating environment.

PG: I guess you relied on donations as part of your operating budget.

HM: Every cancer center does.

But I think donations are only a part of the picture. It certainly is also the grant funding environment and the government environment.

PG: I guess the clinical revenue was something of a problem, too, because the center doesn't have a hospital.

HM: The hospital portion of it is something that we were working on creating. And we obviously focused on the outpatient piece of it as our starting point.

But yes, that part of it also needed to continue to gain critical mass.

And while it did grow, it didn't grow the last year of its operation, but it had grown every year previously, and it's something that we need focus on—making sure that can build that revenue base over time.

PG: There was talk about building a hospital, but it didn't happen.

HM: There was talk about building a hospital. There was also talk about a joint venture effort for a hospital. So yes, that was obviously something that has always been on the table.

PG: Why didn't it happen?

HM: In light of the fact that we opened our doors in 2005, there is only so much you can do at one time.

I think that part of the planning effort for the hospital was really contingent upon what kind of operating environment we had, and also what kind of situation a potential partner might be in here in the state of Nevada. Which, of course, has also changed over time.

We have new participants, and then we have some participants who have pulled back their focus here.

PG: I visited the center once. Why did you decide to build in on the far west fringe of the valley and the fringe of the market area?

HM: I would disagree strongly with your characterization of it as being the fringe. It's actually on the beltway.

We did a full study of the catchment area for the cancer center before we chose our location. It's approximately 12 minutes from the airport and it is within a half-hour drive from any part of Las Vegas.

It's actually relatively easily accessible. And the land was a donation, which also played a role.

PG: But there are also [zoning] restrictions on it; right?

HM: Parts of the land are restricted, yes.

PG: So you really can't build a hospital on it.

HM: It depends on what land you mean, because the land that we have the flagship on is restricted, but we also have 40 acres that are outside the restriction zone that is within a mile of our flagship that we can very easily build a hospital on, should we choose to go that route and find the funding.

PG: I heard that there was a possibility of a deal with the Cleveland Clinic. Is that still alive?

HM: We are looking at a lot of different strategic alternatives, and Cleveland Clinic is one of the nationally recognized players in the valley.

PG: So the Cleveland Clinic deal is still a possibility?

HM: I think that in the realm of all things are possible—sure.

PG: Given what's just happened, is it still a possibility that you would be able to build a new NCI-designated cancer center in Las Vegas?

HM: I do. I think the timetable, obviously, will change. But that, certainly, is not unique to us. It's true for corporate America. It's true for the government. It's going to be true for start-up cancer center, too.

PG: What about the size of the center's debt? Is that going to be a problem? How much was that; $100 million?

HM: From the construction of the buildings, yes.

It depends on the level of your business. It is our belief that the business can be built in a manner that will allow it to service its debt now that we have been able to reduce the cost structure substantially.

PG: Whatever happened to the University Medical Center? I think there was some discussion of building

something with them in 2009. Will there still be a presence there?

HM: We actually still maintain our presence down at UMC. But again, like the rest of the effort, it has been scaled back a little bit.

But we still are doing exactly what we had committed to at the county hospital, to be able to serve their cancer patients.

I think what happens is you get into a situation, depending on the administration you have in place, where there needs to be more of a focus on reducing costs and making sure that the business can support the kind of costs that are incurred.

And this was something that needed to be very much rethought.

PG: The economy is really bad. We all know that. And there is the perfect storm you allude to. But, do you see anything that could have been done better, anything you would have done differently with 20/20 hindsight?

HM: I think we made exactly the right decisions with the information that we had at the time.

And the difficulty that every company has faced over the course of the last five years is that the environment changed extraordinarily rapidly and many aspects of it changed at the same time.

There were a lot of different things that needed to be rethought very quickly, especially when you have an organization that's relatively young from an historical standpoint and still in its formative stages, adjusting to these things needs to be done very, very quickly, as opposed to other organizations that may have longer histories.

Obviously, you have a greater ability to absorb changes with a bigger organization that you do with a smaller one.

I think that a lot of things changed. I think that the recent moves w made are exactly the right ones. It's helpful that in a smaller footprint, with much less overhead, we will be able to accomplish many of the things we set out to do, but just do it in a much more efficient way.

PG: I did hear you say that you are not giving up on the idea of getting NCI designation, and my question would be, do you have the leadership that's suitable for that right now, meaning clinical and scientific?

HM: What we would like to find is a really strong partner to work with to be able to achieve those things. Because I think that while back in 2002, at the inception of the idea of creating a cancer center for Nevada, there were a lot of aspects of making it a homegrown effort that were very appealing.

Frankly, those were the kinds of things are what helped us to get our buildings up, to be able to recruit people.

I think in today's world, there is an argument to be made that it would be better to be a partner, an affiliate, or a part of something that has a much broader base of knowledge and a much deeper fetch.

PG: So the Cleveland Clinic deal is still alive?

HM: They are not the only ones. Frankly, Cleveland Clinic in Las Vegas is very focused on brain issues.

I think there are other national participants that are very focused on cancer specifically that might be interested in having more direct access to the Las Vegas market.

There are a lot of different ways to think about it, either as part of a broader healthcare effort or something that is very specific to cancer. And as a result of that, there are a lot of different ways that the structuring of it could look.

PG: Is U.S. Oncology a player in this?

HM: Yes. They are a player in the sense that they are a large market share participant here in the valley, and they are someone with whom we are having discussions, as we would with any participant right now, and are restructuring it with new leadership.

PG: So this can become something else, that could be a U.S. Oncology kind of clinic?

HM: Again, it would depend on what that would look like.

It would look different if you were to bring in an enterprise whose efforts were much more clinically oriented and less academic.

In that instance, we would hope to provide an academic piece to that, and the other provider would provide more of clinical aspects of it. But in an instance where we would bring a big academic medical center, what we would provide then would be clinical access to our population, and they would provide a lot of the academic infrastructure around it.

We are looking at all different possibilities to achieve the broader mission.

PG: That's fascinating.

HM: It is fascinating, actually. It brings me back to my former life on Wall Street.

PG: It really is that way; isn't it? I guess it's the volatility of the thing. You had three directors in five years.

HM: Yes, there has been a lot of turnover, which, by the way, is not uncommon in a startup enterprise.

PG: What happens next? Is bankruptcy also a

possibility?

HM: I think that if you mean, is bankruptcy a possibility as part of the restructuring, it's an option that a lot of enterprises have looked at and many have utilized successfully, because there are aspects to bankruptcy that—with a good plan in place to restructure and move forward—it is ultimately positive for the balance sheet, because what it will do is reset the debt and reset the terms of debt, but also allow you to move forward in a smaller operation. So it's a consideration in the same way that any opportunity would be.

You don't want to leave it off the table just because it sounds bad. You want to make sure that the reality of it—if the reality could be helpful to the organization in moving it forward—then it certainly would be something that we would look at.

PG: Last time we talked was a very hopeful time. This was going to fly. Is there a take-home message from any of this?

HM: Creating change and doing important things is never easy. And it's also not easy particularly in an environment, which is broadly very challenging. Having a start-up organization that's attempting to do something that has not been done in a community before brings its own set of challenges.

And if you layer onto that the overall economic environment—it's extraordinarily complicated.

In the Cancer Centers:

Group Chairs Submit Comment On NCI's Reorganization Plan

(Continued from page 1)

during these final days of the public comment period."

The group chairs previously endorsed the recommendations made by the Institute of Medicine in April 2010, that the cooperative groups be restructured to optimize scientific innovation, improve efficiency, provide adequate financial support to clinical trials, and incentivize physician and patient participation in clinical trials.

Last November, NCI said that it would support up to five cooperative groups under the new guidelines.

The text of the group chairs' comments follows:

Public Comment
Guiding Principles to Ensure Successful Reconfiguration of the Cancer Cooperative Groups
Statement of Need

On September 20, 2010, cooperative group chairs, through the Coalition of Cancer Cooperative Groups (Coalition), issued a public comment fully endorsing the Institute of Medicine (IOM) analysis "*A National Cancer Clinical Trials System for the 21st Century: Reinvigorating the NCI Cooperative Group Program*" (April 2010). The statement urged that the IOM's recommendations be adopted *in their entirety*, and it voiced our willingness as the cooperative group leadership to work with the IOM, National Cancer Institute (NCI), advocacy organizations, and other stakeholders throughout the academic, governmental, and commercial sectors to develop *reasoned implementation plans* to transform the cooperative group program as recommended.

In this second public comment, we voice our consensus opinion on upcoming changes to the federal funding mechanism by which the cooperative groups will apply for multi-year grant awards from the NCI. The as-yet-to-be-written *Funding Opportunity Announcement* (FOA) will set forth new criteria by which the groups will be reviewed, ranked, judged, and funded in the future. It is expected that many of the IOM recommendations will coalesce in this FOA; thus, it carries the heavy weight of permanence in that it will set the groups' scientific and operational parameters over the long-term. However, simultaneous to the FOA development, several groups are in the midst of voluntary consolidations (IOM Recommendation #1) whose scientific and operational details are being defined. The irreversible forward momentum of these two parallel timelines has created a need for us to comment publicly.

The NCI has circulated a tentative timeframe for the FOA development, including a period for public comment through July 2011. After the period of public comment concludes, various internal NCI committees and the National Institutes of Health (NIH) will develop the FOA, which is scheduled for release in July 2012. We believe that during the period of public comment, it is imperative to aclarify and define the components of a successful re-configuration of the cooperative groups. We have agreed upon a set of guiding principles to ensure that we ourselves advocate consistently for *reasoned implementation plans* to transform the cooperative group program as recommended. By making these principles publicly available, we trust that we are providing greater clarity for stakeholders during these final days of the public comment period.

The IOM report was the catalyst for various changes to the system that are now underway, and it has generated a new level of enthusiasm within the cooperative group leadership. Over the last several months, group leadership, working with the NCI, has made considerable progress in implementing

many of the recommendations in the IOM report, such as increasing the efficiency of group operations, implementing a cross-group information technology (IT) system, and developing plans to consolidate the activities of certain groups into new relationships and entities. There are two over-arching principles on behalf of cancer patients in all of these activities: the first is to provide the framework for the groups to design and conduct innovative, science-driven clinical trials across the clinical research spectrum for the benefit of cancer patients--from advancements in treatment standards and improvements in quality of life to cutting edge early detection, prevention, and diagnostic capabilities. The second principle was well articulated in the IOM report, that "it is imperative to preserve and strengthen unique capabilities of the cooperative group program as a vital component in the NCI's translational research continuum."

Guiding Principles to Ensure Successful Reconfiguration of the Cancer Cooperative Groups:

1. Patients are best served by having strong scientific programs

2. The cooperative groups will function as an integrated hub for large Phase II and Phase III studies

3. Flexibility is required to maximize the potential of the restructured system

4. The strong membership culture of the groups is worth preserving

5. The study review process should incentivize scientific innovation

6. The viability of the new cooperative group hub is linked to its critical resource needs

7. Multi-sector involvement generates funding and science that would not otherwise happen

8. Applicants for cooperative group funding should possess certain *Essential Characteristics*

Principle #1: Patients are best served by having strong scientific programs

The cooperative groups are, at their core, multi-disciplinary, multi-institutional, and multi-disease oriented science-driven clinical research organizations which perform clinical trials designed to move the standard of care forward. The re-configuration should enhance the ability of the groups to perform innovative, science-driven clinical trials. To do so, the new review funding criteria for the groups should give the greatest consideration to each group's scientific expertise, followed by what it brings to the network as a whole. This will help ensure that the groups remain focused on improving the outcomes for patients with cancer.

• The new review criteria should judge the groups upon their ability to design and perform science-based large Phase II and Phase III studies that complement and balance the more tailored approach of industry toward FDA primary and secondary filings for drug approval, e.g. evaluating new targeted agents across disease types not encompassed in the initial FDA filings; determining the optimum characteristics for patient selections across disease types based upon their molecular and genetic characteristics, and designing trials in selected subsets of patients based upon those characteristics; direct comparisons of competing new therapies or combinations of therapies, some of which may be held by more than one company, or may be non-pharmaceutical therapies; and quality of life research.

• In order to perform such studies, the groups must have ready access to agents in development. It is important to acknowledge that while the groups will be judged for their science, and for what they bring to the newly integrated network, it is the role of the NCI to provide ready access to agents within its portfolio.

• A major reflection of the quality of science being performed in the groups is their ability to call upon the specific strengths of their membership to produce NCI funding via R01s, P01s, SPORES, contracts, and other publicly and privately funded peer review mechanisms. The new review criteria should stimulate scientific innovation to flow more efficiently from the cancer centers to the cooperative groups by coordinating leadership and prioritizing cancer centers' biomarker-based research, genomics, novel study designs, and promising Phase II studies**.**

• The system is best served by continuing to have independent, academically-based statistical leadership integrated into each group's scientific leadership.

• Annotated biospecimens, and the biorepositories that process and hold them, are essential to science-based studies. There are three needs in this area: 1) to maintain the current practice of integrating them into group operational/scientific structures; 2) to provide the IT infrastructure to link biorepositories together *aka* a virtual biorepository; and 3) to develop a more robust system to provide to biospecimens for peer-reviewed research.

Principle #2: The cooperative groups will function as an integrated hub for large Phase II and Phase III studies

Cooperative groups are connected by their cross-group scientific and administrative interactions. While each possesses unique capabilities, the cooperative

groups are best viewed collectively, within the newly integrated network, as the hub for Phase II and Phase III studies. The NCI should clearly declare that the re-configured cooperative group system is its major vehicle for performing large Phase II and Phase III studies within its translational research continuum.

• Together, we are committed to developing, performing, and providing the logistical and infrastructure support for large Phase II and Phase III studies independent of which group originates the study. As a corollary, the new criteria should reward network participation by giving equal credit for all trials in which a group and its' members participate.

• We are committed to developing a governance structure to manage cross-group scientific and administrative functions, in conjunction with the NCI, which will include developing guidelines for interactions between the group scientific structure and the steering committees, aligning scientific priorities, creating consensus, and enforcing decisions made by the network leadership.

• Together, the groups are working with the NCI on an integrated IT infrastructure to support studies performed within the network, including the development of a "virtual biorepository" to facilitate access to biospecimens.

• The groups are working with the NCI to continually improve operational efficiencies**.**

Principle #3: Flexibility is required to maximize the potential of the restructured system

The cooperative groups are in the process of restructuring, and once consolidations are complete, the groups will look different from one another based upon their need to preserve and enhance areas of scientific and functional expertise. It is likely that some groups will remain as currently structured, some will combine into one entity, and some into a confederation alliance of several entities. The new federal guidelines for grant review should allow groups to make their own decisions about the formation of their structures—scientifically and operationally.

• Flexibility is needed to preserve and enhance areas of scientific expertise within the groups, e.g. one group may relate more successfully to patients, physicians, researchers, and other people working in a particular disease specialty, or it may be the groups need to form an imaging hub or laboratory to be available for the entire network; flexibility will be required for the groups to determine how such capabilities fit into the entire system.

• The new federal funding guidelines should not require excessive homogeneity in the cooperative groups, or in other words, the criteria should not require groups to be too similar in structure, purpose, or capabilities. Otherwise, if every one of the groups looks the same, there will only be a general competition for funding rather than the more optimal mixing and matching of different scientific and functional expertise in the various groups.

Principle #4: The strong membership culture of the groups is worth preserving

The cooperative groups are member driven networks, which engender a culture of team science, commitment and volunteerism across three core areas of membership: cancer centers and academic sites; Community Cancer Oncology Programs (CCOPs), Minority-Based CCOPs and other community based practices; and patient advocates involved in research. The new review criteria should reward their strong membership culture as follows:

Cancer Centers and Academic Programs: the NCI-designated cancer centers, their clinical investigators, and laboratory programs provide the scientific engine that drives the development and design of Phase II and III studies within the cooperative group system. The reconfigured system should amplify these interactions.

• Under the existing structure, the groups and the cancer centers have benefited mutually from their scientific interactions, e.g. during the last five years 66 RO1s, 6 P01s and 19 SPOREs relating to group work have been awarded to cancer center investigators.

• The entire NCI clinical research infrastructure including the cancer centers, R01 and related grants, SPOREs, Program Projects, and the reconfigured cooperative group system must be aligned accordingly to maximize the functional interactions among these programs. We endorse the recommendations of the Ad Hoc Guidelines Harmonization Working Group as presented to the Clinical Trials and Translational Research Advisory Committee (CTAC), and support their earliest possible implementation. ("Toward a Fully Integrated Clinical Trials System," July 2009. http://deainfo.nci.nih.gov/advisory/ctac/workgroup/GHWG%20Report_Rev.9-2009_FINAL.pdf. Progress reports to CTAC, December 2010. http://deainfo.nci.nih.gov/advisory/ctac/workgroup/GHWGimplementationReport.pdf, and http://deainfo.nci.nih.gov/advisory/ctac/1210/presentations/GHWG.pdf)

• The U10 grant mechanism currently provides an integral connection between the scientific programs of the cooperative groups, cancer centers, and academic institutions; the number of U10 grants in the program

should be increased so that additional qualifying institutions can connect to the groups.

• U10 Principal Investigators and individuals with senior leadership positions within the cooperative groups should be recognized in the senior leadership structure of the cancer centers, and the science they perform within the groups should be acknowledged and rewarded in the cancer center review process. The cancer center core grants should add metrics of success and impact for cooperative group participation via senior leadership positions and participation in active committee membership positions.

• In order to increase opportunities for young investigators to develop and lead clinical trials in the groups, we recommend that both the cancer center core grants and cooperative grant mechanism add aligned metrics of success and impact in the area of "career development."

Community-Based Researchers: CCOPs, Minority-Based CCOPs (MBCCOPs), and community practices affiliated with the cooperative groups are an integral component of the existing system and account for over half of the accrual onto group studies. Community-based researchers view the cooperative group structure as their scientific "home" where they can participate at all levels. They are best served by a cooperative group structure that is multi-disciplinary, multi-institutional and multi-disease oriented. The new review criteria should preserve and strengthen their membership ties with the groups.

• The current structure provides the opportunity for CCOPs and MBCCOPs to align primarily with one cooperative group, but also allows them to participate in the activities of groups of their choosing through the Expanded Participation Project; this practice should continue.

• To provide a stable funding base, high accruing community practices should be provided the opportunity to receive increased per-case reimbursement and infrastructure support through an expanded U10 mechanism, or other such federally funded mechanisms. This is not currently the practice.

• The groups should continue to support, through the CCOP mechanism, risk assessment, early detection, prevention, symptom intervention, health outcomes, and special populations research.

Cooperative Group Patient Advocates: Approximately 100 individuals serve voluntarily as patient advocates in research across the groups; in each, advocates are involved in all aspects of study development, execution, and trial monitoring. The reconfigured cooperative group system must maintain the integral function of patient advocates in its scientific structure.

• We recommend that the consolidation of some of the groups should not result in a substantial reduction in the number of advocates who participate in the groups.

• The high level of involvement of the advocates in all phases of trial development and execution should be maintained.

• In the newly configured system, patient advocates who participate in disease steering committees, SPORES and other parts of the integrated network, would benefit from having increased access to, and interaction with, the cooperative group advocates. Currently, functional interactions among the cooperative group advocates occur primarily through a structured program within the Coalition of Cancer Cooperative Groups.

Principle #5: The study review process should incentivize scientific innovation

In the area of scientific proposal review, we agree that extramural peer review facilitated by the NCI should be employed in assessing scientific proposals, and in helping to define the strategic landscape for a given malignancy. The steering committee approach is in varying stages of development and implementation across diseases; this approach should be evaluated primarily for its ability to encourage and incentivize scientific innovation. The entire concept of task forces should be reconsidered. We are developing a white paper discussing the Steering Committee process and its optimization. Listed here are some top line recommendations:

• Steering committees should be charged with reviewing studies, not designing or re-designing them, and the role of the NCI should be facilitative, rather than controlling, in the process.

• The entire process should be open and transparent.

• Unnecessary layers of review should be eliminated, particularly regarding establishment of multiple task forces.

• As noted in Principle 2, in conjunction with the NCI, we are committed to developing a governance structure to manage cross-group scientific and administrative functions. One imperative of the governance structure will be to develop guidelines for interactions with steering committees, particularly those needed to stimulate innovative trial approaches using disease specific markers and novel study designs.

Principle #6: The viability of the new cooperative group hub is linked to its critical resource needs

While it is widely known, accepted, and

acknowledged by the IOM report that the cooperative group system is grossly underfunded, we also recognize the enormous economic challenges that face our nation. Unfortunately, the crisis in the economy occurs at a time when we are all committed to re-thinking how we operate and work together to enhance the opportunities for patients to participate in innovative ground-breaking clinical trials. As funding priorities within the NCI, NIH, and the federal government are assessed; it is still important to define the critical needs:

• Per Case Reimbursement. Recently, the NCI adjusted the base level funding for large Phase II studies to $5,000/case. The case reimbursement structure for Phase III studies must be addressed in the new federal funding opportunity; the base level funding of $2,000/case has become so non-competitive that it endangers the entire national clinical trials system regardless of its configuration. Current per case reimbursement for Phase III studies does not come close to covering the costs of participation in cooperative group trials. This places a burden upon institutions that participate in cooperative group studies to make up the difference through cost-sharing and dedicated staff members who donate their time—an unsustainable reliance upon volunteerism considering the rising cost of medicine. The case-reimbursement floor for Phase III studies should increase to $4,000, with additional reimbursement set trial-by-trial based on complexity and priority. Whatever the reimbursement for a given trial, the funding level should be the same for high accruing sites, whether they are academically or community based.

• Number of U10 Grants. The U10 grant mechanism currently provides an integral connection between the scientific programs of the cooperative groups, cancer centers, and academic institutions; an increase in the number of U10 grants in the program will enable additional qualifying institutions and their researchers currently "outside the system" to become members of the groups.

• Investigator Compensation. The U10 grant funding should increase, above and beyond case reimbursement, to adequately support investigators for their scientific participation in the groups.

• Common IT Platform. We appreciate the NCI's recent commitment of funds to a cross-group IT platform. Funding is needed for continued development and implementation of the uniform IT infrastructure, which includes protocol authoring, clinical trials data management, and biospecimen management.

• Biorepositories. Funding is required to fully support the groups' biorepositories. Three needs described in Principle #1 are restated here: 1) to maintain the current practice of integrating the banks into group operational and scientific structures; 2) to provide the IT infrastructure to link biorepositories together *aka* a virtual biorepository; and 3) to develop a more robust system to provide to biospecimens for peer-reviewed research

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Principle #7: Multi-sector involvement generates funding and science that would not otherwise happen

The groups bring significant incremental resources to the publicly funded system. Aside from the increased levels of funding defined above, the federal guidelines must continue to provide the flexibility for the cooperative groups to seek and maintain multi-sector funding relationships. These relationships provide a critical financial supplement to the federal funding, in support of NCI-approved clinical and laboratory based studies.

• Close working relationships with industry yield additional resources, on a trial-by-trial basis, to increase inadequate case reimbursement, support laboratory based integral and integrated biomarker studies, and/or address exploratory laboratory investigations. In the latter example, supplemental funding has led to more precise definition of disease and a better understanding of basic tumor biology.

• In addition to industry, the groups successfully generate funds from the non-profit sector, in support of NCI-approved studies relating to specific diseases, supportive care, and survivorship.

• The peer review system should reward groups for generating science through their foundations and bringing it to the network.

Principle #8: Applicants for cooperative group funding should possess certain *Essential Characteristics*

The purpose of the new federal funding guidelines should be to produce excellence in science and ensure groups remain focused on improving the outcomes for patients with cancer. To do so, we recommend that applicants to the upcoming funding opportunity possess the following *Essential Characteristics*:

1. Strong scientific base with representation from cancer centers, academic institutions, and community-based programs, including the Cancer Community Oncology Program (CCOP) and Minority-Based CCOP members;

2. Established track record in designing and executing clinical trials that move the science and standard of cancer care forward and/or change clinical

practice;

3. Documented history of accruing large numbers of patients to high quality clinical research trials;

4. Strong, integrated, and established biorepositories and IT systems;

5. Proven track record in producing NCI R01, P01, and SPORE grants and contracts;

6. Capability to perform clinical trials that incorporate integral and integrated biomarkers, including imaging;

7. Operations/headquarters offices capable of conducting multi-institutional federally funded trials;

8. Academically-based statistical support and data management centers with a successful history of developing, monitoring, and analyzing multi-institutional Phase I-III clinical trials;

9. Robust and established membership structure that brings together both academic and clinically based experts into a multi-disciplinary, multi-disease, and multi-institutional structure; and

10. Track record in abiding by the timelines and guidelines of the NCI Operational Efficiency Working Group.

Signed,

• Mitchell Schnall,
American College of Radiology Imaging Network
• Philip DiSaia,
Gynecologic Oncology Group;
• Heidi Nelson, and David Ota,
American College of Surgeons Oncology Group;
• Norman Wolmark,
National Surgical Adjuvant Breast and Bowel Project;
• Monica Bertagnolli,
Cancer and Leukemia Group B
• Jan Buckner,
North Central Cancer Treatment Group
• Peter Adamson,
Children's Oncology Group
• Walter Curran, Jr.,
Radiation Therapy Oncology Group
• Robert Comis,
Eastern Cooperative Oncology Group;
• Laurence Baker,
SWOG

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In the Cancer Centers:

Lyerly to Step Aside at Duke; Evans Interim Director at St. Jude

(Continued from page 1)

December his plans to step down as president of the institution once his successor is in place. Mendelsohn, president of the institution for 15 years, will step down later this summer, but will remain on the faculty, returning to clinical and translational research as co-director of the new Institute for Personalized Cancer Therapy.

DePinho is the director of the Belfer Institute for Applied Cancer Science at the Dana-Farber Cancer Center and professor of medicine (genetics) at Harvard Medical School. He is a member of the Institute of Medicine of the National Academies and fellow of the American Academy of Arts and Sciences, previously held numerous faculty positions at the Albert Einstein College of Medicine.

His research interest is in the genetic aspects of cancer and the translation of such knowledge into clinical endpoints.

The Houston Chronicle reported that DePinho was chosen over two other finalists, Raymond DuBois, the center's provost, and Cheryl Willman, director of the University of New Mexico Cancer Center. The stories are posted at: http://www.chron.com/disp/story.mpl/metropolitan/7560881.html; http://www.chron.com/disp/story.mpl/metropolitan/7565201.html

Under Texas law, university governing boards must name finalists for a presidency at least 21 days before making a formal appointment. The board is tentatively scheduled to finalize the selection at a meeting in June.

DePinho's wife, **Lynda Chin**, will also join the faculty of MD Anderson. She is the scientific director of the Belfer Institute for Applied Cancer Science at the Dana-Farber Cancer Center and professor of dermatology at the Harvard Medical School and department of medical oncology at Dana-Farber Cancer Institute. A presidential search advisory committee formed in January reviewed more than 70 nominations for the position.

DePinho and Chin received their medical degrees from the Albert Einstein College of Medicine.

MICHAEL KASTAN, director of the Comprehensive Cancer Center at St. Jude Children's Research Hospital, was named the executive director of the **Duke Cancer Institute**.

Kastan said he will work to develop the clinical research mission within the institute, collaborating with faculty and staff to design, implement, monitor and report clinical research. Kastan said an additional goal is to

engage the expertise of university scientists outside the typical cancer disciplines.

The cancer program will reside in a new seven-story facility, currently under construction at the medical center campus and planned to open in February 2012.

Kastan published a series of papers on the p53 protein and its role in cellular repair and responses to damage.

The Duke Cancer Institute is a single entity uniting the center, the school of medicine, the health care system and physician practice plan.

H. Kim Lyerly, the director of the Duke Comprehensive Cancer Center, has been asked to step aside, sources said. He remains the PI of cancer center grant, and the plan is to make Kastan the new PI.

WILLIAM EVANS, CEO of St. Jude Children's Research Hospital, was named **interim director of the cancer center** at St. Jude.

Announcing the changes to the staff, Evans wrote:

By now I am sure you have heard that Duke University has convinced our colleague, Mike Kastan, to become the inaugural Executive Director of the Duke Cancer Institute (DCI).

In 1998, I celebrated the arrival of Mike Kastan as the new chair of Hematology-Oncology at St. Jude Children's Research Hospital, having chaired with Larry Kun the search committee that identified Mike as our top candidate and with the help of Chuck Sherr and others we recruited him from Johns Hopkins.

Now, some 13 years later, I celebrate Mike's many accomplishments while a member of our faculty, our Executive Committee and our senior management team. When I became St. Jude CEO in 2004, I asked Mike to become the Director of our Cancer Center and to become a SJCRH EVP. In his new positions,

Mike appointed several new program leaders in the Cancer Center, helped recruit Les Robison to head the Cancer Prevention and Control Program, and successfully evolved our Center into an NCI Comprehensive Cancer Center in 2008. Under his leadership, we received not 5 but 6 years of funding during our last competing renewal, based on the outstanding score that the CCSG received after the site visit.

All this time Mike continued to run a world-class research program funded by several NIH grants, including a MERIT Award, generating a series of important discoveries and prominent publications. Mike won several awards for his work while at St. Jude, including the 2007 Clowes prize from the American Association of Cancer Research and in 2009 was elected into the Institute of Medicine of the National Academies

Mike will become the inaugural Executive Director of the new Duke Cancer Institute, an amalgamation of their long-standing NCI Comprehensive Cancer Center and their cancer clinical service lines. I tried to talk Mike out of this, but in the end this became his next mountain to climb, and I celebrate his selection and wish him the very best in this new professional challenge. Mike will be returning to North Carolina where he was born, and to the RDU area where he received his undergraduate degree at UNC. One of the many challenges he will face is how to manage his loyalties to UNC and now Duke, especially come basketball season.

Please congratulate Mike on his new position at Duke and thank him for his many years of leadership at St. Jude. He will always be a part of St. Jude and will be sorely missed, but we have a strong group of senior faculty and an incredible stable of emerging talent, and together we will continue to move St. Jude forward.

Mike is not the first "star" to leave St. Jude, but in many ways this is who we are, a place where great people can do their best work, and in so doing establish themselves as world leaders.

They (you) become the targets of other great institutions as they look for their new leaders—fortunately most of our success stories decide to continue their success at SJCRH! For that I and our patients are most grateful. But an important part of what we do is prepare leaders for the world, and in doing so we extend our institutional impact and reputation.

St. Jude has become much bigger and stronger, and it is a sign of our maturity and success that we can lose a leader and continue to move forward and get better. But this is enough for a while!

With Mike's departure (effective August 1), I will become the NCI Comprehensive Cancer Center Director, at least on an interim basis. Over the coming weeks and months, I will be working with you and our Cancer Center Advisory Committee to determine our best long-term course for the Cancer Center Director position.

Prior to Mike, the St. Jude CEO always served as the Cancer Center Director, and so we are returning to a tried and true model while we explore whether the model that has worked very well under Mike's leadership is one that we wish to continue. Either way, St. Jude will continue to be the best and the only NCI Comprehensive Cancer Center devoted solely to children.

Please wish Mike a *bon voyage*, and thank him for all he has done during his time at St. Jude. And the next time any of you get a call from some place looking for a new leader, tell them there is no better place than St. Jude, then hang up!

—Bill