CLINICAL TRIALS
ADMINISTRATOR
An essential resource for managers of clinical trials

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IN THIS ISSUE

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NOVEMBER 2009
VOL. 7, NO. 11 • (pages 121-132)

Clinical trial offices have diverse roles & goals, new survey shows

Consolidation might improve efficiency

Academic health centers have increasingly added clinical trial (CT) and research offices to assist investigators and others involved in the research enterprise. But so far no one model has taken hold in the industry, a new survey reports.

The study's findings suggest there is room for best practices and greater uniformity in establishing CT offices.[1]

"Each institution is very different," says **Elaine Rubin**, PhD, vice president for policy and programs at the Association of Academic Health Centers (AAHC) in Washington, DC.

"Whether they're private or public or large or small, they have different structures and cultures and ways of managing the offices," she says. "While everyone is trying to get to the same goal, we saw different ways of getting there."

These findings surprised Rubin, who began working on the project in late 2008.

"I thought they'd all be doing pretty much the same thing," Rubin says. "But what we found is there are at least 14 activities that can range from contract negotiation to recruitment to protocol development."

Even within the context of education and training of researchers and research staff there was variety, she adds.

"We thought we'd find a little bit more uniformity in the structure, and we did not," Rubin says.

One reason for this trend is that the clinical trial enterprise of academic health centers is relatively small when compared with the organizations' historic research activities, says **Steven Wartman**, MD, PhD, president and chief executive officer of AAHC.

Through funding by the National Institutes of Health (NIH), these organizations have built up tremendous research capabilities and have become world leaders in research, Wartman says.

"We haven't paid similar attention to clinical trials," he explains. "They've been relatively small, but are a vital portion of the research enterprise."

The modest investment in CTs has led to CT offices' variety in roles

and functions, he adds.

"It was only in the last decade that it's caught our attention," Wartman says.

The research industry has begun to see that more emphasis and attention must be paid to clinical research and to the translation of basic science findings into clinical practice, Wartman says.

"The translation of basic science findings into clinical practice is becoming more important as people realize there's a tremendous need to develop that area," he adds.

AAHC's survey documents CT office variety, he notes.

"We thought maybe there is a need for an organization like ours to recommend some methodologies that would describe economies of scale and best practices for clinical trials management," Wartman says. "This goes well beyond academic health centers and the agencies that regulate them."

The next step might be for a professional organization, such as AAHC to publish CT office models that consolidate the various functions.

The AAHC report suggests that clinical trial sites benefit from consolidation or centralization, but this is far from being accomplished.

Consider consolidation

For institutions that have a myriad of CT offices and functions, many within individual departments, they might consider consolidating these offices to reduce overlap and increase efficiency.

Institutions that move to a one-stop-shop model appear to have made it easier for researchers to find the information and assistance they need, Rubin notes.

The lack of a clearly defined organizational structure for clinical trial administration creates stress and challenges for research institutions.

Problems include the lack of mandates for using CT offices, the overlap of general CT offices with departmental services that provide CT assistance, and the lack of skilled technical labor.

CT offices in academic health centers often have parallel structures, Rubin says.

"They're getting the job done, but researchers might be getting help in their department," she explains.

So when an organization establishes a general clinical trials office that can be used by everyone at the institution, there might be a problem with attracting researchers to using it. This is where a mandate requiring its use might be effective.

"What we're finding is there is increasing use of these offices by researchers because they find it helps them and are effective," Rubin says. "But its use is by word-of-mouth, and not by policy."

This means institutions often are not using their CT office resources as effectively as they could be using them, she adds.

Clinical Trials Administrator (ISSN# 1544-8460) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Clinical Trials Administrator*, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $299. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. **Back issues**, when available, are $50 each. (GST registration number R128870672.)

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It's also ineffective to have an overlap of CT functions within departments.

AAHC is working with the Centers for Medicare & Medicaid Services (CMS) to make clinical trial rules less ambiguous and to advocate for more CT funding, Wartman says.

"We'll assist our members in developing methodologies to make sure their management of clinical trials is efficient," he says. "We also have a clinical trial toolkit which was a tremendous endeavor."

The toolkit, which can be purchased through the AAHC Web site, provides assistance with conducting self-assessments and other activities that will help an institution develop more efficient clinical trial management and style, Wartman adds.

AAHC's clinical trial office report features profiles of institutions' clinical trial operations. Each profile is based on one institution and are not necessarily models to follow, Rubin explains.

"We don't have model A, B, or C available yet," Rubin says. "These examples all are working and address the needs of a particular institution."

Some institutions added their CT office to existing infrastructure, and so its functions and purpose are tailored to fit in with what the institution already has, she notes.

"Just like the universities out there, they have different histories, different resources, different research priorities," Rubin says.

But the clinical research enterprise is evolving, and research institutions need to change with the times.

"Academic health centers are deciding they want to put more emphasis on the clinical research arena, so they have to evolve," Rubin says. "We want to stay a little ahead of the curve and provide a model, but we're not there yet."

Key features

As research institutions develop new or modify existing CT offices, they might include these features, Rubin suggests:

- **Budget development:** "They definitely have to deal with budget development and approval," she says.

Also, it's important to conduct cost analyses, Rubin adds.

- **Protocol development:** "They should be helping with protocol development, and this should be linked or at least be in contact with what's happening in the IRB office," Rubin says.
- **Contract negotiations:** Clinical trial offices would be helpful in contract negotiations, she says.
- **Education, training, compliance:** There should be some element of education and training and compliance in the CT office. Or at least the CT office should be linked with the education and training and/or compliance offices of an institution to ensure all regulatory issues are addressed, Rubin says.

"Research coordinators need to have the experience and training to know the research environment, regulations, billing, and recruiting patients," Rubin explains. "These are high-stress jobs, and we see a lot of turnover."

The coordinators who are skilled quickly move up to other jobs, and there often are too few new people moving into these roles, she adds.

Reference

1. Rubin E, Lazar D. Clinical trials offices: what's new in research administration? Published by the Association of Academic Health Centers. September, 2009: Available online at http://www.aahcdc.org. ■

Rock enrollment: Get a boost from health data

Company uses data to find good CT sites

The clinical trial industry's poor outcomes regarding enrollment and trial success are very frustrating to sponsors, as well as to investigators and CT sites.

"I was a sponsor for 17 years in big pharma and small biotechs, and regardless of where I was working or the target indication, I always was frustrated, like many of my colleagues, by the fact that I'd select sites, and they'd do very poorly," says **Malcolm Bohm**, BSc, MMedSc, president of Trialytics in Plymouth Meeting, PA. Bohm was scheduled to speak about applying health care data to site selection and patient recruitment at MAGI's 2009 Clinical Research Conference West, held Oct. 4-7, 2009, in San Diego, CA.

Trialytics, a subsidiary of SDI Health LLC, contracts with sponsors and others in the CT industry to provide and analyze health care data for

the purpose of selecting CT sites and recruiting subjects.

In one study that is typical of sponsors' experience in the CT industry, only 320 out of 440 sites contributed to the study and also met the study's target goals, Bohm recalls.

"So you found that about 30% to 40% of sites basically were a waste of time," he adds. "And this is replicated over and over again."

If anything, the trial site statistics are getting worse, creating a tremendous burden for the CT industry, Bohm says.

It costs sponsors an average of $35,000 to open and close a site that doesn't enroll any subjects, he notes.

"Also, for every site that doesn't contribute, you need to find another one to make your enrollment," Bohm says. "Eighty percent of trials are late by at least one month."

From investigators' perspective, the statistics are just as grim.

"About 45% of investigators in the United States stop doing research every year," Bohm says.

Recruitment driven by data

One key to turning these dismal statistics around is to use available health care data to more efficiently identify and recruit clinical trial sites and to more easily recruit and enroll subjects, Bohm says.

"We use health care data from diagnoses, prescriptions, and procedure data from medical offices and hospitals around the country to determine whether a physician is treating the patients required for a protocol," Bohm says. "We go into our databases online and find, for example, who is treating patients who have intractable epilepsy."

Clinical trial sites can use the same data in a physician's office to identify potential subjects.

The data shows how many patients with this disease are being seen by a particular doctor, which is information a sponsor can use to identify and recruit that physician to be an investigator in a study about intractable epilepsy, Bohm explains.

"We're a niche patient recruitment organization," Bohm says. "We use evidence-based health care data as opposed to more traditional techniques, like media advertising."

Data-driven recruitment practices will be the way of the future if U.S. clinical trial sites are to survive and thrive.

"It's important to find a new recruitment avenue for this kind of enterprise because in the last decade 80% of trials are late, and 30% to 40% are unsuccessful," Bohm says.

While many health care organizations still lack electronic health records, 65% of them have some information technology, particularly in the area of electronic billing. And this is where useful data can be found, Bohm says.

The billing information is made HIPAA-compliant with patient level data that is de-identified, he says.

Sponsors, clinical research organizations (CROs), and clinical trial sites can use the data to make the clinical trial process more efficient and faster.

For example, a clinical trial site can use their electronic systems to conduct a detailed chart review to see if they have patients who meet criteria for a protocol, Bohm suggests.

Investigators can use electronic health care data from their own region to identify physician practices that could be excellent referral sources.

"There are 21,000 research doctors who treat a relatively tiny proportion of the patients available in the United States for clinical trials," Bohm says.

"A lot of trials are globalized and going overseas to recruit patients, but the patients are right here in the United States," Bohm adds. "We're just not doing a good job of asking them if they'd consider a clinical trial."

So if those 21,000 research physicians could use a database to identify doctors in their area who treat the target study populations, then they could send clinical trial staff or recruiters to these physicians' offices to discuss the study and request referrals.

"These are tools that are very simple, highly intuitive, effective, and cheap," Bohm says. "A research coordinator could go to another physician's office and offer to do patient chart reviews so the referring doctor doesn't have to do anything except say that the patient would be a good referral for the study."

Need extra time, money?

Using health care data to identify patients for recruitment could save time and money, Bohm says.

"The opportunity for using this health care data is huge compared with what people traditionally have been doing," Bohm says. "Clinical

trials have been delayed and horribly inefficient for years."

But it will take a paradigm shift for study sponsors and sites to change their old habits, he suggests.

Sponsors recruit sites in the same old ways, regardless of how successful they are, and sites recruit patients often in the same old ways, he says.

Bohm estimates that a data-driven process of identifying CT sites, recruiting subjects, and starting trials could make the study three times faster. "And if you get them up and running faster, you have a chance of finishing on time."

For example, a recent chronic obstructive pulmonary disease (COPD) study used health care data for patient recruitment at 110 sites, which were identified through electronic information, Bohm explains.

"The sponsor held an investigator meeting and told sites, 'We're not giving you any patient recruitment money or support, and we expect you to deliver enrollment from your databases,'" Bohm says. "'That's why we selected you.'"

The study finished enrolling subjects four months early, he adds.

"The value to the pharmaceutical company was huge -- to have four to five extra months on the market," Bohm says. "If you're looking at improving enrollment and start-up, why wouldn't you look for alternative ways to conduct these critical steps?"

From sites' perspective, they'll make more money faster if they employ a recruitment process that has fewer screen failures and enrolls subjects faster, he adds.

"Say your target is to enroll 10 patients, and your break-even point is five patients, then you have an incentive to get to 10 patients more rapidly and efficiently," Bohm says. ■

Wanted: Coordinator with good attitude, will train

Keep metrics to evaluate performance

Like other rural areas in the United States, the Rocky Mountain Diabetes and Osteoporosis Center in Idaho Falls, ID, sometimes has trouble finding study coordinators.

"Finding someone who is experienced in research almost never happens," says **Delos Jones**, RN, MSN, CCRC, research manager for Rocky Mountain Diabetes and Osteoporosis Center.

So it's crucial that the research site have an effective way to train and evaluate clinical trial staff.

Here are some tips on better managing CT staff:

1. Hire people with potential and good attitudes.

"When we have a candidate we're seriously considering hiring, we have several people in on the interviews, including myself and the operations manager," Jones says.

The site sometimes asks job candidates to spend time speaking with study coordinators and staff in the regulatory department.

"This helps them see how personalities fit and how this person fits in," Jones says.

Another good strategy is to hire interns who've already worked at a site for several months.

"Everyone in the office gets to work with interns, and they see them on a good day and on a bad day," Jones explains. "And people get to see how they work with everyone."

2. Provide adequate training.

"We send all our coordinators to Northwestern University in Chicago, IL, for three days of training, so they all get basic training," Jones says. "Then we bring them back and have them work with coordinators and monitors."

Also, CT sites can send at least some staff to conferences, and this also could serve as a motivator.

"One thing we do on an annual basis is we choose a number of coordinators to attend an ACRP convention," Jones says. "It's based on their performance, length of time they're with the company, whether or not they're certified, and when they had last attended a conference."

3. Evaluate staff in all available ways.

Staff evaluations are an effective tool for identifying areas where employees need more training and determining which coordinator is good at specific tasks and which needs mentoring.

"We do general office evaluations, looking at employees' organizational skills, how they treat patients and monitors, and we look at their overall behavior in the office setting," Jones says.

Each year there is a formal evaluation interview, but when problems occur in the interim, a manager will meet with the coordinator and work it out.

The ways clinical trial sites can identify criteria for evaluating staff is through published research,

the use of evaluation tools, and talking to monitors to see what makes a good coordinator in their eyes, Jones says.

"We've developed a tool that looks at clinical trial coordinators' professional development and also at their skills as a coordinator," Jones says.

These skills include drug accountability, query resolution, case report form entry time, and retention of patients.

"The biggest thing we've learned is you really have to catch problems in their early stages," Jones says. "If you wait until the annual review to deal with issues it's generally too late, and they're too far behind or too entrenched in what they're doing — so the evaluation has to be an ongoing daily activity."

4. Work with monitors to collect evaluation data.

Study monitors collect query resolution data, and they can share it with a site.

"They can tell you the number of queries the coordinators have and how long it takes to resolve a query," Jones says. "So they can give you a lot of good information about how well the coordinator is doing."

Monitors also can provide information on drug accountability. They look at drug logs and binders and make sure coordinators have logged drug shipments into the drug binder as an expense immediately after they arrive, Jones says.

Clinical trial sites have their own patient retention data, and it is simple to see how many patients who entered a trial did not finish for each study coordinator.

"We want to know what their reasons are for not finishing, whether they had an adverse event or whether they didn't feel they were being taken care of," Jones says. "Maybe the person lost interest in the study, and this is something the coordinator could do something about."

Coordinators who have a poor track record in patient retention generally will have a meeting with their supervisor to address the problem, Jones adds.

Monitors keep data on case report form entry time, and it's relatively easy for them to retrieve the information since it's mostly in an electronic format.

"Sponsors generally have a metric they want met, such as having the case report form entered within five days of the visit," Jones explains. "We talk with monitors and coordinators to make sure that metric is being met."

If a coordinator is not meeting the documentation goals, then site managers will work with the coordinator at better managing his or her time.

Sometimes a site will need to invest in a data entry employee who will enter case report forms for a coordinator who is busy handling high-enrolling studies.

5. Prevent morale problems.

While it's very important to evaluate study coordinators' work and skills, it's also important to motivate coordinators as part of a strategy to help them maintain their morale.

The research site also holds in-house drawings for movie tickets, dinner certificates, car washes, and other prizes. These drawings are held monthly and serve as rewards for coordinators who are the most productive, Jones adds.

It's also necessary to keep coordinators' workloads manageable.

"One of their biggest complaints is that their workload continues to increase, but their time for work doesn't," Jones explains. "So if you give a coordinator one big study, then you might give them another small study, or one coordinator might have four or five small studies."

Also, CT managers can give a highly-skilled coordinator an assistant who will do the time-consuming tasks, such as blood draws, obtaining vital signs, and case report form data entry.

"These are the time-consuming things that pull them away from the patient," Jones says. "The coordinator then will focus on finding patients and working with patients to make sure they understand the protocol."

6. Provide professional growth opportunities.

It's also important for study coordinators to have some professional mobility.

For instance, Rocky Mountain Diabetes Center has a position called the lead coordinator that the most experienced study coordinator can become.

"Also, we do quite a bit of intern work with physician assistants and pre-med students and medical assistance students, and we put experienced coordinators with them as their mentors," Jones says.

After coordinators have been working for the site for a couple of years then they can take a certification exam, and the site will give them a pay increase if they become certified.

"We'll assist them with their certification renewal, whether it's through assisting them with funding of continuing education or attending conferences," Jones says. ■

Improving site-sponsor-CRO relationship

Resolve issues by being proactive

Conflicts inevitably happen between clinical trial (CT) sites, sponsors, and clinical research organizations (CROs). But when they occur they can be handled efficiently and in a way that doesn't slow down the trial or reduce efficiency.

Also, some CT sites have developed proactive measures to reduce conflicts, improve communication, and foster trust in this three-pronged relationship.

Here are some of the issues that arise:

• **Protocol design:** "The big issues come up with protocol design," says **June Cassano**, RN, BSN, MBA, a research administrator for the Heart & Vascular Institute, as well as one of the managers at the Center for Clinical Research of the Cleveland Clinic in Cleveland, OH.

In a best case scenario, sponsors will ask clinical trial sites and investigators to review study protocols and provide feedback, Cassano notes.

Many problems involving protocols could be resolved in advance if sponsors were to solicit input from CT researchers, but this probably doesn't happen as often as it could, she adds.

• **Assess enrollment potential:** CT sites could prevent much of the recruitment and enrollment problems that plague the CT industry if they'd conduct thorough feasibility assessments.

"I'm not sure if every site has taken a critical look at protocols coming their way," Cassano says.

Perhaps the most effective way to assess a study's feasibility is by conducting a mock protocol assessment with a retrospective two-week screening for patients who meet a study's inclusion/exclusion criteria, she suggests.

"When we do feasibility assessments, and depending on the type of trial, we would like to see that at least 50% of patients qualify for the trial, and the higher the number the better," Cassano says.

The easiest trials to enroll are those that have more general criteria for a specific disease process. But others require CT sites to use specific parameters, and these need to be thoroughly assessed, she adds.

At the Cleveland Clinic, a study coordinator will perform the retrospective assessment, and the manager will help analyze the findings, Cassano says.

"Some of the information will be available electronically, and some will require a manual process where we have to dig a little deeper," she adds.

For example, a CT coordinator might look at the inclusion/exclusion criteria for a study that would involve patients in the interventional cardiovascular medicine section of the Cleveland Clinic's Heart and Vascular Institute, Cassano says.

"We assess patients who came out of the cath lab over the past two weeks to see if they fit the criteria, and maybe we have a total of 600 patients," she explains. "So what percentage of those patients makes the inclusion/exclusion criteria, and what percentage of those who meet the criteria might enroll in the study?"

If only 30% meet the criteria, then the site's leadership will have to consider whether it's worthwhile to continue with the study, she adds.

"You might want to move forward with some types of trials that involve the latest and greatest and hottest technology because they're state-of-the-art," Cassano says.

• **Assess sponsor and CRO experience:** Another part of assessing study feasibility is to assess the particular sponsor and CRO.

"Has your previous experience with the sponsor or CRO been satisfactory?" Cassano says. "If you haven't had any experience with them then have you checked with colleagues to see if they have a good reputation?"

Site managers should ask these questions as part of sponsor/CRO assessment:

- Are the study's enrollment goals realistic?
- Is the enrollment period realistic?
- Will there be competition with other studies using this population?
- If there is competition, how will you handle it?
- Do you expect a significant number of adverse events?
- Will there be frequent subject follow-up?
- Is there a big commitment on the patient's part with regard to travel, and could that impact enrollment and retention?

"These are all part of feasibility assessment," Cassano says.

The potential for adverse events is particularly important to assess, she notes.

"At the Cleveland Clinic, we had one study with a drug where one FTE (full-time equivalent) had to be devoted to report all of the adverse events from that particular drug," Cassano recalls.

The sponsor hadn't included funding to sup-

port that position in the study budget, so the clinic negotiated a slight increase that helped the site recoup some of the lost revenue, she adds.

• **Handling delays:** Sometimes CRO monitors get behind on site visits, and this will delay payment to the site, Cassano says.

"Sometimes there's a backlog of patients, and then the monitor needs to come in for a few days to go over this, and that can tie up the coordinator, who has other duties and other trials," she explains.

"When this happens, we'll speak directly with the sponsor or CRO about the problem," Cassano says. "We have complained about this in the past to a CRO, and the CRO listened to us and tried to come in on a more regular basis."

• **Resolving complaints:** CRO monitors sometimes will note communications or documentation problems with study coordinators in monitoring reports even though these could have been handled directly through communication with the site, Cassano says.

"We have found that some items they've listed as a concern were not problems," she adds. "So we've had to go back to the sponsor and have them update the report based on that communication."

The key to preventing these types of issues is for the study coordinator to develop a good relationship with monitors, Cassano says.

"On the day the monitor is coming in to visit, the coordinator has to have this on the schedule and tend to the needs of the monitor," she adds. "That helps."

Also, before a monitor leaves, the coordinator should sit down with the monitor and work out any issues or questions, Cassano says. ■

A sponsor's perspective in negotiating fair terms

Sponsor asks for itemized list of costs

Sponsors and clinical trial sites often disagree on what type of contract payment terms are fair and reasonable.

Part of this disagreement is due to the nature of the industry and its poor success statistics. But part of it also is due to the lack of clear communication about expectations, needs, and goals.

"If both sites and sponsors can recognize each other's non-financial goals then that can help a lot in terms of insuring a more smooth study," says **Shawn Gibbs**, JD, contract manager with C. R. Bard Inc., a device company based in Murray Hill, NJ. Gibbs was a scheduled speaker about the sponsor's perspective in contract negotiations at the MAGI 2009 Clinical Research Conference West, held Oct. 4-7, 2009, in San Diego, CA.

Gibbs describes some of the major negotiating sticking points between sponsors and sites:

• **Initial payments:** "From the sponsor's perspective, I look at it as the clock starts once a decision is reached by the site that they'll participate in the study," Gibbs says. "We recognize the amount of work and preparation that sites put in up front."

When sites begin adding in ancillary costs, the issue gets hazy, he notes.

"Very often, if a site requires what I consider a large start-up payment, I ask them to break it down," Gibbs says. "From a compliance perspective, we need to know it will go toward [actual] work."

For instance, a sponsor might not feel obliged to pay for contract review and budget review time on the site's itemized list.

"I see it as each site is evaluating whether to enter into this agreement or whether they want to work with the sponsor, so for the sponsor to pay for someone at the site to review the agreement or budget seems a bit skewed," Gibbs says.

IRB work, pharmacy fees, and regulatory preparation are legitimate start-up costs, and sponsors recognize these, he adds.

"We view IRB fees as pass-through fees," Gibbs says.

The sponsor asks that IRB fees be invoiced and will pay the IRB directly, he adds.

"But it's a good idea to stay away from those things that incur costs on both sides," Gibbs says. "If you put an offer on a house, you don't pay the other side to review your offer; these are preparatory business concerns."

• **Marketing, recruiting, advertising fees:** "Advertising is more prevalent in drug trials than in device trials," Gibbs says.

"Device trials are done more in hospitals with patients who are receiving investigatory devices as part of their standard care," he says. "For drug trial advertising, my experience is that sites would use up their budget very quickly and then try to get more money out of you."

Clinical trial sites should use their advertising budgets more wisely, Gibbs suggests.

"They should put on their public relations hat

and say, 'Where are these ad dollars going to be most effective? Is it in the newspaper ad or online advertisement or radio or TV spot?" he says. "It involves determining what is the best medium for reaching your target population."

• **Milestone payments:** "Whenever possible, sites should use electronic data capture which would help in speeding up milestone payments," Gibbs says.

"The sponsor wants clean data, so if it requires the monitor to go out and do 100 percent source documentation and to collect the case report form (CRF) on paper, then it's a time-consuming process," he explains. "If you build in electronic data capture, the query rate should be lower, and you should be able to ensure sites have met their visits or enrollment."

One point of negotiation should be how fast a site is paid, whether it's each quarter or each month, Gibbs says.

"Sites would like monthly payments," he adds.

• **Screen failures:** "At the beginning of a trial, I think the sponsor owes sites an obligation to make an honest appraisal of what they expect screen failure rates to be and how much work is going to be built into screening activities before subjects essentially are consented and enrolled," Gibbs says.

Occasionally, an investigator will have screened a patient, given the person informed consent, and then are about to enroll the patient when a problem is discovered, and the patient has to be excluded from the study.

"This is a case that is out of the site's hands and the sponsor's hands, and the site should be rewarded for the work the site put into handling that patient," Gibbs says.

"We like to pay a flat rate per screen failure, and we take the total enrollment and divide it by the number of sites," Gibbs says. "Each site is capped in the number of screen failures."

The cap is necessary because it encourages sites to do diligent pre-screening prior to enrollment, he adds.

• **Hold-back payments:** Sponsors shouldn't hold-back payments until all sites are enrolled, Gibbs says.

"I'd take the hold-back payments on a site-by-site basis," he says. "If you've locked all queries out of one site then I would think you'd move forward and make that final payment."

The sponsor's driving goal is to obtain clean data. The final payment's purpose is to encourage sites to cooperate as they're wrapping up the database, Gibbs explains.

"From the sponsor's perspective, there may be times when they made the final payment and then had to go back in and make another query," he says. "And sometimes they found sites have moved on and might not realize the sense of urgency the sponsor has in getting the database locked."

But sponsors also should not penalize efficient and successful sites for other sites' lack of management, so the hold-backs should be made according to how each site has performed and not on a group performance basis, Gibbs says.

• **Unanticipated costs:** These types of costs could include frequent protocol amendments, which require extra work, or higher than anticipated screen failures.

A site might need ancillary equipment to run the study, such as a refrigerator for a drug study, Gibbs says.

"These are the kinds of things we would work with sites to make sure they have what they need," he says. "Maybe we'd lease you a refrigerator for the duration of the study."

Or if the screen failure rate is 15%-20% higher than anticipated, then the sponsor might have to adjust for that, Gibbs says.

"Some sites like to put in clauses for inflation, and I think that's difficult and very complicated to manage," he notes. "If it's a long study, maybe eight to 10 years, then I can understand it more, but from an accounting perspective, it would be very difficult to keep up with the inflation rate."

When sponsors are funding trial sites overseas, there might be unanticipated costs related to currency fluctuation, Gibbs says.

"It can have an impact on trial costs, and sponsors generally are amenable to paying for non-cancelable expenses," he says. "We'll reimburse you for those costs; those are fair things." ■

Lessons learned from starting in the trenches

Keep overhead costs as low as possible

There have been many peaks and valleys in the nearly 10 years since a former clinical trial coordinator founded Mountain View Clinical Research of Denver, CO.

"When I opened Mountain View in 2000, I was already working as a clinical trial coordinator in

the area and working with physicians, and they were willing to transition to working with me as a coordinator in their offices to contracting with me," says **Kristen Johnson**, BSRRT, CCRC, president of Mountain View Clinical Research.

Johnson's goal was to start a stand-alone company that conducted a variety of studies.

"I started the company with my personal funds and debt on credit cards, and it was hard work that required dedication," Johnson says.

"While it's gratifying on one hand, you have to be committed to putting in a tremendous amount of blood, sweat, and tears to make it work," she adds. "And you'll have sleepless nights."

She achieved her goal very rapidly, and that was the first lesson she learned about starting new clinical trial sites: Don't grow too fast.

"At one point it grew too fast, and that's the biggest word of caution I could offer anybody starting their own business," Johnson says. "Be careful growing too quickly."

It's easy in this industry to be blinded by contracts coming across the desk, thinking that it might not be an economic feast for long, she notes.

"Then before you know it you have way too many studies and not enough help," Johnson says. "So you have to hire more staff, expand your space, and six months go by, and you have more space and help than you need."

This happened with Mountain View Clinical Research. The small clinical trial site grew to seven employees, but now has decreased to four employees.

"Now I'm trying to do more work with contract employees who can come and go with the studies," Johnson says. "This can save you money on the back end in taxes, unemployment insurance, and, in Denver, an occupational privilege tax."

Johnson quickly learned this lesson and was able to reduce her overhead costs and weather the economic downturn.

"We took over two other research practices this summer," she notes. "They were closing, and the only difference between my business and theirs was I keep my overhead low."

Here are some of the other lessons Johnson learned while running a small clinical trial site:

• Seek alternative sources of business financing.

Clinical trial site start-ups should seek out all and any available funding because cash flow could become an issue.

"The small business association is more willing right now to give loans than they were nine years ago," Johnson says.

"There's also an association for disadvantaged business owners, female or minorities," she adds. "And micro-loans are available."

If a site manager can convince a bank that the money will come in, but the site needs a loan to keep the business running, the bank might be open to making the loan, Johnson says.

"Also, there are peer-to-peer lending clubs," she adds.

• Find staff through cheap or free advertising sources.

"I've advertised for part-time help on Craig's List before, and I've gotten good employees through that," Johnson says.

Craig's List is an online classified advertising Web site that doesn't charge people who post information.

"I'm very active here with the Association of Clinical Research Professionals, and that's a good way to identify experienced coordinators," Johnson says.

If Johnson is looking for a skilled contractor, she also checks out ACRP news.

• Commit only to studies you know will meet enrollment.

"It took me five years to realize I can't make that commitment of a study that can't be enrolled," Johnson says.

"When I was just starting I was eager to take any study," she says. "Now, I encourage people to look carefully at a study, protocol, and budget, and to turn down those studies where you think it won't be possible to enroll patients."

Everyone loses when a CT site begins a study and then has to close without enrolling a single patient, she adds.

"Studies are harder to enroll now because patients have access to more medications," Johnson notes.

For example, patients who once needed to enroll in a clinical trial for the latest and greatest medications for high blood pressure, now can choose between more than a dozen generic drugs on the market, she explains.

Of course the current recession has shifted the balance slightly as now more people are uninsured and might be more interested in participating in clinical research, Johnson adds.

"One thing I tell people is to capitalize on our current economy by offering options to patients who potentially do not have access to care," she says.

• Keep your overhead low.

"I buy used and refurbished equipment from a local vendor," Johnson says. "I have negotiated and found facilities that do MRIs and other procedures at lower costs."

These facilities are willing to negotiate at a much lower cash fee than what sponsors typically will pay for the procedure, so the CT business can benefit from this difference, she adds.

Johnson suggests sites ask themselves these key questions in order to make sure their overhead costs are where they need to be:

- Have you evaluated the space you need?
- Do you need a big fancy office?
- Do you need a coordinator assistant, recruiter, and other extraneous employees?
- What do you really need for both space and employees?

It might also be wise to negotiate with physician investigators about having all of the study visits conducted at their locations to save money and space, Johnson says.

CNE/CME Objectives / Instructions

The CNE/CME objectives for *Clinical Trials Administrator* are to help physicians and nurses be able to:

- **review** pertinent regulatory mandates;
- **develop** practical clinical trial oversight strategies;
- **review** best practices shared by facilities that successfully conduct clinical trials.

Physicians and nurses participate in this medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

After completing this activity at the end of each semester, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

COMING IN FUTURE MONTHS

- ■ Here are best practices in billing compliance
- ■ Prevent enrollment glitches with these strategies
- ■ E-technology can help with participant compliance
- ■ Contain costs following these tips
- ■ Improve study feasibility assessment

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Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Clincal Trials Administrator	1 5 4 4 - 8 4 6 0	10/1/09
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$299.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Robert Mate, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Gary Evans, same as above

Managing Editor *(Name and Complete Mailing Address)*
Coles McKagen, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor
	Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Clinical Trials Administrator

14. Issue Date for Circulation Data Below: September 2009

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			313	272
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	157	173
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	8	6
	(4)	Other Classes Mailed Through the USPS	36	25
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			201	204
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	16	18
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
f. Total Free Distribution *(Sum of 15d and 15e)*			36	38
g. Total Distribution *(Sum of 15c and 15f)*			237	242
h. Copies Not Distributed			76	30
i. Total *(Sum of 15g. and h.*			313	272
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			85%	84%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2009 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: President and CEO — Date: 9/27/09

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PS Form **3526**, September 1999 *(Reverse)*

CNE/CME*questions*

17. A new survey of academic medical center research sites found that many have clinical trial offices, but, overall they lack which of the following?
    A. Diversity
    B. Uniformity
    C. Goals
    D. Funding

18. How much on average does it cost sponsors to open and close a clinical trial site that doesn't enroll subjects?
    A. $17,500
    B. $24,000
    C. $35,000
    D. $41,000

19. Which of the following is a good strategy for managing clinical trial coordinators?
    A. Use site data and information from monitors to assess coordinators' performance on various metrics
    B. Provide professional development growth opportunities
    C. Hire people with good attitudes
    D. All of the above

20. When performing a study feasibility assessment which of the following is not a useful question to ask?
    A. Are the study's enrollment goals realistic?
    B. Are your patients mostly elderly or below age 40?
    C. Is the enrollment period realistic?
    D. Do you expect a significant number of adverse events?

Answers: 17. A; 18. C; 19. D; 20. B.

• Be prepared for ups and downs.

Although Johnson has tried to keep steady with CT work, there are inevitable shifts in workload.

"I'm in a position now where at the beginning of the year things were slowing down, so I looked at studies I might have potentially turned away, and now they're coming to fruition," Johnson says. ■