Want to Get the Most Out of Patient-centric Trials? Make Sure They're Site-centric, Too

PEER REVIEWED

The push by pharma companies to develop more targeted compounds in response to unmet medical needs, and the large return on investment these successful therapies generate, has led to what Dr Peter Bach, director of the Center for Health Policy and Outcomes at Memorial Sloan Kettering Cancer Center, calls an "exuberant rush to market."[1]

One consequence of this rush is the increasing difficulty of recruiting and retaining patients with the disease condition and precise genetic profile for which a therapy is intended. This is an industry-wide challenge for developers trying to get needed new drugs to market faster and more cost-effectively.

The competition for patients is not limited to cancer and precision medicine; it is not disease-specific. Any successful clinical trial depends upon the expeditious enrolment of the target patient population.

Aware of this problem, many developers, and the clinical research organisations (CROs) that assist them, have adopted an increasingly patient-centric approach to trial design that optimises study protocols to achieve a balance between the need to generate adequate safety and efficacy data for regulators and the need for patient-friendly elements (tailored to the target population), such as:

- Less onerous schedule of assessments/interventions;
- Easier access to clinical trial investigators and sites;
- Patient support (for example, assisting with childcare during site visits); and
- A focus on patient quality of life during the trial.

However, as the nexus for patient recruitment is hospitals and clinics – the trial sites – developers benefit from combining patient-centricity with site-centricity, working to actively reduce the burden on sites (as they are attempting to do for patients) and generally improve the clinical trial experience for front-line clinical staff while addressing the pain points that have led some centres to decline trials. Indeed, due to these pain points, Yale Cancer Center today participates in fewer than 10% of the clinical trials it is asked to join.[2]

This is a growing problem in the competitive field of clinical research and it requires thinking about sites in much the same way developers and CROs think about patients.

A Strong and Meaningful Relationship with Sites is Critical to Successful Trials

When done correctly, site-centricity flows naturally from patient-centricity. And while patients, of course, are the main beneficiaries of successful clinical trials, there also many benefits for the hospitals and clinics that participate in them. Most importantly, trials provide hospitals an opportunity to offer their patients potentially effective medicines that can extend and improve their lives. They also provide a scientific adjunct to the ethos around evidence-based medicine and financial support to extend services and pay for staff that can offer patients better care. And they can enhance the reputation of healthcare organisations, allowing them to publish in prestigious medical journals and thereby improve physician and patient recruitment.

However, despite these benefits, participating in clinical trials poses difficulties for hospitals and clinics already overwhelmed by changes in reimbursement policies, buried in paperwork, and grappling with ever more complex protocols. In the decade from

2002 to 2012, the average number of endpoints included in a pivotal trial nearly doubled, and the average number of procedures that a trial participant underwent rose from 106 to 167 – an increase of 58%.[3]

It is up to pharma developers and CROs to help investigate how sites deal with the challenges of clinical trials by cultivating long-term strategic relationships with them. This can ease the burden of site start-up, provide support and knowledge throughout the duration of a trial, and ensure effective and efficient communications, achieving the goal of bringing needed medicines to market as swiftly as possible.

Address the Pain Points for Sites

1. Executing the Confidentiality Disclosure Agreement (CDA)

As the CDA – which assures the confidentiality of the developer's protocol – must be signed and agreed upon before a hospital or clinic can even assess whether it has a patient population suitable for a trial (or has the capability to enroll one), the time (it can take as long as two weeks) and effort the clinic spends on paperwork may end up being wasted. To address this issue, PAREXEL created the Site Alliance Network (SAN) of approximately 350 sites that all have a signed general business agreement – with confidentiality baked in – that needn't be revisited, thereby relieving SAN members of excessive and duplicative paperwork. Piloting the electronic CDA process with simple "click-through" capability is another way to streamline the process.

2. Bridging the Communication Gap between Caregivers and Developers

When principal investigators (PIs) and nurses – fresh from the front lines of patient care – meet with the CRO or pharma company personnel running a trial, their interests do not always perfectly align. While the patient is front-and-centre for caregivers, CROs and trial sponsors, while never ignoring patient welfare, are focused on a trial's proper conduct. Bridging this potential gap requires a strong, ongoing personal relationship between the caregivers and the individuals responsible for the trial.

It is crucial for CROs and developers to see the site's doctors and nurses as critical stakeholders in the process and expand the traditional role of clinical research associates (CRAs) from simply monitoring trial data collection to serving as relationship managers. To reflect those increased responsibilities, CRAs should be called clinical site managers (CSMs). A CSM is not only responsible for delivery of the basics (quality data, logistics excellence, protocol compliance, etc.) at a single site at any given time, they are also in charge of building relationships with the investigational team.

In the past, CROs were perceived by sites as working for pharma companies, service providers who would come and go. The site-CRO relationship should instead be considered a long-term partnership. Working as partners to resolve issues between investigators, caregivers and study monitors creates goodwill for future studies, rather than a short-term "one and done" approach. It provides predictability and allows trials to be run more efficiently by building on experience. It also enhances the relationship between key site staff and CRO staff who can communicate with greater trust and accountability in the context of an ongoing relationship.

3. Point of Contact

Clinical trials are complex, with many moving parts, and there are always problems that need to be resolved. Naturally, site staff want to be kept up to date on the status of a trial: Is it on track? Was it cancelled? Frequently, however, the controlling authorities at the site don't know to whom to bring their issues and questions: To the pharma company? To the CRO?

Therefore, it is vital to provide each institution in its network a single point of contact: the Site Relationship Manager (SRM). SRMS are provided to the largest institutions/sites which conduct several clinical trials in parallel. SRMs operate at the site level, not the study level, and act as a liaison between CROs and the sites. Alliance institutions nominate a single point of contact (SPOC) to work directly with the SRM to identify efficiencies and drive both start-up and recruitment. This arrangement also allows sites to be involved from the early stages of protocol development, offering expertise from PIs and key opinion leaders (KOLs) on protocol design and patient recruitment strategies. While clearing up confusion, this practice also accelerates the conduct of the trial because everyone at the site knows who to ask when they have a question.

4. New Technologies

The adoption of new medical technologies – electronic medical records (EMRs), electronic health records (EHRs), new wearables and monitoring devices – tend to be driven by the back-office, IT. Increasingly, CROs are using more devices, as well as new and advanced risk-based monitoring systems, and multiple websites that require doctors and nurses to keep track of many logins and passwords.

In CROs' relationships with the clinical site organisations, tests can be carried out on every new technology to ensure that it is not a solution in search of a problem. There is no purpose to introducing new technologies to sites, or scrapping tried-and-true procedures, if they create new problems for doctors and nurses treating patients. For example, a new way to automate the distribution and receipt of clinical medications was piloted at a handful of UK sites. Before implementing it broadly, site staff got to use the technology and provide constructive feedback to ensure that the final product would work smoothly in the real world.

Patient-centricity and Site-centricity are Two Sides of the Same Coin

New targeted, genomic-based medicines, combined with accelerated regulatory mechanisms for drug approval, plus the hypercompetitive nature of an increasingly fragmented pharma space, have only increased the importance of the timely recruitment (and retention) of eligible patient populations. But the only way to access these populations (even with the myriad of patient outreach methodologies that exist) is via the sites.

Accordingly, pharma developers and CROs should develop a site-centric approach that aligns with and reinforces their quest for patient-centricity, viewing both sites and patients as partners in the work. A site-centric approach means seeking out and listening to sites: eliciting their feedback and addressing their concerns as expeditiously and effectively as possible.

Data show that site-centricity works. One CRO is able to demonstrate sites with active relationship management outperform those sites without an SRM, resulting in patient recruitment rates 50% higher on average, an improvement observed across all therapeutic areas. In addition, investigator satisfaction is greater at those sites managed by an SRM.

A site- and patient-centric approach generates a virtuous circle. Focusing on the site means focusing on physicians and nurses, the air traffic controllers of patient care. That improves the patient experience and increases compliance, which improves R&D efficiency. In short, patient- and site-centricity go hand-in-hand. You can't have one without the other. At least, not successfully.

REFERENCES

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