U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH
NATIONAL CANCER INSTITUTE
170th NATIONAL CANCER ADVISORY BOARD

Summary of Meeting
17 March 2026

Conference Room TE 406, East Wing, Shady Grove Campus
National Cancer Institute
National Institutes of Health
Bethesda, Maryland

NATIONAL CANCER ADVISORY BOARD
BETHESDA, MARYLAND
Summary of Meeting
17 March 2026

The National Cancer Advisory Board (NCAB) convened for its 170th regular meeting on 17 March 2026. The meeting was open to the public on Tuesday, 17 March 2026, from 9:00 a.m. to 2:37 p.m. and closed to the public from 2:45 p.m. to 3:10 p.m. The NCAB Chair, Dr. John D. Carpten, Director, Comprehensive Cancer Center, Director and Chief Science Officer, Beckman Research Institute of City of Hope, presided during both the open and closed sessions.

NCAB Members

Dr. John D. Carpten (Chair)
Ms. Margaret Anne Anderson
Dr. Nilofer S. Azad
Dr. Richard J. Boxer
Dr. Callisia N. Clarke
Ms. Ysabel Duron
Dr. Karen M. Emmons
Ms. Tamika Felder
Dr. Christopher R. Friese
Ms. Julie Papanek Grant (absent)
Dr. Amy B. Heimberger (absent)
Dr. Ana Navas-Acien
Dr. Edjah K. Nduom
Dr. Kimberly Stegmaier
Dr. Fred K. Tabung
Dr. Ashani T. Weeraratna
Dr. Karen M. Winkfield

President's Cancer Panel

Dr. Harvey Risch (Chair)
Dr. Mitchel S. Berger (absent)
Dr. Carol L. Brown

Alternate *Ex Officio* NCAB Members

Dr. John Gordon, CPSC (absent)
Dr. Michelle L. Heacock, NIEHS
Dr. Michael Kelley, VA (absent)
Dr. Matthew J. Memoli, NIH (absent)
Dr. Richard Pazdur, FDA (absent)
Dr. Craig D. Shriver, DoD
Dr. Kerry Souza, NIOSH (absent)
Dr. Boris Wawrik, DOE

Members, Scientific Program Leaders, National Cancer Institute, NIH

Dr. Geraldina Dominguez, Director, AIDS Malignancy Program, Office of HIV and AIDS Malignancy
Dr. Gary Ellison, Deputy Director, Division of Cancer Control and Population Sciences
Dr. Michael Espey, Deputy Associate Director, Cancer Imaging Program, Division of Cancer Treatment and Diagnosis
Dr. Nicole Senft Everson, Program Director, Health Communication and Informatics Research Branch, Behavioral Research Program, Division of Cancer Control and Population Sciences
Dr. Suzanne Forry, Program Director, Developmental Therapeutics Program, Division of Cancer Treatment and Diagnosis
Dr. Paige Green, Chief, Basic Biobehavioral and Psychological Sciences Branch, Behavioral Research Program, Division of Cancer Control and Population Sciences
Dr. Piotr Grodzinski, Chief, Nanodelivery Systems and Devices Branch, Cancer Imaging Program, Division of Cancer Treatment and Diagnosis
Dr. Brandy Heckman-Stoddard, Chief Program Officer, Breast and Gynecologic Cancer, Division of Cancer Prevention
Dr. Kirsten A. Herrick, Program Director, Risk Factor Assessment Branch, Epidemiology and Genomics Research Program, Division of Cancer Control and Population Sciences
Ms. M.K. Holohan, Director, Office of Government and Congressional Relations
Dr. Shannon Hughes, Deputy Director, Division of Cancer Biology
Dr. Fatou Jallow, Program Director, Center for Global Health
Dr. Warren A. Kibbe, Deputy Director for Data Science and Strategy
Dr. Sarah Kobrin, Chief, Health Systems and Interventions Research Branch, Healthcare Delivery Research Program, Division of Cancer Control and Population Sciences
Dr. Peter Kraft, Director, Trans-Divisional Research Program, Division of Cancer Epidemiology and Genetics
Dr. Andrew Kurtz, Program Director, Center for Strategic Scientific Initiatives
Dr. Tram Kim Lam, Chief, Environmental Epidemiology Branch, Epidemiology and Genomics Research Program, Division of Cancer Control and Population Sciences
Dr. Anthony Letai, Director
Ms. Amber Lowery, Deputy Director for Management and Executive Officer
Dr. Douglas R. Lowy, Principal Deputy Director
Dr. Hala R. Makhlouf, Acting Chief, Pathology Investigation & Resources Branch, Division of Cancer Treatment and Diagnosis
Dr. Lori Minasian, Deputy Director, Division of Cancer Prevention
Dr. Krzysztof Ptak, Director, Office of Cancer Centers
Dr. Anu Puri, Program Director, Cancer Training Branch, Center for Cancer Training
Mr. Weston Ricks, Director, Office of Budget and Finance
Dr. Nita Seibel, Head, Pediatric Solid Tumors, Clinical Investigations Branch, Division of Cancer Treatment and Diagnosis
Dr. George Sigounas, Chief Science Advisor
Dr. Dinah S. Singer, Acting Director, Division of Extramural Activities, and Deputy Director for Scientific Strategy and Development
Dr. Sanya A. Springfield, Acting Deputy Director, Strategic Enhancement, Director, Center to Reduce Cancer Health Disparities
Dr. Shamala Srinivas, Associate Director, Scientific Review and Policy, Division of Extramural Activities
Dr. Peter Ujhazy, Deputy Associate Director, Translational Research Program, Division of Cancer Treatment and Diagnosis
Dr. Asad Umar, Chief Program Officer, Gastrointestinal and Other Cancers, Division of Cancer Prevention

Dr. Tiffany Wallace, Program Director, Center to Reduce Cancer Health Disparities
Dr. Joanna Watson, Chief, Tumor Metastasis Branch, Division of Cancer Biology
Ms. Amy Williams, Director, Office of Advocacy Relations
Ms. Crystal Wolfrey, Director, Office of Grants Administration and Chief Grants Management Officer

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TUESDAY, 17 MARCH 2026

I. CALL TO ORDER AND OPENING REMARKS—DR. JOHN D. CARPTEN

Dr. John D. Carpten called to order the 170th meeting of the National Cancer Advisory Board (NCAB). He welcomed members of the Board, *ex officio* members, President's Cancer Panel members, liaison representatives, staff, and guests. Members of the public were welcomed and invited to submit any comments regarding items discussed during the meeting to Dr. Shamala Srinivas, Associate Director, Scientific Review and Policy, Division of Extramural Activities (DEA), National Cancer Institute (NCI), in writing and within 10 days. Dr. Carpten reviewed the confidentiality and conflict-of-interest practices required of Board members in their deliberations.

Motion. A motion to accept the minutes of the 2 December 2025 Meeting of the NCAB was approved unanimously.

II. FUTURE BOARD MEETING DATES—DR. JOHN D. CARPTEN

Dr. Carpten called Board members' attention to the future meeting dates listed on the agenda.

III. NCI DIRECTOR'S REPORT—DR. ANTHONY LETAI

Dr. Anthony Letai, Director, NCI, welcomed NCAB members and attendees to the 170th meeting. He reported on NCI's stability and competitiveness, cancer research updates, the NIH unified funding strategy, and research project grant (RPG) funding trends.

NCI Stability and Competitiveness. Dr. Letai underscored his commitment to ensuring that NCI's programs remain stable and that its research keeps pace with that of international competitors. He stated that NCI's mission, resources, and processes have remained stable. NCI's mission is to reduce the suffering from cancer across the United States. He reminded the attendees that NCI's budget was increased in congressional appropriations, which will enhance the institute's ability to achieve its mission. NCI is doing its best to fund as many grants as possible while adhering to regulations established by Congress and the Office of Management and Budget (OMB). NCI will continue to fund new RPGs, as well as additional new early-stage investigator awards.

Dr. Letai highlighted the importance of ensuring NCI's international competitiveness in science, underscoring the value of strong leadership in this space. Global biomedical innovation is accelerating, and the United States must remain a leader in cancer research. He noted that many early-phase clinical trials in oncology have been performed in other countries, including China, Australia, and New Zealand. He spoke on the need to optimize the costs and efficiencies associated with conducting such trials. Dr. Letai noted that other U.S. Department of Health and Human Services (HHS) agencies have focused on efforts in this space; coordination across multiple groups (including biotechnology and pharmaceutical companies, the U.S. Food and Drug Administration [FDA], NCI-Designated Cancer Centers [Cancer Centers], practitioners, and patient advocates) will be needed to address this problem.

Cancer Research Updates. Dr. Letai identified immuno-oncology as a top priority for NCI, noting that cancer vaccines offer significant potential. He referenced research on cancer vaccines for preventing cancer relapse and increasing long-term survival. Large-scale clinical trials will be needed to advance progress in this space. NCI has partnered with the Foundation for the National Institutes of Health (FNIH) to convene a panel of experts from across the United States to develop a roadmap for a clinical trials program to be implemented over the next 3 years. The panel will provide guidance on implementing existing technologies for vaccine development. HHS Secretary Robert F. Kennedy, Jr. has

expressed strong support for this effort. Dr. Letai noted that NCI will provide financial and other support for this effort, and he underscored the value of public–private partnerships for progress in this space.

Dr. Letai also highlighted functional precision medicine, which he noted is of high interest to NCI. He noted that efforts in this area offer the potential for significant impact using a relatively small portion of NCI's overall budget. Functional precision medicine is aligned with NIH priorities, as it involves the use of human-based models to address research questions and inform decision-making. NCI is organizing a workshop and expert panel to develop intramural and extramural programs for supporting functional precision medicine research. Dr. Letai emphasized that the goal of this effort is aligned with that of genomic precision medicine: to deliver the right drugs to the right patients. This approach can be applied for basic discovery, companion biomarkers, and personalized diagnostics. Dr. Letai remarked that significant advancements have been made in this space, and he expressed NCI's support for further development.

Dr. Letai discussed NIH's initiative to reduce the use of animal models in research, with an increased focus on human-based models. He emphasized that this approach offers significant scientific benefits because human-based models are a relatively underexplored area in cancer research. He also noted that recent technological advancements offer new opportunities in this space. Animal models will not be prohibited, but their use should be considered thoughtfully. Researchers are now required to explicitly justify their use of animal models in grant applications. NCI has been involved in the development of NIH's Standardized Organoid Modeling (SOM) Center, which was established to improve the reproducibility and standardization of organoid models, with a goal of ensuring their reproducibility in research. Dr. Letai noted that SOM's mission is applicable to NCI's toxicity studies in that organoid models can be used to predict toxicities of novel agents.

NIH Unified Funding Strategy and RPG Funding Trends. NIH recently announced a unified funding strategy to help guide clearer and consistent funding decisions across all Institutes, Centers, and Offices (ICOs). Going forward, ICOs will not rely on funding paylines in developing pay plans. Dr. Letai emphasized that scientific peer review by the Center for Scientific Review (CSR) is the most important parameter for funding decisions. All ICO funding policies should align with the NIH mission, prioritize scientific merit, integrate a breadth of topics and approaches relevant to the ICOs' priorities, consider investigator career stage and foster sustainability of the biomedical research workforce, promote broad distribution and geographic balance of funding, and align with the availability of ICO funds.

Dr. Letai addressed concerns regarding the rate of grant payouts. He explained that NIH RePORTER is not updated in real time, and information regarding NCI's payouts may be outdated. Dr. Letai also noted that payouts can be affected by several factors, including finalization of institutional review board (IRB) protocols, NIH-level approvals, and negotiations for contracting with the individual institutions. Generally, these processes require 90 days to complete. These routine delays have been exacerbated by other factors, including the recent government shutdown that resulted in canceled study sections and delayed grant approvals. He emphasized that NCI is working to expedite the grant approval process and that this issue is not expected to persist long term.

Dr. Letai also affirmed that NCI's funding decisions are made by scientists and are not informed by political influences. He noted that as a political appointee, he is responsible for the ultimate decisions on NCI's funding. He also acknowledged recent concerns regarding multiyear funding. He noted that although these funds remain uncertain for future fiscal years, NCI intends to operate close to its funding ceiling for fiscal year (FY) 2026. He stated that he is optimistic that NCI will be able to adjust its approach as needed. Often, multiyear funding is challenging to implement during periods of transition. NCI paid out more funds for RPGs in FY 2025 than in previous years, although the number of new grants was decreased because of payouts for multiyear awards.

Questions and Answers

Dr. Callisia N. Clarke, Chief, Division of Surgical Oncology, Associate Professor of Surgery, Department of Surgery, Medical College of Wisconsin, remarked that the prioritization of grant funding after the scientific merit scoring continues to be a challenge for researchers. She requested additional information on how the prioritization score is calculated, as well as feedback for researchers on funding decisions. Dr. Letai explained that CSR provides the scores and a summary statement. This information is shared with NCI's programs and divisions. NCI's program leaders evaluate the grants and rank them based on priority. He emphasized that CSR's score is the most important element for consideration. He encouraged applicants to contact their program officials with questions regarding funding decisions.

Dr. Christopher R. Friese, Vice Provost, Academic and Faculty Affairs, Elizabeth Tone Hosmer Professor of Nursing, Professor of Health Management and Policy, Associate Director, Cancer Control and Population Sciences, Rogel Cancer Center, University of Michigan, requested an update on NCI's personnel changes, particularly regarding its communications team. Dr. Letai acknowledged that NCI lost a significant number of staff in 2025, and the institute recently received approval to initiate hiring efforts to refill some of the vacant positions. He noted that NCI will strive to hire critical personnel where they are most needed. He acknowledged that NCI's communications department was reduced significantly and that many remaining staff were centralized to NIH. NCI has since regained some of its communications staff, and progress in this area is ongoing. He added that NCI's communications programs will be launched at a future date.

Dr. Friese asked how NCI will communicate its top priorities to the scientific community moving forward. Dr. Letai acknowledged that NCI is subject to restrictions regarding the number of notices of funding opportunities (NOFOs) that can be released. He noted that going forward, NCI will focus on NOFOs for large group programs that do not have access to alternative funding sources. Additionally, in the future, highlighted topics will be shared through other platforms besides NOFOs.

Dr. Edjah K. Nduom, Daniel Louis Barro Endowed Chair, Professor, Department of Neurosurgery, Emory University School of Medicine, Brain Tumor Disease Leader, Winship Cancer Institute, noted that lack of funding has created significant challenges across research institutions, often leading to laboratory closures and loss of personnel. He expressed that NCAB members face challenges in communicating with their colleagues on this topic. Dr. Letai stated that NCI is committed to providing funding for the research community going forward, particularly for early-stage investigators. He acknowledged that funding for grants remains highly competitive due to existing budget limitations, so many applications will not be funded; this issue does not relate to any recent challenges in the federal environment.

Dr. Nduom noted that NCI previously supported diversity supplement awards for trainees. He asked about other awards to support trainees in the future. Dr. Letai acknowledged that diversity supplements likely will not be supported going forward, but NCI provides numerous training opportunities that will be continued in the future. He offered to have an NCI staff member follow up with additional information on the institute's training supplements.

Dr. Fred K. Tabung, Associate Professor, Division of Medical Oncology, Department of Internal Medicine, The Ohio State University Comprehensive Cancer Center, James College of Medicine, The Ohio State University Wexner Medical Center, requested additional information on NCI's use of administrative supplements within the new context of grant funding. Dr. Letai offered to provide additional details on this topic via email. Dr. Tabung also inquired about guidance from Congress on multiyear funding. Dr. Letai explained that Congress has directed NIH to limit its multiyear funding to the proportion of multiyear funding that was used in FY 2025. NCI has a ceiling of approximately $480 million (M).

Ms. Margaret Anne Anderson, Managing Director, Deloitte Consulting LLP, requested additional information on HHS' broader efforts to ensure NCI's international competitiveness. She noted that nonprofit disease foundations are highly engaged in discussions on this topic. Dr. Letai acknowledged the need for improvement in this space and noted that some centralized issues are impossible to address fully. He added, however, that Australia has enhanced its efficiency for conducting trials by setting up a system that does not require involvement of the Therapeutic Goods Administration (Australia's equivalent to the FDA). This approach could be used as a model for early-phase trials in the United States. He also highlighted the value of centralized contracting language and centralized IRB protocols (e.g., across Cancer Centers).

Ms. Ysabel Duron, Founder and Executive Director, The Latino Cancer Institute, asked about approaches to increase transparency in grant awards to assure communities of color that their concerns are still being funded at fair and equitable proportions. She voiced concerns from the advocacy community about flagged language in funding applications. Dr. Letai acknowledged Ms. Duron's concerns. He noted that all funded grants are published and that information is publicly available.

IV. NCI BUDGET UPDATE—MR. WESTON RICKS

Mr. Weston Ricks, Director, Office of Budget and Finance, NCI, reviewed the budget landscape for NCI activities over time. He expressed appreciation to his colleagues for their help with this presentation.

Appropriations. Mr. Ricks outlined the process of government funding. Congress approves government funding, and if a spending bill is not passed by October 1, the government shuts down. Continuing resolutions (CRs) are used as a stopgap as needed to provide temporary government funding. Mr. Ricks presented data on the total duration of CRs from FY 2002 to FY 2026. The President's Budget to Congress is required by law and serves as the beginning of the congressional budget process for the upcoming fiscal year. A late submission of the statement can delay other aspects of the budget process. Mr. Ricks showed data on the President's Budget versus the enacted NCI budget from FY 2000 to FY 2026 to outline the differences observed over time. He noted that the two budgets were aligned across several years. Mr. Ricks highlighted the number of days without an enacted budget compared with the number of days the President's Budget was provided before the start of the upcoming fiscal year. In discussing delays of previous fiscal year budgets, he highlighted that the budget was passed by Congress on time in 2019.

NIH Grant Portfolio Analysis. Mr. Ricks emphasized that the key performance indicators and metrics used by NIH need to change. Outyear grants (OGs) are multiyear funding for RPGs, which are paid up front, in full. He referenced R15 grants as an example. Obligation reports do not capture these RPGs. Although these OGs are active in the current fiscal year, they would not be captured in the report because they are not newly awarded RPGs. Since FY 2023, OGs have become an increasingly significant portion of NIH's portfolio of supported grants. More than 400 OGs are continuing into FY 2026. Mr. Ricks displayed a line graph comparing OGs with the number of noncompeting and competing RPGs. He highlighted that this is not an accurate measurement of NCI support. As NCI goes through a transition period, more multiyear funding is spent on RPGs. He highlighted that using this outyear grant funding mechanism allows NCI to support additional years of research with a single payment, but this support needs to be reflected in reports because it currently appears that NCI is granting fewer awards, which is not accurate. NCI provided more than $200 M in funding to the research community in the previous fiscal year. He projected competing grant awards to increase for FY 2026 over the next several months. A number of factors have resulted in a delay in awarding competing grants, but more than 1,000 grants have been awarded in the current fiscal year. Mr. Ricks emphasized that NCI is committed to funding science and addressing the needs of the research community.

Mr. Ricks noted that he has received several questions regarding the OMB apportionment. He provided an overview of the process. After a congressional appropriation is received, NIH completes paperwork and submits it to OMB for review. When the paperwork is approved, OMB establishes an apportionment, which allows NIH to receive funds. NCI is allotted a portion of those funds. Mr. Ricks emphasized that this is a significant workflow to complete. The full year of funds should be available without the same constraints as the previous fiscal year.

Questions and Answers

Dr. Clarke queried whether all grants will be funded using the multiyear method and whether this transition phase would suppress innovation with fewer grants funded. Dr. Letai responded that NCI complies with Congress and OMB's requirements for the proportion of grants funded using the multiyear funding mechanism. If the amount of multiyear funding remains stable, there is no impact on what can be funded. Mr. Ricks continued that the ability to provide multiyear funding is advantageous when managing NCI's budget over several years. Determining the required amount of multiyear funding involves an ongoing, dynamic conversation. Dr. Clarke clarified that it was the term "transition" that caused concern.

Dr. Ana Navas-Acien, Professor of Environmental Health Sciences, Department of Environmental Health Sciences, Mailman School of Public Health, Columbia University, commented that multiyear funding is beneficial for investigators. She questioned whether multiyear funding was less of an administrative burden for NCI. Mr. Ricks stated that there is less of an administrative burden and that challenges differ depending on the funding type. He continued that multiyear funding is advantageous when budgeting for future needs. Dr. Navas-Acien commented that the transition period is challenging, especially for early-career scientists. She expressed concern that the multiyear funding could be allocated to only well-established investigators.

Dr. Carpten asked which grant types will most likely receive multiyear funding. Mr. Ricks responded that R15s will receive multiyear funding. Internal discussions at NCI are ongoing about which other grant types will receive multiyear funding. NCI staff would like to support 2-year grants, R03s and R21s, with multiyear funding to reduce administrative burden. PL1s will likely not receive multiyear funding because they cost more than R01s.

V. PRESIDENT'S CANCER PANEL REPORT—DR. CAROL BROWN

Dr. Carol L. Brown, Senior Vice President and Chief Health Equity Officer, Nicholls-Biondi Chair for Health Equity, Memorial Sloan Kettering Cancer Center, provided an update on the panel's recent report "Ensuring a Strong Future for America's Cancer Workforce." The three-member panel was established by the National Cancer Act of 1971, and it oversees the development and implementation of National Cancer Program activities. The panel reports directly to the President, and its decisions and recommendations are independent of government agencies. Patients affected by cancer are the foundation of the National Cancer Program, and they are represented by the three pillars of the program: government, health care providers, and private organizations. Opportunities to enhance the cancer care workforce are fundamental to eliminating cancer in the United States. Increased demands for cancer care, reduced cancer care team staffing, an altered landscape for cancer research, and the added burden of administrative tasks and systems are key challenges that undermine the U.S. cancer workforce's ability to provide patient care and further progress in cancer care and research.

In September 2024, National Cancer Program stakeholders met to discuss key challenges within the cancer workforce and potential strategies for addressing these challenges. The meeting outlined skills and resources needed to deliver high-quality care, improve access to clinical trials, and conduct cutting-edge research. Dr. Brown highlighted that the key takeaways from the meeting informed the President's Cancer Panel's report. The report emphasizes three critical priorities: create partnerships, expand education

and training pathways, and support care team productivity. To successfully implement these priorities, several recommendations were outlined. First, cross-institutional, regional, and cross-sector partnerships must be facilitated. Dr. Brown emphasized that approximately two-thirds of rural counties do not have access to oncologists. Partnerships with pharmaceutical and biotechnology companies will foster and support the cancer workforce. Additionally, programs and pathways should be developed or expanded to increase the number of qualified and skilled caretakers, including oncologists and allied health care workers. Dr. Brown noted that NCI is committed to training early-career scientists. However, limited federal funding requires collaboration outside of NIH to improve the cancer care workforce. Finally, electronic health records need to be improved, and prior authorization processes should be reformed to minimize administrative burden. This would support cancer care team productivity.

Actionable steps in these key priorities will allow the United States to maintain progress in advancing groundbreaking cancer research and remaining a leader in innovative cancer care and treatments. Dr. Brown highlighted that competition outside the United States has increased and that our cancer care workforce is moving abroad, which will impact the country's ability to eliminate cancer. She concluded that health care and research organizations, government agencies, and private sector companies must collaborate and commit to building a strong and effective cancer workforce.

Questions and Answers

Dr. Clarke emphasized concern over the number of physicians leaving the United States. Physicians are not covered in these priorities, so this should be addressed. Messaging and partnerships are vital. Dr. Clarke worried that physicians do not view the current landscape as temporary, leading to the loss of physicians to positions abroad. Dr. Brown agreed that cancer care delivery cannot be solved without allied health providers. There is a unique opportunity to address health care and research physician workforce concerns.

Dr. Friese underscored the importance of partnership and crowdsourcing. He explained that strategic collaboration with industry is vital. Dr. Brown noted she would reach out to Dr. Friese to coordinate further.

Ms. Duron recommended that the plans and recommendations include partnerships with community health care workers. There are not enough professional workers, and the concept of who is funded should be expanded. Dr. Brown noted that the topic of community members was discussed at the September 2024 meeting. The President's Cancer Panel's report references payment of community members by grants and partnerships at the local and regional levels. Ms. Duron responded that it is difficult to pay volunteers with the current systems and that research should be brought into the community. Funding mechanisms should be developed that financially support these individuals, which would promote earlier screening and diagnosis.

Dr. Karen M. Winkfield, Executive Director, Meharry-Vanderbilt Alliance, Ingram Professor of Cancer Research, Professor of Radiation Oncology, Vanderbilt University School of Medicine, stated that it is difficult to directly compare the United States with other countries that have universal health care. She queried whether the President's Cancer Panel discussed complications and restrictions of the U.S. health care system design that affects the cancer workforce were discussed. Dr. Brown agreed that the structure of the health care system is a major issue and is a focus of priority three of the report. Actionable recommendations should be identified, and discussions about for-profit endeavors in the health care system should occur.

Dr. Nilofer S. Azad, Professor of Oncology, Co-Director of the Developmental Therapeutics Program, Co-Leader of Cancer Genetics and Epigenetics, Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins University, highlighted that the competitiveness associated with early-phase clinical trials

and noted that speed is lacking in early-phase clinical trials within the United States. She commented that incentives should be created to increase centralized language and community collaboration. Dr. Letai agreed and noted that NCI is working on this recommendation.

Dr. Tabung queried whether the President's Cancer Panel has input or feedback regarding the President's Budget. Dr. Brown responded that the Panel's role is to advise the President and that the report does not affect the NCI budget provided by Congress.

Dr. Kimberly Stegmaier, Chair, Department of Oncology, Dana-Farber Cancer Institute, Associate Chief, Division of Hematology/Oncology, Boston Children's Hospital, David G. Nathan Professor of Pediatrics, Harvard Medical School, Institute Member, Broad Institute of Harvard and MIT, noted that the pediatrics workforce is struggling to fill positions beginning at the residency stage. She queried whether there was representation from biotechnology companies at the September 2024 meeting. Dr. Brown responded that private sector companies should be involved in cancer workforce funding efforts and that an additional meeting should be held with key stakeholders.

VI. NCI CANCER CENTERS PROGRAM UPDATES—DR. KRZYSZTOF PTAK

Dr. Krzysztof Ptak, Director, Office of Cancer Centers, NCI, provided an update on the NCI-Designated Cancer Centers Program. He noted that he worked closely with program leadership to identify challenges and opportunities in this space. The Cancer Centers Program was established through the 1971 National Cancer Act and was expanded in 1974. The program follows four principles: scientific merit, disparities reduction, geographic equity, and institutional capacity.

Currently, NCI supports 73 Cancer Centers in 36 states, in addition to the District of Columbia. Approximately 80 percent of all NCI extramural funding is awarded to Cancer Centers, which makes the program a foundational mechanism through which NCI carries out its national mission. An estimated 19,000 members are organized into 365 research programs that are supported by 682 shared resources. In 2024, the Cancer Centers supported an estimated 444,300 newly diagnosed cancer patients and 216,000 patients on interventional trials, including 46,000 on treatment trials. These efforts have yielded an approximately 38-fold return on investment.

The Cancer Center Support Grants (CCSGs) NOFO was published on 25 November 2025. Peer review was transitioned to the CSR, and NCI's established processes have been changed as a result, including the removal of site visits. Dr. Ptak detailed his efforts to streamline and simplify the CCSG process. He is focused on four areas: engaging communities, enabling nationwide efforts to achieve unifying cancer goals, empowering and recognizing work that crosses cancer boundaries, and renewing the CCSG program. He underscored the importance of modernizing the program and reducing administrative burden for the Cancer Centers. He also has met with Cancer Center Directors to discuss approaches for streamlining CCSG preparation, maximizing leadership and reviewer engagement without site visits, and identifying key CCSG data.

These discussions yielded several key themes. First, the Cancer Centers are unique and contribute to the national cancer mission. Optimized impact, rather than optimized processes, should be rewarded. Cross-Center collaboration also should be rewarded. Missions should be broadened to cancer-adjacent topics (e.g., autoimmune diseases, aging) to enhance impact, although cancer should still remain the central focus of such efforts. Additionally, efforts should be made to ensure that prevention and early detection receive recognition comparable to treatment trials. Areas for de-emphasis include over-reliance on processes, growth metrics (e.g., space, membership), and over-weighting of community outreach and engagement (COE) in impact scoring. An opportunity for streamlining would be to combine various application components. Certain attachments can be reduced, information can be converted to value-added tables, and information should be collected systematically for easier writing and review.

Dr. Ptak presented a proposed redesign of the research programs. He emphasized that research programs are the central components of each Cancer Center; they drive discovery and translation. Additionally, writeups have become too long and narrative heavy. Redundancy appears across sections, and reviewers struggle without a defined structure. Attachments do not add sufficient value, and data are inconsistent. The new structure would include a program overview and snapshot table, integrated scientific and cancer impact, a value-added table, catchment area research alignment, a translational pathway and trial impact summary, and leadership and future strategy.

A request for information was released to collect input on catchment area, strategies and scope, Cancer Center integration, administration, evaluation and metrics, and guidance and review. NCI received a total of 48 submissions. Dr. Ptak shared that the feedback was notably uniform. Recommendations included performing routine mixed-methods assessments, with reporting inside and outside the Cancer Center; considering catchment area expansion; spanning community, clinical, policy, and research domains; prioritizing trusted partnerships and community-driven research; integrating COE into the Cancer Center's strategic plan, mission, leadership, research, and operations; and assessing processes and outcomes with rigor and flexibility. Going forward, NCI will focus on impact, innovation, and each Cancer Center's unique contribution to the program. The program will continue refining its efforts to improve streamlining, fairness, and impact. The final NOFO concept will be presented at the Cancer Center Directors Meeting in May 2026, and the new NOFO will be reissued with a target receipt date of 25 January 2027. Dr. Ptak concluded by briefly highlighting the value added by CCSG site visits; he noted that in 2016, the NCAB affirmed site visits as essential to ensuring the program's quality and recommended that they be made mandatory. He explained that an NCAB *ad hoc* Working Group has been proposed to address this gap.

Through a structured in-person meeting, the Working Group will assess institutional commitment, infrastructure and facilities, leadership and governance, the Cancer Center's cohesiveness as an integrated entity, consortium arrangements, clinical trial oversight, comprehensiveness, and responsiveness to national priorities. The program assessment follows CSR peer review and precedes NCAB's second-level review; it does not duplicate or modify CSR impact scores or component-level merit evaluations. Membership will include Cancer Center Directors and Associate Directors of Administration. The Working Group advises the NCAB and NCI Director on the Cancer Center's overall value, including the granting or renewal designation, comprehensiveness requests, consortium arrangements, and CCSG award amount and duration.

Questions and Answers

Dr. Winkfield underscored the importance of COE for driving program impact. She also recommended ensuring that community members are represented within the Working Group. Dr. Ptak explained that NCI does not plan to de-emphasize COE. The request for information was released to gather information as broadly as possible. Dr. Ptak agreed on the importance of broad perspectives and clarified that currently, membership is limited to the Directors to ensure that representation is consistent across different areas of research. Dr. Winkfield reiterated that the Working Group still needs COE representation. Cancer Center Directors do not have in-depth knowledge of COE, unlike staff within these offices at the Centers.

Ms. Duron underscored the importance of COE representation in the Working Group. She emphasized that science is important, but that people are ultimately affected by the science, and their voices must be included to inform program direction.

Dr. Clarke suggested that the Working Group include Directors from non-NCI-Designated Cancer Centers. This inclusion would help ensure that a broader scope of voices is included in the discussions. Dr. Ptak agreed with this suggestion, pending additional leadership approval.

Dr. Karen M. Emmons, Professor, Department of Social and Behavioral Science, Harvard T.H. Chan School of Public Health, underscored the importance of a specific focus on COE in reviews. Dr. Ptak commented that many Cancer Center Directors have placed strong emphasis on this topic. It was noted, however, that this emphasis will depend on the specific membership of the Working Group. Dr. Ptak explained that guidelines are being developed on specific areas of focus for the Working Group, and modifications can be made as needed.

Based on discussions from several NCAB members, Dr. Carpten noted that modifications to the Working Group's constitution are being requested to include COE and non-NCI-Designated Cancer Center representation.

In response to a question about disagreements in evaluation and scoring, Drs. Carpten and Ptak clarified that the Working Group will not make changes to the summary statement. The Working Group members will review applications with a focus on specific elements that are needed for a Cancer Center to be successful. The report from this review will be shared with the NCAB and can help inform funding decisions.

Dr. Winkfield asked for clarification on how impact will be defined. Dr. Ptak explained that the Directors will have information from the CSR review; this can be discussed within the Working Group. He emphasized that major issues and areas for clarification will be considered in discussions.

Motion. A motion to concur regarding establishing an NCAB *ad hoc* Working Group for Programmatic Evaluation of Cancer Centers was approved with 14 ayes, 0 nays, and 1 abstention.

VII. CANCER VACCINES PRESENTATION—DR. CATHERINE J. WU

Dr. Catherine J. Wu, Professor of Medicine and Chief, Division of Stem Cell Transplantation and Cellular Therapies, Lavine Family Chair for Preventative Cancer Therapies, Dana-Farber Cancer Institute, presented on the roadmap for cancer vaccines. Dr. Wu emphasized that not all vaccines are the same; cancer requires therapeutic vaccines to increase the breadth and diversity of the tumor-specific immune response. The effectiveness of cancer therapies is challenged by tumor heterogeneity and evolution. By the time patients are diagnosed with cancer, many tumors are already in the escape phase, which is a therapeutic challenge. Advances in immunotherapy, including immune checkpoint inhibitors and bispecific T-cell engagers, have been vital to decrease cancer death rates in the past 2 decades. Dr. Wu highlighted that although death rates have declined, 70 percent of patients still need to receive effective treatment options. Vaccines are important immune modulators that can amplify the preexisting T-cell responses and expand anti-tumor T-cell responses, which promotes immune surveillance and memory. Several pitfalls with single-antigen targeting have been observed, including poor *in vivo* T-cell functionality and a weak signal in Phase III clinical trials.

Improved epitope prediction, immune checkpoint blockade, and next-generation sequencing have resulted in neoantigens (NeoAgs) as immune targets for cancer. Tumor NeoAgs are unique to cancer cells, which makes them an ideal target. Dr. Wu provided an overview of encouraging results and growing momentum in cancer vaccines since 2017. Publications have shown safety and feasibility, immunogenicity, evidence of on-tumor targeting, decreased recurrences after adjuvant vaccines, and benefits in a randomized clinical trial for several cancers (e.g., melanoma). Personalized NeoAg mRNA vaccines demonstrated a benefit in recurrence-free survival when used with pembro compared with pembro treatment alone in high-risk melanoma patients. Dr. Wu stated that cancer vaccines can fit anywhere within the cancer treatment continuum. The immune system is impaired during advanced and metastatic disease stages, so different treatments need to be combined. Current algorithms, vaccine delivery systems, and biomarkers have limitations and need more data. Sequencing more patient tumor samples will provide the data needed for NeoAg-targeting cancer vaccines.

The Cancer Vaccine Roadmap Advisory Committee is charged with mapping out an approach to rapidly test hypotheses for developing cancer vaccines. The committee will (1) identify technologies and approaches that address the top cancer vaccine research questions, (2) test these approaches in proof-of-concept clinical studies, and (3) determine how to broadly implement these approaches across all cancer populations. The investment in this initiative will allow NCI to understand whether cancer vaccines can play a pivotal role in improving survival in patients with solid tumor cancers. Dr. Wu briefly discussed the committee roster, which included members from universities, societies, foundations, and industries. The committee held a kickoff call on 23 December 2025 before three subcommittees were established to formulate ideas. The full committee reconvened on 28 January 2026, and committee member input was synthesized into the draft roadmap. The roadmap was finalized by 21 February 2026, and it was presented to NCI leadership on 23 February 2026.

Dr. Wu defined the key questions that need to be addressed for the development of successful cancer vaccines, such as identifying the optimal delivery approaches and most potent targets for each cancer subtype and stage. The committee's strategy will prioritize feasible projects; sustainable innovation; expansion of vaccine breadth, scalability, and access; and partnerships between academia and industry. Three tracks, with two stages for each track, will be pursued: vaccine delivery platform innovation; antigen discovery, characterization, and functional prioritization; and clinical trial design and deployment. Infrastructure must be enabled, including centralized biobanking, centralized manufacturing and production, and an operational hub to foster rigorous science while deploying the cancer vaccine efforts as quickly and efficiently as possible. Dr. Wu highlighted that a centralized design with regional centers of excellence fosters a network for clinical testing and will allow scalability to maximize reach and national availability. The FNIH will provide funding support, and she explained that partnerships are critical. The budget for this initiative was outlined for the different tasks within the tracks.

Questions and Answers

Dr. Azad commented that impactful clinical trials are needed and that they should be completed outside of the standard NCI infrastructure. Discussions should be held early in the process to ensure that innovative pilot clinical trial methodologies are used. Dr. Wu agreed with this comment.

Dr. Brown noted that surgery is still the primary method used for solid tumors. She queried how this initiative could collaborate with surgeons to maximize impact for patients. Dr. Wu agreed that surgeons will be important for completing a deep dive into disease knowledge and different types of oncology care.

Dr. Richard J. Boxer, Clinical Professor, David Geffen School of Medicine, University of California, Los Angeles, questioned whether the elimination of NIH funding for mRNA vaccines will impact this research. Dr. Letai explained that this initiative has strong programmatic support from NIH and HHS.

Dr. Winkfield noted that certain communities are left behind during innovation. She queried what communities were involved in this process. Dr. Wu noted that the Cancer Vaccine Roadmap Advisory Committee had a patient advocate. This committee was small, but community involvement will be considered as this program is expanded.

Dr. Stegmaier asked how tumors with low mutation burdens would be impacted by this initiative. Dr. Wu responded that these low mutation tumors would be addressed with antigen discovery and prioritization in track 2. Discovery efforts will allow differentiation between off-the-shelf treatment versus personalized treatment.

Dr. Carpten asked whether lipids and lipidomic methods were discussed. Dr. Wu stated that this was not done but could be included.

VIII. CANCER GRAND CHALLENGES—DR. ANDREW KURTZ

Dr. Andrew Kurtz, Program Director, Center for Strategic Scientific Initiatives, NCI, presented an update on NCI's Cancer Grand Challenges program. From 2011 to 2021, NCI hosted the Provocative Questions program. The goal of this program was to fund R01 and R21 grant awards to researchers in the cancer research community who would tackle key questions in areas that were understudied, perplexing, or paradoxical. These key questions were identified through workshops at which extramural stakeholders could provide input. The Cancer Grand Challenges program was established in 2022 and has a similar identification process for key questions. The goal of the program is to identify major challenges that require additional resources and fund multidisciplinary, international research teams to accelerate progress and address these challenges. Cancer Research UK (CRUK) was formed in 2002. It is the world's largest cancer research charity and is funded by small private donations and partnerships. CRUK supports research into the causes, diagnosis, prevention, and treatment of cancer through investigator-initiated grants; training fellowships; and large-scale research infrastructure, institutes, and centers. Through a memorandum of understanding in 2020, NCI and CRUK established a partnership to co-fund multidisciplinary international research teams. The awards are up to $25 M over 5 years; NCI and CRUK split the funding costs equally. The partnership funds up to four research teams every round. A round occurs approximately every 2 years, and the agreement states funding for three rounds.

A joint steering committee defines the research challenges and selects applications to fund. CRUK acts as the operational manager, supervising the application and external peer-review processes. NCI and CRUK monitor progress of ongoing projects. Dr. Kurtz stated that over the three funding rounds, 24 unique research challenges have been launched, such as chemotherapy-induced neurotoxicity and neuropathy. These challenges aim to identify important and complex problems in cancer research that would have a significant impact on patients if solved. The research challenges span the continuum of cancer progression, from characterization of normal tissue to systemic disease. When applying, research teams can propose a broad range of techniques and approaches in basic research, translational research, and population-based research. Dr. Kurtz emphasized that the proposed study must be on a large scale and have a wide scope to require intellectual contributions from multiple researchers. NCI and CRUK have supported 13 projects across three funding rounds. Four projects were funded in 2022 and in 2024. In 2026, five projects will be funded. Dr. Kurtz highlighted that CRUK secured additional donations from partners to support a fifth project.

The program's initiative is guided by people affected by cancer and an external scientific committee. The external scientific committee (1) leads community-based think tanks that generate ideas for research challenges, (2) provides advice on the final list of research challenges, (3) reviews applications and recommends projects to fund, and (4) handles annual reviews of the funded research teams. Members serve on the external scientific committee for 5 years, which allows new research ideas and perspectives to be recommended as the program progresses. For the most recent funding round, committee members co-led eight in-person workshops to obtain suggestions from more than 120 cancer experts. Dr. Kurtz highlighted that one workshop was held at NCI so that NCI staff and scientists were able to provide feedback on potential research challenges. The external scientific committee reviewed the input received from these workshops to develop seven research challenges in March 2025. Dr. Kurtz outlined the application process. Interested research teams submit a three-page expression of interest. The external scientific committee reviews and recommends applications for in-person interviews before funding selections are finalized. For the funding call in 2025, 227 expressions of interest were received, representing almost 1,700 investigators across 57 countries.

Dr. Kurtz highlighted several research projects. One project is trying to understand the generation and action of extrachromosomal DNA (ecDNA) in cancer to develop novel approaches that would target these cancer mechanisms. The research team has used a cutting-edge bioinformatics approach to understand the expression of ecDNA across a broad range of cancers. Results from the study have shown that ecDNA encode oncogenes that drive cancer and that cells that contain ecDNA are vulnerable to certain treatment strategies. The Cancer Grand Challenges program partnered with the research team to coordinate the first international conference on ecDNA held at the Royal Society in London, United Kingdom, 11–13 June 2025. Another research study is focused on understanding and reversing cachexia in cancer patients. Cachexia affects approximately half of cancer patients, and it is a complex syndrome that causes such symptoms as systemic inflammation, progressive muscle and fat tissue loss, and anorexia. The research team has identified cachexia subtypes, and it plans to develop treatments for these different subtypes. A project selected on the most recent funding call will uncover the root causes of mutational patterns that drive cancer. This research could reveal the sources of unexplained mutational patterns to guide new prevention strategies. The Cancer Grand Challenges program provides training opportunities for junior scientists, including postdoctoral trainees and graduate students. More than 300 junior scientists are involved in the Cancer Grand Challenges program portfolio. The junior scientists coordinate an annual Future Leaders Conference that allows attendees to showcase their research. This conference also includes keynote speakers, panel discussions, and future direction sessions. The 5th Future Leaders Conference was held in November 2025 in Milan, Italy.

Questions and Answers

Dr. Winkfield emphasized the importance of CRUK initiatives and expressed her appreciation for NCI's role in this program.

Dr. Carpten asked whether there were specific research areas of emphasis for the program going forward. Dr. Kurtz responded that a robust program evaluation will be completed and that an external review panel is currently being recruited. The program evaluation will allow NCI to understand the extent to which international collaboration is helping drive progress in cancer research. The external panel will help evaluate program processes, including the identification of potential research challenges and research gaps.

IX. ANNUAL DELEGATIONS OF AUTHORITY—DR. SHAMALA K. SRINIVAS

Dr. Shamala K. Srinivas, Associate Director, Scientific Review and Policy, DEA, NCI, outlined two Delegations of Authority for the NCAB. She described the delegations and provisions in the Statement of Understanding. Delegation A allows the Director to obtain the services of not more than 151 special experts or consultants who have scientific or professional qualifications. Delegation B specifies that the NCAB delegates authority to the NCI Director to appoint one or more advisory committees composed of private citizens and officials of federal, state, and local governments to advise the Director with respect to his or her functions. The Statement of Understanding with NCI Staff on Operating Principles in Extramural Grants also falls within the Delegations of Authority to the Director, NCI. NCAB operations are conducted in accordance with management and review procedures described in the NIH Manual Issuance 4513. Concurrence of the NCAB with recommendations of initial review groups (IRGs) will be required, except for the following: (1) Training grants and fellowships and other non-research grant applications are not subject to NCAB review and approval and, without other concerns, may be awarded without presentation to the NCAB for concurrence, with the exception of Ruth L. Kirschstein National Research Service Awards; and (2) All application listings and summary statements will be considered as a whole by the NCAB.

Expedited Concurrence. (1) For R01 and R21 applications, excluding foreign organizations, with percentiled or raw scores that are being considered for funding by NCI with no noted administrative

concerns, a process of expedited concurrence will be used. Potential administrative concerns would include human subjects, animal welfare, biohazards, or the inclusion of women and children and appropriate distribution of minority populations. (2) The Executive Secretary will alert Board members with the responsibility for expedited concurrence when review outcomes for eligible applications are available on the Electronic Expedited Concurrence portion of the Electronic Council Book. A minimum of two members must be in concurrence, with no votes for nonconcurrence for application approval. Expedited applications that do not receive the necessary minimum of two votes will be presented to the NCAB at its regular meeting.

Administrative Adjustments. (1) Permission is delegated to the Director, NCI, to allow staff to negotiate appropriate adjustments in dollars or other terms and conditions of grant and cooperative agreement awards. (2) Administrative requests for increases in direct costs that are the result of marked expansion or significant change in the scientific content of a program after formal peer review will be referred to the Board for advice and recommendations. (3) Actions not requiring Board review or advice—such as change of institution, change of principal investigator (PI), phaseout of interim support, or additional support—need not be reported to the Board. (4) NCI staff may restore requested time and support that were deleted by the IRG when justified by the PI in an appeal letter or when restoration is in the best interest of NCI and the project is of high NCI programmatic relevance. As circumstances require, after programmatic consideration and consultation with the NCAB Chair, the Director of NCI may make exceptions to these guidelines.

To continue responsible stewardship of public funds, NIH has instituted a policy of Special Council Review of applications from well-funded investigators. Applications from PIs who have $2 M or more in direct costs from active NIH RPGs must be given additional consideration. Immediately following this meeting, applications from PIs in that category will be provided with that additional consideration. The $2 M is a threshold for review, and investigators who have additional research support may still receive additional awards as warranted. For FY 2026, NIH has instructed the NCAB that a Special Council Review of applications greater than $2 M is not required.

Questions and Answers

Dr. Carpten asked for clarification about the responsible stewardship of public funds. Dr. Srinivas confirmed that for FY 2026 only, the NCAB will not review applications with requests of $2 M or more in direct costs.

Motion. A motion to approve the NCI Annual Delegations of Authority was approved unanimously.

X. NCI COMMUNITY ONCOLOGY RESEARCH PROGRAM BRIDGE FUNDING—DR. BRANDY HECKMAN-STODDARD

Dr. Brandy Heckman-Stoddard, Chief Program Officer, Breast and Gynecologic Cancer, Acting Chief, Community Oncology and Prevention Trials, Division of Cancer Prevention, NCI, presented on a request for NCI Community Oncology Research Program (NCORP) bridge funding. The NCORP designs and conducts cancer control, prevention, screening, care, and quality of life clinical trials; increases patient and provider access to clinical trials conducted through the National Clinical Trials Network (NCTN); and incorporates cancer disparities research.

Dr. Heckman-Stoddard provided an overview of the current NCORP infrastructure. The entire network uses core NCI infrastructure through NCTN. Two cancer-based direct awards have been provided to 45 community sites that have more than 1,000 community affiliates. More than 2,200 enrolling sites are available across the United States and collaborating international locations.

Dr. Heckman-Stoddard displayed an NCORP coverage map that showed the number of NCORP affiliates for each state. Montana has affiliate sites across neighboring states (i.e., Oregon, Idaho, and Wyoming). Several states, such as New Hampshire, Massachusetts, Rhode Island, and Connecticut, have member sites but do not have community sites. West Virginia is the only state that does not have a participating member or community site within NCORP. The number of physicians has remained relatively steady from FY 2019 to FY 2024. The number of non-physician investigators continues to grow each fiscal year; in FY 2024, there were 1,528 non-physician investigators compared with only 309 non-physician investigators in FY 2019. Dr. Heckman-Stoddard emphasized that the numbers of registered research staff and affiliate and sub-affiliate sites continue to increase, as well. Overall, NCORP has continued to grow and expand since the last re-competition cycle in FY 2019.

Dr. Heckman-Stoddard explained that there are currently 213 active studies in the community sites, which include NCORP and NCTN trials. The NCORP research bases currently support 38 active studies, 57 quality-of-life trials embedded in treatment protocols, 3 studies that are temporarily closed for interim analysis, and 39 studies that are closed for primary and secondary analyses. The NCORP request for applications (RFA) was a funding period of 6 years from FY 2019 to FY 2024. A reissuance of program funding was received at the December 2024 joint Board of Scientific Advisors and NCAB meeting. This RFA was delayed by several factors, such as executive orders, new NOFO review processes, an updated NIH policy on foreign subawards, and a government shutdown. Because of these challenges, the current NOFO has not been released yet, and current funding will expire on 31 July 2026. Dr. Heckman-Stoddard explained that the NOFO is under NIH review. The purpose of this presentation is to receive NCAB's approval to ensure patient safety and trial integrity. She stated that the NCORP bridge funding request will be conducted in spring 2027.

Questions and Answers

Dr. Carpten asked about the number of sites. Dr. Heckman-Stoddard clarified that there are approximately 1,000 sites that are members of the NCORP Research Bases, which receive direct funding. The other Cancer Centers and affiliate sites receive research-based grants. Dr. Carpten requested additional information about the NOFO timeline. Dr. Heckman-Stoddard responded that the NOFO was submitted to NIH in December 2025.

XI. ONGOING AND NEW BUSINESS—DR. JOHN D. CARPTEN

NCAB *ad hoc* Working Group on Extramural Research Concepts and Programs Report

Dr. Cornelia M. Ulrich, Chief Scientific Officer and Executive Director, Comprehensive Cancer Center, Huntsman Cancer Institute, The University of Utah, introduced NCI-initiated concepts that were recommended for funding consideration. On 6 February 2026, 32 members of the NCAB *ad hoc* Working Group on Extramural Research Concepts and Programs met to review these NCI-initiated concepts. Dr. Ulrich highlighted that the Working Group evaluates new and reissued concepts for future funding announcements. Working Group members ensure that the concepts have scientific merit, are timely, and advance NCI's current research efforts.

Dr. Ulrich introduced the four proposals. The first proposal focuses on non-hereditary early-onset cancers for individuals aged 18 through 49. R01 and R21 research projects would be funded to investigate the etiology and mechanisms of early-onset cancers and develop early detection strategies. This research program would prioritize understudied cancers, including uterine, kidney, and pancreatic cancers, along with other cancers, such as colorectal cancer. Working Group members recommended that the proposal strengthen health disparities language; establish robust data-sharing requirements; and emphasize community engagement, the use of existing cohorts, and multiple principal investigators across

disciplines. A future program announcement with special receipt, referral, and/or review considerations (known as PAR) for survivorship studies also was recommended.

The second proposal is a reissuance of the Man's Best Friend: Canine Cancer Immunotherapy Network. This comparative oncology program leverages clinical trials on canine cancer immunotherapy as predictive models for identifying effective cancer treatments for people. The proposal budget is $3 M per year for 5 years. Dr. Ulrich emphasized that canines develop cancer at a higher rate than humans. Tumors have changing microenvironments, undergo immunoediting, show broad variability, and develop in hosts with intact immune systems. These advantages are not always replicated with *in vitro* systems or murine preclinical models. Dr. Ulrich highlighted the strengths of the proposal, which included the ethical approach of providing innovative treatments to canines naturally suffering from cancer, the bidirectional translation of results between veterinary and human medicine, and the value of several clinical trials for the program cost. Working Group members recommended the inclusion of antibody-conjugates and theranostics.

The third proposal is a reissuance of the Small Cell Lung Cancer Consortium Resource Center. It is a limited competition for U24-mechanism funding, and the estimated budget is $1.18 M per year for 5 years. Dr. Ulrich stressed that this concept has been very productive, resulting in more than 1,100 publications that have been cited more than 61,000 times. This critical infrastructure has resulted in the first precision-guided small cell lung cancer therapies entering clinical practice in 2024. Working Group members noted in their review that this resource center program could be a model for other disease areas.

The fourth proposal involves two reissuances of the Research Specialist Award for Laboratory, Core and Clinician Scientists. A budget of $5.9 M per year for each cohort was requested. The program provides salary support to remarkable researchers shown to make critical contributions to NCI-funded research. These researchers do not seek independent investigator status and have clinical degrees with active licenses. Dr. Ulrich stated that the program provides critical funding for the workforce gap between training positions and independent research grants. Working Group members recommended that clinician–scientist eligibility be expanded to individuals outside the network trials, including research coordinators in Cancer Center offices. The two reissuances also should be combined under a single announcement.

Questions and Answers

Dr. Carpten queried whether Man's Best Friend: Canine Cancer Immunotherapy Network was a reissuance. Dr. Ulrich confirmed that it is a reissuance and noted that the program has resulted in key products from bench to bedside. Pets receive treatments, and the information gained from this work is directly relevant to human patients. Dr. Carpten queried whether new approach methodologies (NAMs) are restricted to refining and reducing the use of small animal models. Dr. Letai responded that use of NAMs can be more ethical than small animal models. This is not a concern for this program because the tumors are naturally occurring in these dogs. Dr. Letai continued that animal models do not always predict the complexity of humans, which is a limitation for any disease model. Testing cutting-edge therapies in naturally occurring cancer within dogs is advantageous compared with xenografts in an immunoincompetent preclinical model. Dr. Ulrich stated that the Working Group received a letter from the People for the Ethical Treatment of Animals (also known as PETA) stating they recognized how the program serves the pet community.

Motion. A motion to approve the four concepts from the *ad hoc* Working Group on Extramural Research Concepts and Programs was approved unanimously.

Consideration of Public Comments. Dr. Carpten informed the Board that a comment was received from Dr. Jarrod Bailey from the Physicians Committee for Responsible Medicine. Dr. Bailey

encouraged NCI to support the agency-wide prioritization of NAMs and human-based technologies and research. He recommended that the NCAB embrace these initiatives. Dr. Letai responded that his research career focused on optimizing human models to study cancer. He acknowledged that certain research questions require a whole-organism approach, but the use of animal models by researchers will need to be appropriately justified because technology is available to utilize human tissue more often. Dr. Carpten reiterated that the public may submit their perspectives in writing to NCI within 10 days about topics discussed during the open session of the NCAB meeting.

Future Agenda Items. Members suggested discussing how to optimize the clinical trial enterprise to remain competitive, maximize reach, and ensure quality. Members recommended a review of available training grants and administrative supplements and an update on funding being considered in place of diversity supplements. Updates on grants funded in the current fiscal year and the proportion of funding provided to investigators from underserved populations and the percentage of funding that includes a study component for underserved populations were requested. NCAB members were asked to forward any additional suggestions for future agenda items to Dr. Srinivas.

XII. ADJOURNMENT OF OPEN SESSION—DR. JOHN D. CARPTEN

Dr. Carpten adjourned the open session. Only Board members and designated NCI staff remained for the closed session.

XIII. CLOSED SESSION—DR. JOHN D. CARPTEN

"This portion of the meeting was closed to the public in accordance with the provisions set forth in Sections 552b(c)(4), 552b(c)(6), Title 5 U.S. code, and 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2)."

There was a review of grants and a discussion of personnel and proprietary issues. Members absented themselves from the meeting during discussions for which there was potential conflict of interest, real or apparent.

The Board was informed that a comprehensive listing of all grant applications to be included in the **en bloc** vote was in the Special Actions package. Those grant applications, as well as those announced during the closed session, could be considered for funding by the institute.

The NCAB **en bloc** motion to concur with IRG recommendations was unanimously approved. During the closed session, a total of 2,487.

XIV. ADJOURNMENT—DR. JOHN D. CARPTEN

Dr. Carpten thanked all the Board members, as well as the visitors and observers, for attending. There being no further business, the 170th meeting of the NCAB was adjourned at 5:00 p.m. on Tuesday, 17 March 2026.

Date	John D. Carpten, Ph.D., Chair, NCAB
Date	Shamala K. Srinivas, Ph.D., Executive Secretary