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IN THIS ISSUE

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Study shows that most research participants want their results

Debate continues over ethics of decision

As research ethicists and others debate the merits of giving clinical trial participants the personal and aggregate results of studies, recent research suggests that participants want this information.

"We had done work on the ethics side of this issue, and the debate rages on," says **David J. Shalowitz**, a medical student and member of the Bioethics Program at the University of Michigan Medical School in Ann Arbor.

"But we realized that in looking at ethics literature and debate surrounding the issue, there are many claims being made that depend on empirical data," Shalowitz adds. "For example, many commentators will make references to participants' desires."

So Shalowitz and co-investigator **Franklin G. Miller**, PhD, of the department of bioethics at the National Institutes of Health in Bethesda, MD, decided to study available data on participants' desires with regard to disclosure of study results. Their study, titled, "Communicating the results of clinical research to participants: Attitudes, practices and future directions," has been accepted for publication in *PLoS Medicine* and will be published on-line at www.plosmedicine.org.

"Overwhelmingly, participants want to know aggregate results of research, as well as clinically relevant individual results," Shalowitz says. "We reported a median of 90% based on a review of available literature."

Investigators reviewed studies from between 1950 and 2007, selecting those that provided qualitative or quantitative data on communicating research results with respect to participants' preferences, investigators' attitudes and practices, psychological or behavioral impact on participants, costs, and effect on participants' perceptions of research or investigators.

While a median of 69% of investigators support disclosing study results, fewer than half of the cases involved disclosure, Shalowitz notes.

There is a presumptive responsibility of investigators to report empirical results, Shalowitz notes.

"In the past, we've argued that the responsibility can come from

different sources," he explains. "For one, investigators depend on the voluntary contributions of participants in order to get their data, and, in some ways, it shows respect and gratitude to those participants when investigators make the data available to them."

Other arguments concentrate on whether participants want to know the information and whether it will change the way they behave with regard to health care decisions, he adds.

"Many investigators are concerned with the costs of disclosing results," Shalowitz says.

There are time demands too, he adds.

"And there are discussions of whether communication with participants will increase transparency as a whole and whether it will increase trust or enrollment," Shalowitz adds. "These are empirical questions that need to be answered."

The disclosure research found that only a minority of investigators currently disclose results to participants, Shalowitz adds.

Barriers to disclosure

Despite the evidence that participants want to know study results, there still are barriers to investigators reporting aggregate results, Shalowitz notes.

One barrier involves resources, he says.

"If it turns out that it would be very costly in terms of time and money to make those results available to participants, then there's an argument that given the [paucity] of grant funding and the demands on researchers, this is low on the list of what needs to be done," he explains.

A second barrier could be institutional, including policies and procedures that discourage or prohibit the communication of research results, Shalowitz says.

"Some institutions have policies that say, 'We don't do that sort of thing, and disclosure is not the rule,'" he explains.

Another argument is that the line between aggregate and individual results can be blurred.

"You can show that the gene is associated with the condition, so what is the impact of aggregate results when these have many similarities with individual results?" Shalowitz says.

The ethical barriers are more apparent with the disclosure of individual results.

"Investigators' No. 1 concern tends to be the impact on participants when they find out information that is still in development about themselves," Shalowitz says. "Many research interventions have not been clinically vetted, and many investigators are worried that participants will misinterpret information."

For instance, a research participant might pursue an intervention based on research results, and this could be unnecessary or an overreaction.

One example is how some women who discovered they carry the gene that leads to early breast cancer pursued prophylactic surgery by having

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their breasts removed, Shalowitz says.

Also, investigators sometimes are concerned that disclosure of individual results will require genetic counseling in an intensive, one-on-one setting, he notes.

But research suggests that participants typically are happy to receive written disclosure communication and only a minority of sensitive information would require more labor-intensive disclosure, Shalowitz says.

Consider participant reaction to results

Shalowitz and Miller researched the reactions of participants when they were given individual information from a research study.

"We found that researchers can be guaranteed that some portion of participant population will have a positive psychological response, and some portion will have a negative psychological response," Shalowitz says.

"They might feel satisfaction, relief on the positive side," he says. "Negative reactions might include anxiety, anger, guilt, and being upset."

The take-home message is that participants overwhelmingly want to receive the research results, regardless of the potential for negative reactions, Shalowitz adds.

"When asked, 'Do you want to receive research results if it makes you feel XYZ,' they overwhelmingly say, 'Yes,'" he explains.

It remains important that researchers ask the question about how disclosure will impact subjects, Shalowitz notes.

"They need to make sure they're minimizing the risk and harm to participants," he says. "And they need to make sure that overall they're doing well by participants."

The next issue is how to disclose results.

It's important to give each participant a choice of whether to receive the results, Shalowitz says.

"There is widespread belief that they should not be told results they don't want to know," he says. "The vast majority of information is disclosed on a request basis."

For aggregate results, investigators could give participants a telephone number to call for information or a web site to visit to find out the results, he suggests.

"It turns out that many participants think a written communication with results and a number provided for additional questions is a more acceptable way of receiving research data," Shalowitz says.

Disclosure likely will increase as health consumers become more accustomed to medical transparency and finding information on-line.

"It should be established empirically, but it's likely that if investigators are more open and transparent about what's going on in research that participants will be more likely to be open and trusting in researchers," Shalowitz says. ■

Best Practices Spotlight

[Editor's note: In this issue of Clinical Trials Administrator *we begin a regular feature about best practices in the research industry. Our debuts focuses on the novel and successful subject recruitment and retention practices of Southeast Regional Research Group of Columbus, GA. If your site has a best practice you'd like us to highlight in a future issue, please contact editor Melinda Young at MelindaGYoung@charter.net or by calling (864) 241-4449.]*

Southeast Regional Research Group treats clinical trials like a business

Referrals remain high, enrollment is fast

Southeast Regional Research Group of Columbus, GA, starts serious discussions about where clinical trial participants can be found even before the new trial begins.

"Our advertising and marketing department discusses where we will get patients and which advertising we need," says **Jeff Kingsley**, DO, chief executive officer of the organization, which has five active research sites in Georgia and Alabama.

Start-up speed is crucial to successful enrollment, he says.

"The clinical trials industry is moving toward more globalization because they can find patients and cut costs," Kingsley says.

But moving trials overseas is a lot of hassle and requires extensive legal work, and this means that U.S. investigators have an opportunity to increase their business if they adopt strategies that lead to faster enrollment, he notes.

"I view this trend as a sign that we're dropping

the ball," Kingsley says. "We need to ask ourselves why we can't give the industry the most benefit and what we need to do to retain the business the industry needs."

Southeast Regional Research Group has adopted professional strategies for each step of the clinical trial process to improve efficiency, enroll faster, and to operate as a business.

"If a sponsor and CRO [clinical research organization] are looking for a fast start-up too, we can be up on a study in two weeks," Kingsley says.

In an industry where about a third of trial sites never enroll a single subject, Southeast Regional's own track record is that easily 80-90% of trials meet enrollment deadlines, Kingsley notes.

"We typically go way over enrollment goals," he says. "If a sponsor wants 10 patients, I make sure there is not a cap, and I get pre-authorization to go over that number; I can come up with 60 patients if they want 10."

While improving enrollment is a top priority, it's also important to retain the patients who do enroll, Kingsley says.

To keep those patients in the study, investigators and CR staff go to great lengths, including personally visiting patients who have missed visits. **(See story on improving retention, p. 29.)**

The organization uses these specific strategies and practices to improve enrollment:

• **Customize marketing approach for each referral source:** "When we meet with a new physician we find out who really runs the office," Kingsley says. "We find out who we should contact, and we create a database that has information about whether they prefer telephone calls, faxes, or e-mails."

Once this information is collected, it's used to tailor the marketing pitch and recruitment strategies to each referral source's business, he adds.

Even the thank you is tailored to the source: "We send the ERs pizza and coffee, and on holidays, we send them special food," Kingsley says. "On Christmas Day we sent BBQ to the ERs as something unique."

The organization has even sent sushi to the ER.

"They thought that was the neatest thing in the world," Kingsley says. "We also send them thank you notes when we get a referral, and these are written both personally and typewritten."

Southeast Regional also provides referral sources with tools that make it easier to refer patients. For example, there are tear-off sheets customized for the referral sources, Kingsley says.

"The sheets give directions from the ER to our doorstep, and we have directions for the local urgent care center to our doorstep," he adds.

The marketing department staff regularly speaks with physicians and physician assistants about upcoming trials.

"We say, 'When you see your next rheumatoid arthritis patient, we have a trial that could help these people,'" Kingsley explains. "As a result we become high enrollers in all of our trials."

• **Give referral sources what they need:** "We tell our referral sources that we will never bounce a patient back to them," Kingsley says. "If the ER doctor sends a patient to us, and that patient doesn't fit in our trial, then we take care of the patient anyway — for free."

This is a relief to ER physicians and others because they need to know that when they make a referral the patient will be seen and treated. Otherwise, if the patient was referred to a research site and not enrolled in the study, then the patient might end up back at the ER for treatment of an acute episode of the same disease or problem, Kingsley explains.

Once ER physicians make a referral to Southeast Regional Research Group, they know the patient won't return to their facility with the same untreated condition.

All referral patients are given whatever medical services they need, Kingsley says.

"We think it's a huge incentive that we won't send patients back," Kingsley says.

ER physicians always are wondering whether their patients have enough money to afford a return trip to a doctor or to purchase the prescription that will heal them, he explains.

"An ER physician might see the same patient in three nights from now if the person doesn't get the prescription filled," Kingsley says. "But Southeast Regional Research Group is open 24/7, so if they send the patient here, they know the patient will be taken care of for free, and it allows the ER doctor to breathe a sigh of relief."

Even patients who can't be enrolled are treated.

For example, Southeast Regional Research Group conducts many IV infusion studies for antibiotics, and referral sources are accustomed to sending over patients for these trials.

"So right now we're in between trials for IV antibiotics, but we were referred four patients who are receiving IV antibiotics, and the cost is completely on us," Kingsley says. "We don't have a study right now, but we're maintaining our

referral sources, and that is far more valuable to us than what it costs to give these patients free care."

The word is out in the community that the research organization has this policy, and this makes ER and other physicians more likely to refer patients to the group, he says.

• **Improve quality of referrals:** Screening potential participants often is very time-consuming and expensive, so the research group has a checklist that makes the process more efficient.

Referral sources are given a one-page checklist for each study. It has highlights of the inclusion/exclusion criteria, formed as questions that physicians quickly can check as either "yes" or "no."

"The ER doctor grabs that piece of paper, puts the person's name on top and checks 'yes, yes, yes,' or 'no, no, no,' signs it, and sends it back to us," Kingsley explains. "That's done before the patient ever meets us, and it becomes a part of the patient's record, showing that another physician thought that patient was appropriate for this trial."

The checklist helps to formalize the referral process, and it serves as a good reminder to physicians about the trial, he adds.

While some physicians don't like the checklist, most do, Kingsley says.

"We've learned which physicians are very friendly to us," Kingsley says. "There are three hospitals in Columbus, and we've received referrals from all of their emergency rooms." ■

Improve your site's subject retention, follow these specific strategies

Investigators will knock on doors

It's a maxim in business marketing that it costs four to six times as much to find new customers as it does to keep existing ones.

For clinical trial sites, subject enrollment might be even costlier, so sites should work as hard as good businesses do to keep the people they already have, an expert says.

"We run research like a stand-alone business," says **Jeff Kingsley**, DO, chief executive officer of Southeast Regional Research Group in Columbus, GA.

"Too many research sites treat research as a sideline," Kingsley says.

By making a business of research and treating clinical trial (CT) participants as well as a business might treat its customers, Southeast Regional Research Group has maintained a high enrollment and retention rate, exceeding industry averages, Kingsley says.

Only about 10-20% of the trials fail to meet enrollment deadlines, and patient retention is 75-90%, depending on study length, he says.

Here's how the research group keeps retention high and trial participants satisfied:

• **Make follow-up a priority:** "It makes no sense to lose a patient," Kingsley says.

"Our job is to provide data to the sponsor that will help them present to the FDA," he says. "If a patient doesn't stay until the end of therapy, then the data are worthless."

It's also important to keep participants enrolled from the perspective of an ethical obligation to see that they are observed for adverse events (AEs), he notes.

"There are follow-up labs that look at liver, EKGs, and to lose that patient means we don't truly know whether the patient had some AE," Kingsley explains.

So, unless a subject asks to be taken out of a study, there are strong obligations on the part of the clinical trial site to keep that person enrolled.

One common reason patients are dropped from a study is that the patient simply stops showing up because of a lack of transportation or forgetting appointments.

"If patients don't have transportation, then we pick them up," Kingsley says. "If the only time a patient can come into our office is at 6 a.m., then we're here."

When patients don't respond to phone calls, the research group sends staff to their home to knock on their doors, he adds. Investigators, including Kingsley, have made these home calls.

"Everyone in the company adopts the same philosophy," he says. "If a patient says, 'I'm done and not coming back,' then he has that right."

But patients who don't return because of transportation or similar obstacles need to be helped so that they can stay enrolled, he adds.

"We have patients who don't come in for their test of cure, which typically is the last visit for a study of pneumonia or flu," Kingsley says. "We call and call and call, and if they still don't come in, we'll drive out to their house."

The investigator or clinical trial professional will say to the patient, "We care about you and want to see you at the office," Kingsley says.

"And sure enough, that person will be in the office the next morning," he adds.

"Our retention rate is very high, depending on the indication and length of the study," Kingsley says. "Across the industry, retention is 75%, and we can beat that: On an acute study that's two weeks long, we have 90% retention."

• **Make participants feel important:** When clinical trial participants are treated as if they're very important and their own needs are met, then they'll both stay in the study and return to enroll in future studies.

The CT offices have water coolers, coffee, big comfortable chairs, recliners, and a flat screen wall television, Kingsley says.

"We have patients who say 'Good-bye' to the television," he says.

"If we have a patient without a car, then we send a taxi to his home and pick him up and bring him back here," Kingsley says. "If we have patients without telephones, we provide them with a prepaid cell phone for the duration of the study."

There's no reason why a study site should lose patients because of small obstacles like the lack of telephones or cars, he notes.

In fact, some patients have returned years later, and they've referred their family members and colleagues to the research site.

"We typically pay patients, tailoring the amount to how much time they spend on the trial," he says. "Our patients will self-refer and come back to us if we have another study." ■

Create a formal initiation process and SOPs for IND clinical trials

Research office monitors educate

When a research institution is its own sponsor of investigational new drugs (INDs), there often aren't solid standard operating procedures (SOPs) for investigators.

This is an oversight that the University of Texas M.D. Anderson Cancer Center in Houston, TX, sought to rectify when a formal IND initiation process was established a few years ago.

"As our department grew, we wanted to standardize the process," says **Cathy Henceroth**, RN, BSN, manager of the office of research education and regulatory management at M.D. Anderson Cancer Center.

"We developed an SOP and working timelines and different source documents," Henceroth says. "It's been an ongoing process since 2005."

The institution's clinical trial monitors identified some of the issues that often occurred with IND trials and these experiences helped the regulatory office develop the SOP content, says **Christina Amos**, RN, CCRC, a senior clinical research monitor.

Research institutions sometimes do not have formal processes for handling IND trials, notes **Joyce E. Brown**, RN, BSN, CCRP, a senior clinical research monitor.

At the Dec. 1-4, 2007 Annual Human Research Protection Program (HRPP) Conference, sponsored by Public Responsibility in Medicine and Research (PRIM&R), the M.D. Anderson group discussed the importance of a comprehensive initiation process for INDs. It was clear from audience questions that quite a few people don't have handbooks, SOPs, or standard policies on initiation, Brown says.

A team of about five people worked on improving the IND process and revamping an existing initiation handbook, Henceroth says.

"We developed some additional SOPs and approaches to our monitoring process, and we beefed up the initiation handbook to incorporate all of those additions," Henceroth says. "It's a multifaceted, printed, spiral notebook with tabs."

The institution has about 85 open trials and has about 20-25 new INDs per year, Henceroth says.

New investigators and their teams have reported that the IND initiation SOPs have been very helpful, Amos notes.

Investigators work with different sponsors, and each sponsor has different expectations, so investigators say it's very helpful to have these expectations written out in a 100-page handbook, Amos adds.

Here are some examples of how the institution has improved its initiation process for IND trials:

• **Make the initiation handbook a comprehensive resource:** The office of research education and regulatory management beefed up the original initiation handbook to include comprehensive

instructions on how to handle data collection, general monitoring, deviations and violations, protocol revisions, and other CR items.

"We have a section to talk about the study drug, and we included SOPs on how we talk about drug accountability," Henceroth says. "We share a sample patient diary so they have that to review as well."

The handbook discusses source documentation, providing guidance on how to write a note to file, and it includes samples of institutional forms used for tracking and utilization of source document, she adds.

"We have a section on informed consent that has all the current SOPs for obtaining informed consent, and we go over that process in detail," Henceroth says. "We have a section that talks about the cohort summary and an interim analysis, and we have one section that deals with adverse event reporting and recording and what the expectations are for tracking SAEs at M.D. Anderson."

The handbook is updated periodically.

Also, the handbook's information is used for educating clinical trial staff and investigators.

They bring the handbook to initiation meetings with the research staff, she notes.

Also, copies are given to the PI and research coordinator, Henceroth says.

"My senior monitors are taking this one step further and are developing a PowerPoint presentation that is [like] the handbook," Henceroth says. "But instead of didactic reading, it will be a presentation that mirrors the handbook."

• **Create a clarification list:** "We do a complete review of the protocol and informed consent, and then we create a clarification list," Amos says. "We identify any inconsistencies or issues that might need attention from the principal investigator or research team."

The clarification list is an Excel spreadsheet with a column for clarification and questions, Henceroth says.

It clearly demonstrates where the protocol specified one particular procedure and where the informed consent document did not agree.

"The final column is a place for discussion or remarks from the principal investigator," Henceroth says. "The PI can put in a response of 'We'll amend the informed consent to match the protocol.'"

Then the clarification list with all of the questions and responses as agreed by the research team and monitoring team are attached to the initiation report, Henceroth says.

Monitors send those issues to investigators so they can be prepared to address them before or during the initiation meeting, Amos adds.

"Sometimes we'll uncover small things that prevent them from opening their trial," Henceroth says. "For example, the language may not be correct between the informed consent and the protocol."

Both Henceroth and the monitor assigned to the protocol will review it, Amos notes.

"We'll have two sets of eyes looking at it, and then we'll meet to discuss any issues with it," she adds.

"One common issue is the documentation of birth control," Amos says. "The protocol will say that patients need to be on a formal birth control method, and so I'll ask what type of birth control the patient will be using."

Other common red flags involve whether the eligibility requirements make sense and how they will be documented, Henceroth says.

"We review the abstract, informed consent document, and the protocol to make sure they all say the same thing," she adds.

Any problems identified in the protocol will be noted on a statement that is given to investigators before initiation of the trial, Amos says.

"We like to send the information to them ahead of time so they can make the necessary revisions," she says. "We try to give them enough time to have that done so they can start enrolling patients."

• **Focus on time frames:** "One thing we've found that's common when physicians write a protocol is that the protocols are usually concrete," Amos says. "There are no parameters, such as time frames for conducting diagnostic tests, and there are no parameters for evaluations and follow-up."

So monitors will remind investigators that protocols should not be so exact because patients will not always come in on precisely the correct day for a visit or procedure, she says.

"We ask the CR team to include parameters so that as long as the visit is made within the time frame, allowing some variance, then they won't be constantly writing deviation reports," Amos says.

It's also a wise idea to provide more flexibility on the time frames listed for the visits. Instead of saying a visit won't take longer than 60 minutes,

the protocol should provide safe time parameters. This will help prevent the CR staff from writing up numerous violations, she adds.

When investigators hear these suggestions, they typically agree, Henceroth says.

"They don't want to violate their protocol," she says. "With some things you can have a sizeable variance, and with others you can't."

• **Educate investigators about some common problems:** One of the common issues that occurs with investigator protocols involves adverse events, Amos says.

"We try to have physicians identify in the protocol how they are going to track adverse events," she says. "Because we have a lot of leukemia protocols, there may be expected AEs that PIs won't need to track."

The monitors don't want them to report all toxicities that occur when many of these are common and expected.

"An investigator will say he'll record all toxicities per National Cancer Institute criteria, but he's not thinking about it closely," Henceroth explains. "So we'll say, 'Then, we'd expect every single toxicity recorded and tracked.'"

But this isn't always possible because some AEs, like anemia, are so common that investigators really don't want to track these, she adds.

"The way we scrutinize a protocol is with a monitor's eyes, which is totally different than other eyes," Henceroth says. "The protocol has to be very practical, and it has to work." ■

Expert offers specific strategies for improving recruitment in rural areas

Key is to use influential locals

Recruiting clinical trial participants is rarely easy, but finding subjects in rural areas where transportation and trust are big obstacles can be particularly challenging.

"You need to be really familiar at the community level to understand the population you're seeking knowledge about," says **Shannon Golden**, MA, a research associate at Wake Forest University Health Sciences in Winston-Salem, NC.

Golden has worked on a Centers for Disease Control and Prevention grant that had researchers conduct focus groups throughout West Virginia to get people with diabetes to talk about their self care.

"I can't think of a more rural place than West Virginia to get this experience of recruiting rural volunteers," Golden says.

"Because of the rural environment, there were geographical barriers where people didn't have access to health care," Golden explains. "They didn't have access to people they felt were approachable, such as doctors they could trust."

Also, there were few specialists in these rural regions, so the rural populations were underserved for their medical needs, she adds.

Finding people to participate in the focus groups was a similar process to finding patients to screen for clinical trial enrollment, and Golden developed some specific enrollment strategies as a result. Here are her suggestions for improving enrollment in rural areas:

• **Find central gathering places and gatekeepers:** "We spent a lot of time in the community, finding the central gathering places," Golden says. "It might be a local convenience store that draws a crowd, or it could be a fast food restaurant."

The key is to find areas where CT marketing processionals or recruiters can hang fliers or schedule a town meeting to discuss an upcoming trial, she adds.

"The bottom line is that you're an outsider," Golden says.

So when CT professionals meet with people at the common watering hole, they'll gain a better understanding of the trust issues and priorities of the community.

And this is also the way to identify gatekeepers. Gatekeepers are the well-trusted people who have influence over others in the community, Golden says.

"Gatekeepers sometimes are professionals, but often they are not," she says. "A gatekeeper could be a local nurse or a librarian, or it could be the old lady in the corner house, who has lived there since she was born."

"These are the trusted members of the community, who will help you promote your study," Golden says. "By working with them, you gain legitimacy and acceptance."

• **Approach the community's professionals first:** "You start with the professionals because

you talk the same language, and you can promote your purpose with more clarity there," Golden says. "So when you're conducting health research, start with the diabetes educators, nurses, or home health aides."

These professionals will help CT staff identify community-level gatekeepers and people who might be willing to enroll in a study.

"They're your avenue to that person's doorstep," Golden says. "There are two tiers of gatekeepers: the ones at the professional level who speak the same language as you, and they're the ones who can point you in the right direction for the community folks, who are not necessarily professionals."

Community gatekeepers might help CT professionals gain access to the local church group or knitting circle, she adds.

This process can take time, particularly when a rural community is self-sufficient and not as interested in the benefits of participation in research.

"If you're writing a grant, you should budget six months for really good community entry work," Golden suggests. "You'll attend local events, attend town meetings and show up for stuff without always promoting your study."

One CT professional could handle this community introduction work for many studies.

"But if you will have a group of clinical research people descend on the community, then you will want all of their faces and names around the area before the study begins," Golden says. "If there are town meetings and group activities, then you will want to attend those."

• **Hire local people on the research team:** "If your research team is not made up of local people, then you should hire from the community for your team," Golden suggests.

"The CR team can place ads in local papers, describing the job," Golden says. "We try to get the point across [in the ads] that people have to be flexible and approachable."

Once applicants respond, it's good to screen them for basic job-holding skills, but the resume takes backseat to the interview.

"To find someone local, we interviewed in the community," she says. "And the funny thing is that the interview is more important than anything on their resume."

Through a job interview, investigators will learn how well the person presents himself or herself, and there will be clues to how well the potential employee is accepted in the community.

"They might have suggestions at the interview about what might work and not work in the recruitment efforts," Golden says. "They know the local politics."

A CR team member from the community will understand the nuances of connections in the community as recruitment begins.

For instance, it's possible that the CR team has been listening to a very vocal community member who happens to be disliked in many circles. Just having an association with this person might dampen enrollment, Golden says.

The local member should help the team steer clear of these problems.

It's these people savvy and political skills that are more important than experience in finding the right person for the job, Golden notes.

"Some of the best people we've hired in communities had no health training at all," she says. "We trained them to do data collection and finger pricks."

• **Have local CR workers be the project's front:** "We want the community hire to lead the research team by being a face on the project," Golden says. "This is the contact person who becomes our key gatekeeper."

The local folks are invaluable to the project.

"You invest a lot of trust in your new research team member, who will give you wise advice on how to maneuver the community successfully," Golden says. "We've had some projects where we allow the local person to perform the interviews rather than the principal investigator because she's the one who the community will relate to."

The PI's academic credentials might intimidate potential participants, she adds.

• **Recruit community gatekeepers to help with recruitment:** "You can place newspaper advertisements, announcements in church bulletins, and buy radio spots," Golden says. "But truly and honestly, these are all less effective than having a really good gatekeeper."

The community CR team member can assist with recruiting community gatekeepers who will talk positively about the study at their PTA meetings and sewing circles, Golden says.

"More often than not they are not compensated and do the work all for good will," Golden says.

But there are ways to pay back these recruitment volunteers.

"For example, in a study with focus groups, we were able to recruit volunteers for a gatekeeper

pool," Golden says. "And after the focus group we had medical students on rotation answer questions by the focus group about diabetes."

Although the volunteers weren't paid, they did receive an incentive of having access to medical experts.

"If we were in touch with a certified diabetes educator, we might promote her availability to a local diabetes support group," Golden says.

If a CR team is holding a group meeting for local residents, then it's a good idea to provide daycare services, she notes.

"If your grant presents a problem, then you could always find a Girl Scout troop that would benefit from community service," Golden says. "Find a location that's neutral and accessible and that has facilities conducive to what you're trying to achieve."

Other incentives include providing snacks and beverages at group meetings.

"We always offer refreshments," Golden says. "In the past, what we have also done is if we work closely with senior centers, we'll reward them by donating a large bushel of apples or other fruit."

The important thing is that community gatekeepers and local organizations remember the CR team and realize that researchers thought they were important to the project, she adds.

Rewarding organizations that assist in recruitment is a good way to ensure future assistance.

"We've given senior centers gift baskets for letting us do a recruitment session at their facility, or we might have a raffle where we give out tickets and pull out names for individual baskets," Golden says. "That way the senior center feels thanked and appreciated for their efforts to get their clients there for us." ■

Create a prospective fiscal approval process for research trials

Centralized process creates efficiencies

One major academic research institution has developed a process for prospectively checking protocols for fiscal responsibility and compliance.

"We started this process two years ago," says **René Jooste**, MPharm, CCRP, a clinical trials billing officer at the office of human research at the University of Alabama at Birmingham.

"We piloted this process in the beginning with a high area research group, the oncology department," Jooste says. "As we progressed through it, we added some more units and have a big area of the campus involved with this now."

The prospective fiscal approval process was implemented for two reasons, Jooste says.

"One was to be in compliance and see that all activities performed on clinical trials are performed correctly and to follow all laws and regulations," she explains. "The other reason is to assist investigators in getting budgets properly negotiated."

The key to the latter reason is to create costs of what an institution should be, Jooste says.

Investigators send the fiscal approval office a packet of information, including the following:

- the protocol;
- the informed consent document;
- the clinical trial agreement with the sponsor; and
- a proposed budget, departmental budget, or sponsor's budget.

"In our office, we review this protocol or research trial, and we tease out all the activities required by the trial, which have the potential of clinical billing," Jooste says. "Those items with the potential of clinical billing are the ones that could go to the patient's insurance or to the sponsor."

Any research procedure that has the potential for billing both a patient's insurer and the sponsor is reviewed by the office, she adds.

Another task the office has tackled involves reaching an agreement with other departments for establishing a research fee schedule, Jooste says.

Jooste negotiated with various departments about their fees, essentially reaching agreements that are very close to Medicare rates, she says.

"So if you were to do some kind of study in one area of the campus, and it's research-related, the cost to a sponsor is the same, and there's no need to negotiate a deal with individual doctors," she says.

For example, the research fee schedule details the cost of a chest X-ray that is done on campus.

"We look at what it costs to get clinical services performed at UAB," Jooste says.

"What we charge the sponsor is something different," she adds. "We don't get involved with

the complete budget, such as how much to charge the sponsor for nursing hours and going to meetings."

Jooste's office only is concerned about the items that could be billed to insurance and to the patient.

The prospective fiscal review is conducted on an Excel spreadsheet that lists items, visit by visit in the protocol. The research fees are included.

"Once [the CR team] gets that back they can go back and develop the complete budget," Jooste says. "They can add to our spreadsheet the personnel costs, IRB costs, and other things they need to do, and they also need to decide how much they want to charge the sponsor for doing this."

For example, the typical scenario is that a sponsor will come to the principal investigator to offer X amount for enrolling patients in the study, Jooste explains.

The PI has to decide whether this will cover his or her costs. The prospective fiscal analysis helps the PI make this decision.

"I would say that the contribution we make is basically providing investigators with the research fee costs, but it's only a part of the feasibility assessment," Jooste says. "Then you have to add time and other administrative costs and overhead, and we don't get involved with that."

While the office doesn't assist with the budget negotiations and budget feasibility much beyond the research fee and protocol/informed consent review, there is a possibility that the role will be expanded.

"People are curious of whether we might get involved in a complete budget process in the future," Jooste notes. "We haven't excluded that for future plans."

The spreadsheet analysis also assists the institution with billing compliance, Jooste notes.

"This information is very helpful to people in the billing offices, which have to prepare bills for patients, insurance companies, and sponsors for things going on in clinical trials," Jooste says.

The feasibility office also assists investigators with checking language in the informed consent forms.

"We typically concentrate on making sure information in the document agrees with what the protocol has shown to be the costs of having the patient participate in the trial," Jooste says.

For example, if the protocol mentions possible out-of-pocket costs for patients or their insurance companies, then the informed consent document should have language about these, as well.

"Sometimes when we review the protocol there is a discrepancy between what the protocol states, how things are to be billed and who pays for specific procedures, and these are not consistent with the informed consent document," Jooste explains.

Another part that Jooste checks is that specific items that are billed to a patient's insurance company will not have local coverage issues, excluding a certain drug or procedure from insurance reimbursement.

"So if something like that is an issue on a protocol, then we want to give investigators information about coverage and potential problems," Jooste says. "We'll assist him with feasibility

CE/CME Objectives / Instructions

The CE/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

- The VA leads way on master CT agreements
- Determine feasibility of enrolling patient population
- Resolve consent challenges of translational CTs
- Check out research tool with approval action plan

problems that might require a PI to go back to the sponsor and say that we'd planned it this way but will have coverage problems."

Since the institution began prospective fiscal feasibility reviews, PIs have been much more accurate in their budgeting, Jooste notes.

"It still remains a very complicated process to tease out everything on your study, but having it synchronized remains a big help," she says.

Prior to the reviews, each investigator would call the various departments to negotiate his or her own fees. Now they need only make a submission to the feasibility office to obtain the information they need, Jooste says.

"It's centralized the whole request procedure, and that's been very beneficial and cut time for the internal staff," Jooste says. ■

CE/CME *questions*

9. According to recent study result disclosures research, most research participants do *not* want to hear the results of the study in which they participated.
   A. True
   B. False

10. Which of the following is a good recruitment strategy for clinical trials?
    A. Customize marketing approaches for each referral source
    B. Give referral sources what they need
    C. Improve quality of referrals
    D. All of the above

11. Which of the following is a common mistake physicians sometimes make when writing protocols for INDs?
    A. Often recruitment expectations are too low.
    B. Sometimes they write too concretely, providing no parameters and time frames for conducting diagnostic tests.
    C. Typically, they have poor methodology built into the protocol.
    D. None of the above

12. In recruiting for a study among rural communities, which of the following is *not* a good strategy for increasing enrollment?
    A. Approach local professionals to find out where and who might help with local recruitment.
    B. Find local gatekeepers, the people who are well-trusted in the community and who might help with local recruitment through word-by-mouth.
    C. Provide small incentives to local organizations, including gift baskets, for holding meetings and assisting with recruitment.
    D. Send investigators into the community to talk about their credentials and plans for publishing the research

Answers: 9. (b), 10. (d), 11. (b), 12. (d).