

**National Cancer Institute (NCI)
National Cancer Advisory Board (NCAB)
Subcommittee on Cancer Centers
Monday, June 19, 2017
5:30–7:00 p.m. EST
Pooks Hill Marriott Hotel, Bethesda, MD**

Subcommittee Members Present

Dr. Judy Garber (Chair)
Dr. Henry Ciolino (Executive Secretary)
Dr. Chanita Hughes-Halbert
Dr. Yuan Chang
Dr. Elizabeth Jaffee
Dr. Margaret Spitz
Dr. Max Wicha

Welcome and Introductions

Dr. Judy Garber (Chair) called the meeting to order at 5:40 p.m. EST. She thanked the subcommittee members for attending and noted that she had previously sent them documents for their review and discussion. She briefly described the review bodies and the review processes, noting that review bodies are largely composed of people who are themselves Cancer Center directors. The review bodies looked closely at redistributing funding to the smaller Cancer Centers took place. She commented that the subcommittee needed to identify how it could be useful to NCI's Office of Cancer Centers. Dr. Garber introduced Dr. Henry Ciolino, Director, Office of Cancer Centers, NCI, and noted that his presentation would cover activities since 2012.

Update on the NCI Cancer Centers Program – Dr. Henry Ciolino

Dr. Ciolino provided a thorough review on Cancer Center administrative activities since the last meeting of the subcommittee, held in 2012. His presentation covered Cancer Center funding, history, and funding opportunity announcements (FOAs), as well as key components of Cancer Center activities.

In reviewing the recent funding, Dr. Ciolino discussed Cancer Center Support Grant (CCSG) funding since 2010. Funding has increased since 2016, and projections indicate additional increases and the addition of new centers through 2022. In the 2012 version of the FOA, Cancer Centers could request only a 10 percent increase over than their last award. Before that, a benchmark ratio had been in place, and increases generally were based on 15 percent of existing NCI funding. This seemed to satisfy most Centers, but not permitting Centers to ask for more than 10 percent caused concern. A letter was sent to Linda Weiss, Director, OCC, followed by another letter from Cancer Center directors, that questioned this approach, stating that it would lock them into a small CCSG award. In response, then-NCI Director Dr. Harold Varmus formed a working group to discuss these Cancer Center funding issues, holding seven meetings in 2013. A resulting 2014 report determined that it was most beneficial to dismiss all history and decide Cancer Center funding on base awards given to every Center at different levels (basic, clinical, and comprehensive), with a portion then allotted to merit score, and a portion allotted to the size of the portfolio.

In 2015, infrastructure grants were reassessed, because taking money away from the CCSG also was taking away some of the leverage the Cancer Centers have at their institutions. It was decided that metrics

of merit and size of the base award would be used to determine how to split up the new funding. This was termed a rebalancing phase. Giving more money to the smaller Cancer Centers is still part of the short-term strategy. OCC was given \$40 million (M) to establish a base award, which raised the awards of 21 Cancer Centers in Fiscal Year (FY) 2016, and new funding for all centers.

The NIH is required to report to Congress on how it allocates its funding, and when it comes up for review, every Cancer Center's research is reviewed for cancer relevance, or how it meets the "Cancer Fingerprint." Cancer relevance is rated on a scale from 0 to 100. For example, if a program of the National Heart, Lung, and Blood Institute receives a 45 percent score, it can be considered fully cancer relevant. This approach provides an objective measure by which every grant can be judged, and all grants to all 69 Cancer Centers will be evaluated under these terms. This will determine budget eligibility.

Every Cancer Center has a chance to increase its award by at least 10 percent; the merit score helps determine their ultimate funding, with some being eligible for full funding, some for 50 percent funding, and others for no additional funding. A Cancer Center may be put on "diet funding," with its award cut by 50 percent for a 3-year review period designed to encourage the institution to make positive changes. No CCSGs have been terminated since the 1990s.

In discussion, Dr. Garber noted that trying to increase the budget of the smaller Centers proportionately seems like part of the goal, so that the small centers would not always be small. Dr. Max Wicha commented that this approach was the fairest he has seen. An earlier source of inequity had been dependence on that year's NCI budget, with the NCI committed to awarding a specific amount of money regardless of its budget for that fiscal year. Dr. Ciolino noted that this was the key to discussing cuts in the FY 2018 budget.

In a discussion of cancer relevance in program funding, it was noted that the concept of "cancer relevance" can be a difficult determination to make objectively. Reviewers may be pressed for time, and they may have their own strictness and criteria that they apply to their own Centers. Every Center makes its own determinations about cancer relevance.

Discussion also included coverage across the nation, noting that parts of the country are not represented well, for example, Arkansas, Louisiana, Mississippi, and Oklahoma. Georgia has only one Center and Florida has two, despite their large populations.

The FOA was revised in 2013 and 2017 and now uses a format that is NIH-compliant, similar to the P30s of other Institutes. Revisions are possible in 2018 or 2020, because FOAs are good for 3 years. The FOA has not changed the Director's Overview or the Six Essential Characteristics. Cancer focus was not addressed, and the review and update also did not touch clinical components, but it has been agreed that the protocol review and monitoring system need updating; the definition of "catchment area" has not been revised.

Dr. Wicha commented that applying catchment to basic science programs is difficult, because the belief is that "basic science helps everyone." Dr. Ciolino replied that clinical trials must address catchment, but that basic science is not required to do so. Purely basic science programs without translational aspects are not required to address catchment.

Research programs were provided a new minimum and a reworded review criteria that seeks to identify the impact of the research of the program. Publications in top-tier journals in that field were specifically noted. Other markers include the generation of paradigm-changing hypotheses, movement of scientific findings through the translational pipeline, and changes of standards of care. Dr. Ciolino also outlined the

new cancer focus question on how well peer-reviewed non-NCI projects are cancer-focused. Data table 2A in the review document was changed to require reporting on the entire grant, with specific cancer-relevant content identified to simplify the process for reviewers. Calculations on funding are completely separated from what Centers report in their grants.

Discussion of evaluation criteria also addressed how collaborative the program is across the themes and specific aims within the program, with the Center's other programs, and with other NCI-designated Cancer Centers. Clinical trial programs looking at effects in the catchment area especially are important, as is the effectiveness of the clinical trial as it relates to enhancing the science. The number of newly enrolled participants was removed from Data Table 2A, helping reviewers evaluate the impact of the clinical trial effort.

Dr. Ciolino explained that the shared resources section has been shortened and includes new review criteria, such as—

- How well does the shared resource provide access to state-of-the-art capabilities?
- How critical is the shared resource to the research of the Center?
- Are the future plans for the shared resource aligned with member needs?

Addressing comprehensiveness, Dr. Ciolino noted that the revisions to the FOA make it easier for applicants to develop a single comprehensive narrative. Cancer research career enhancement and related activities also were discussed, including career enhancement, community outreach and engagement criteria. These are elements of a new approach—NCI's emphasis as it relates to catchment area. This is expected to have some effect on the overall impact score of the Center, although not as important at the Six Essential Characteristics.

Dr. Ciolino discussed community outreach and engagement, explaining that presentations that can be shown to reduce the cancer burden and improve outcomes in the community are important. Catchment was again emphasized, notably if the Center has plans for extending its reach within and beyond the catchment area. It also is important to give the Centers credit for enhancing the standard of care by incorporating coalition partners. The support of young clinicians who are not yet at K-award level was addressed in terms of giving them protected time and using developmental funds to get them involved in clinical trials. Dr. Wicha noted that this often is done through philanthropy; some directors would rather use that means instead of funding these efforts through grants.

Following his presentation, Dr. Ciolino reiterated that materials had been emailed to the subcommittee members (marked as draft), including information on site visits. Discussion about site visits involved their merits and their considerable costs. It was noted that the site visits have a significant impact and are good for institutional commitment and enhancing institutional awareness. The documents also discuss a recommendation to further define eligibility requirements and what it means to be a comprehensive Cancer Center. A comprehensive Cancer Center has depth and breadth across the basic clinical and population sciences. 20 of the 69 Centers are not comprehensive: Some have no population sciences; some lack time; some lack population resources. Comprehensive status generates prestige and enhances marketing opportunities. Eligibility criteria may be developed for designating comprehensive status.

Dr. Garber will send Dr. Ciolino's presentation to the subcommittee, because many members were unable to attend the meeting. She noted that the smaller Cancer Centers are getting more assistance than before, but it is a huge amount of work. She asked Dr. Ciolino to consider what this committee's role or function is in this effort. Does it provide him a good mechanism for feedback? Is it even needed to support his efforts? Is there a way to emphasize the science and reduce the bureaucracy?

Closing discussion addressed that the current FOA approach does not necessarily give Centers a chance to “tell their stories.” They need to be able explain what they are doing and weave a story, not just list publications. In addition, review groups need to be educated on learning how to read the story, not just focusing on numbers.

Conclusion and Adjournment

Dr. Garber stated that the Subcommittee will “stay on the books” and be available to advise Dr. Ciolino as needed, but it is unlikely to be reconvened within the next 2 years. She thanked the subcommittee members for attending and adjourned the meeting at 6:54 p.m. EST.

/s/ Dr. Judy Garber 6/20/2017
Dr. Judy Garber Date
Acting Chair

/s/ Dr. Henry Ciolino 6/20/2017
Dr. Henry Ciolino Date
Executive Secretary