Communities as Partners in Cancer Clinical Trials: Changing Research, Practice and Policy

Report Summary
Communities as Partners in Cancer Clinical Trials is supported by grant number 1-R13-HS016471 from the Agency for Healthcare Research and Quality (AHRQ), with co-funding from the National Cancer Institute (NCI).

The project also received financial support from the American Society of Clinical Oncology, Genentech, GlaxoSmithKline, the Intercultural Cancer Council, the Lance Armstrong Foundation, the California Breast Cancer Research Program, the Wellness Community, and the University of Michigan Comprehensive Cancer Center.

Any opinions, findings, conclusions, or recommendations expressed in this publication do not necessarily reflect the views of the individuals or organizations that provided support for this project.

Why Multi-site Therapeutic Phase III Cancer Clinical Trials?
Multi-site therapeutic phase III cancer clinical trials are the focus of this initiative for a number of reasons:

1. They are designed nationally by public or private sponsors but implemented locally, providing opportunities for community engagement at both national and local levels.

2. More than 20,000 people with cancer participate each year in NCI-sponsored phase III trials, making them the most common type of trial in which cancer patients participate.

3. Community engagement strategies have not yet been implemented systematically in cancer treatment trials as they have to some degree in large cancer screening and prevention trials.

[Public] distrust of medical research is firmly entrenched and is a significant obstacle to clinical trials participation... Involving the community...in assessing the need for specific studies and in planning and conducting the research itself, has proven effective in overcoming distrust... Specifically, communities must be involved early in research protocol development, and researchers must ensure that the community benefits from participation and receives research results. Further, the expertise of cancer advocates and survivors, who can help maintain a patient-centered focus on research projects, could be utilized more fully. Community involvement and support is particularly crucial to ensure the sustainability of interventions shown to be of benefit.¹

President’s Cancer Panel
Translating Research into Cancer Care: Delivering on the Promise
June 2005

Introduction

Less than three percent of all adult cancer patients participate in clinical trials. The accrual rate is even lower among people of color, older people, and the medically underserved, who tend to have higher cancer mortality rates than the population as a whole. These low numbers compromise the value of clinical research and raise important questions about access to quality care and social justice for all communities affected by cancer.

In recent years, a number of reports have called for the inclusion of public representatives in research design and implementation to address low accrual and improve research outcomes. Communities as Partners in Cancer Clinical Trials: Changing Research, Practice and Policy, a national initiative spearheaded by the Education Network to Advance Cancer Clinical Trials (ENACCT) and Community-Campus Partnerships for Health
(CCPH), with core funding from the Agency for Healthcare Research and Quality (AHRQ) and the National Cancer Institute (NCI), is exploring the potential for improving multi-site, therapeutic phase III cancer clinical trials through the use of community-based participatory research principles and approaches. *Communities as Partners* is the first national report to detail why and how the cancer clinical trial process can involve communities affected by cancer – from trial design to implementation to dissemination of results - with a focus on community engagement strategies.

Over a two year period, ENACCT and CCPH assembled a diverse group of stakeholders - including Federal agencies, patient advocacy and community-based organizations, cancer centers, oncology practices, health professional schools, the pharmaceutical industry and health care professional societies – to develop recommendations for improving accrual rates and addressing persistent disparities in phase III therapeutic cancer trials.

**The Promise of Community-Based Participatory Research Approaches to Addressing Clinical Trials Disparities and Accrual Challenges**

Central to many successful initiatives that seek to understand and improve the health of underserved groups – especially people from racial and ethnic minority groups and those with low socioeconomic status – are participatory models in which communities are actively engaged in the research process through partnerships with researchers.2,3 Community-based participatory research (CBPR) can be defined as an approach to “scientific inquiry conducted in communities in which community members, persons affected by the condition or issue under study and other key stakeholders in the community’s health have the opportunity to be full participants in each phase of the work, including conception, design, conduct, analysis, interpretation, conclusions and communication of results.”4

A 2004 AHRQ Evidence Report suggests that the utilization of CBPR can improve research quality, enhance intervention quality, improve outcomes, and enhance research recruitment efforts.5 Although CBPR has been more often utilized in public health research,6 we believe that the principles and approaches of CBPR can be systematically and integrally incorporated into many aspects of clinical research design and implementation. A CBPR approach to cancer clinical trials holds the potential for ensuring:

- Well-designed, high quality, cost-effective trials that will accrue, in a timely manner, sufficient numbers and diversity of patients
- Trials that are more universally relevant to the real lives of patients
- Enhanced community trust of researchers, research institutions and the research process
- Enhanced dissemination of research findings to the public and community clinicians

**The Definition of “Community” in the Context of this Report**

For the purposes of this report, we adopt the definition of community advanced by the Centers for Disease Control and Prevention: *those whose participation is necessary for the implementation of the research and whose well-being is likely to be affected by the conduct of the research.*7 Although cancer treatment trials solely enroll patients with cancer, there are many “communities” affected by cancer. Those groups that are disproportionately affected by cancer morbidity and mortality should be well represented in each component of phase III cancer clinical trial design and implementation.

Currently, many cancer patient advocates provide critical input into the design and implementation of clinical trials at both national and local levels, and their work is essential to the success of cancer research. However, we believe that to reap the full benefit of community engagement in phase III cancer clinical trials, we need to increase their numbers, strengthen their roles and be more inclusive of all communities whose participation is necessary for the
implementation of the research and whose well-being is likely to be affected by the conduct of the research.

When considering who best represents the community perspective in multi-site therapeutic phase III cancer clinical trials, we recommend that the cancer clinical trial research system strive to include both community representatives and patient advocates, recognizing that both are essential to the research process:

- **Community representatives** have experience with the healthy population at risk and ideally are affiliated with a community-based organization or group whose constituency is disproportionately affected by cancer.

- **Patient advocates** have experience as a patient with cancer, caregiver or family member and ideally are affiliated with a cancer advocacy organization or group.

Throughout the document, we refer to them collectively as “community representatives/patient advocates” or “CR/PAs.”

### Challenges to Implementing the Communities as Partners Recommendations

**Funding:** We recognize that lack of funding is a critical barrier to implementing certain recommendations, and are cognizant of concerns about “unfunded mandates.” However, these recommendations should be viewed as goals to be achieved over time. They are intended to serve as a strategic plan for key stakeholder discussion and implementation. Some recommendations are quite ambitious, requiring a reallocation of resources. Others can be implemented relatively quickly, with little or no need for additional funding. We suggest that stakeholders consider our recommendations in their efforts to enhance trial design and accrual.

**Evidence:** In the course of this project, some have suggested that in the absence of strong evidence that CBPR can improve the quality of cancer research, accelerate protocol development and review, or increase the rate of accrual, such approaches should not be implemented. However, national groups and reports have repeatedly called for the inclusion of public representatives in the design and implementation of clinical research based on the evidence from CBPR approaches in other health areas, which demonstrates its promise in addressing accrual challenges currently faced by cancer clinical trial sponsors and investigators. The Communities as Partners initiative has heeded these calls for action, and sets forth specific recommendations for including public representatives throughout the cancer clinical research continuum.

**Additional time requirements:** Concern has been expressed that the expanded use of patient advocates and community representatives throughout the clinical trial enterprise will slow down a system already overburdened with regulation and bureaucracy. It is important to note that concurrent to this project, NCI, through its Coordinating Center for Clinical Trials (CCCT), is spearheading efforts to address systemic challenges within the clinical trials system. Moreover, while initial implementation and set-up of the more ambitious recommendations in this report may be time-consuming, we believe that with careful implementation, they will not add to time burden, and can ultimately address accrual challenges currently faced by cancer clinical trials sponsors and investigators.

### Recommendations for Community Engagement in Multi-site Therapeutic Phase III Cancer Clinical Trials

Our 58 recommendations center around seven broad themes, which help to define the involvement of communities in the development and implementation of phase III cancer clinical trials. The complete report details these recommendations with a full rationale, as well as an extensive appendix, with strategies and resources for implementation. The full report, with recommendations and appendices, is available at: www.communitiesaspartners.org.
I. Ensuring a Meaningful Role for Community Representatives/Patient Advocates (CR/PAs) in Phase III Cancer Clinical Trials

The vital role of patient advocates in clinical research design and implementation is well documented; and it is important that we continue to broaden existing advocate involvement in clinical research through expanded opportunities for both community representatives and patient advocates. However, if CR/PAs are to be ethically and meaningfully involved in the research process, the system itself must ensure fairness, transparency, training, clear role definition, and meaningful integration into the larger research process.

We recommend that public and private sponsors of phase III cancer clinical trials:

6. Implement specific approaches to appropriately recognize, support and compensate CR/PAs serving at the national level for the services they provide.

7. Acknowledge, promote and publicize the ongoing important role of CR/PAs in the national research process.

We recommend that local research sites implementing phase III cancer clinical trials:

8. Implement training for local level CR/PAs to prepare them sufficiently for the activities they will undertake.

9. Implement training for individual investigators and research teams on optimal ways to integrate CR/PAs into local level research activities.

10. Implement specific approaches to appropriately recognize, support and compensate CR/PAs serving at the local level for the services they provide.

11. Acknowledge, promote and publicize the ongoing important role of CR/PAs in the local research process.

We recommend that

1. Ensure that the application and selection process for community representatives/patient advocates (CR/PAs) serving at the national level is open and transparent. Opportunities to serve should be widely communicated both to traditional and non-traditional sources of potential candidates.

2. Ensure that the roles, responsibilities, expectations and length of service of CR/PAs serving at the national level are explicit, well-defined and adequately communicated to all parties involved.

3. Ensure appropriate training for CR/PAs serving at the national level to prepare them sufficiently for the activities they will undertake.

4. Support appropriate training for CR/PAs at the local level, to prepare them sufficiently for the activities they will undertake.

5. Support training for individual investigators on optimal ways to integrate CR/PAs into research activities at both the national and local levels.

continued
II. Ensuring Community Perspectives in the Institutional Review Board (IRB) Review Process

Although phase III trials are designed nationally, IRBs play an important role not only in approving the study from an ethical perspective, but also in ensuring locally appropriate consent and recruitment activities. IRBs present an important and often overlooked opportunity for community participation.

We recommend that IRBs that review phase III cancer clinical trials, including the NCI Central IRB:

1. Be comprised of 25% community IRB members who are properly oriented, trained, mentored and compensated by the IRB sponsoring institution.
2. Ensure that all members are trained in strategies for community engagement in research, and oriented to community member roles on the IRB.
3. Consider evidence of community engagement in and community support for studies seeking IRB approval.

We recommend that investigators submitting phase III cancer clinical trial protocols to IRBs:

4. Include evidence of community engagement in and community support for the study.

We recommend that the Association for the Accreditation of Human Research Protection Programs include in its accreditation standards that IRBs:

5. Be comprised of 25% community IRB members who are properly oriented, trained, mentored and compensated by the IRB sponsoring institution.
6. Ensure that all members are trained in strategies for community engagement in research, and oriented to community member roles on the IRB.
7. Consider evidence of community engagement in and support for studies seeking IRB approval.

III. Improving the Informed Consent Process

The complexity of the informed consent process presents a formidable barrier to clinical trial entry, particularly for underserved populations. Existing tools that may improve the informed consent process - including the OHRP-approved “short form” and patient navigation – are underutilized in the cancer clinical trial system. Moreover, additional approaches to address the needs of non-English speaking, Limited English Proficiency (LEP) and low-literacy individuals in the informed consent process are sorely needed.

We recommend that the Office for Human Research Protections (OHRP) and the U.S. Food and Drug Administration (FDA):

1. Provide guidance on and encourage use of the OHRP-approved “short form” and its accompanying procedures with IRBs and investigators.
2. Monitor and manage quality improvement efforts to address ongoing challenges to the consent process.

We recommend that IRBs reviewing phase III cancer clinical trials, including the NCI Central IRB:

3. Ensure that all members are trained in approaches to address the needs of minority, low-literacy, poor and elderly, underserved, and Limited English Proficiency (LEP) populations in the informed consent process.
4. Permit use of the OHRP-approved “short form” and its accompanying procedures if submitted by an investigator.

We recommend that public and private sponsors of phase III cancer clinical trials:

5. Promote and encourage the appropriate use of the OHRP-approved “short form” and its accompanying procedures, with specific recommendations for its use in the field.
We recommend that local research sites enrolling patients in phase III cancer clinical trials:

6. Consider using the OHRP-approved “short form” and its accompanying procedures in the consent process.

7. Implement the consent process through trained staff, including, when available, patient navigators who can assist in the consent process at the patient’s request.

8. Utilize trained medical interpreters or a telephone language line for LEP individuals, throughout the informed consent process and when consent forms are not available in the individual’s native language.

As the leader of the National Cancer Program, we recommend that the National Cancer Institute:

9. Develop policies for optimal ways to use the OHRP approved “short-form” for Cooperative Group trials, complementary to the existing template.

10. Develop policies and procedures for improving the consent process for LEP populations participating in Cooperative Group trials, including translation of forms and questionnaires.

11. Conduct research on optimal ways to implement the informed consent process beyond the written page, allowing for differences in learning styles (e.g., the use of pictures and videos), which will provide replicable practices for local research sites.

12. Expand funding for patient navigation programs, to include assisting in the informed consent process.

IV. Ensuring Community Perspectives in Protocol Development, Trial Design and Implementation

At the national level, trained CR/PAs should be actively involved in protocol development and trial design. By contributing their perspectives to decisions involving eligibility criteria, informed consent and site selection, CR/PAs can improve trial design and implementation. At the local level, community engagement in trial implementation requires partnership building between investigators and communities, and the development of reliable mechanisms for community feedback on proposed trials. One effective approach utilized in health research is the Community Advisory Board (CAB).

We recommend that public and private sponsors of phase III cancer clinical trials:

1. Develop explicit system-wide procedures to ensure that all concepts and proposed study protocols are appropriately and sufficiently reviewed by trained CR/PAs before the study is submitted for final approval, and ideally throughout the development process.

2. Encourage and permit funding for local research sites to develop mechanisms, such as community advisory boards (CABs), for ongoing community participation in study implementation.

3. Expand site selection criteria to include demonstrated local community engagement and cultural competence, as a means of ensuring community perspective.

We recommend that local research sites implementing phase III cancer clinical trials:

4. Develop mechanisms for ongoing community participation in trial implementation.

5. Develop specific criteria for selection of clinical trials in which they will participate.

continued
V. Improving Trial Participant Recruitment, Accrual and Retention

Accrual of patients to trials remains an enormous challenge for sponsors and investigators; moreover, substantial uncertainty exists about effective approaches for cancer clinical trial recruitment, especially among minority populations. Clearly defined recruitment and retention plans, though rare in treatment trials, may increase the likelihood of recruitment success, particularly with diverse populations. Additional community engagement approaches for improving participant recruitment and retention include cultural competency training for research staff; adoption of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) within the research setting; ongoing collaboration with primary care providers in communication of trial availability; and acknowledgement and appreciation for trial participants.

We recommend that public and private sponsors of phase III cancer clinical trials:

1. Facilitate the development of national recruitment and retention plans to assist local investigators in optimally identifying potentially appropriate research participants, with additional focus on reaching minority and non-English speaking populations.
2. Clearly articulate funding consequences if trial recruitment and retention targets and/or substantive progress towards achieving them are not demonstrated.
3. Expand site selection criteria to include those who have adopted relevant National Standards on Culturally and Linguistically Appropriate Services (CLAS), as a means of enhancing optimal recruitment and retention.
4. Expand patient navigator programs to include responsibilities related to discussion of clinical trial opportunities with eligible cancer patients.

We recommend that local research sites implementing phase III cancer clinical trials:

5. Ensure that each research team is trained in cultural competency, as it relates to clinical trials access, recruitment, and retention.
6. Establish an explicit and standardized approach for discussing clinical trials with all eligible patients at the time of initial treatment consultation.

We recommend that local research sites implementing phase III cancer clinical trials set clear expectations and guidelines for research teams to:

7. Collaborate with primary care providers, patient navigators and other professionals involved in patient care, in order to encourage communication of trial availability to individuals recently diagnosed with cancer.
8. Develop participant recruitment and retention plans for groups of trials and ensure they are reviewed by community partners and/or existing CABs, prior to or concurrent with local IRB submission.
9. Demonstrate respect, acknowledgement and appreciation of trial participants through a variety of means, such as periodic correspondence about the trial, newsletters, cards, and special events.

At the Federal level, we recommend:

10. NCI expand research funding to document and demonstrate promising practices in cancer clinical trial recruitment and retention efforts, and in particular, on efforts to involve members of underserved minority, non-English speaking, poor and elderly communities.
11. AHRQ commission an update of its 2005 “Evidence Report/Technology Assessment on Knowledge and Access to Information on Recruitment of Underrepresented Populations to Cancer Clinical Trials.”
VI. Enhancing Local Community Support for Cancer Research

Increasingly, partnerships between researchers and local communities are seen as an essential ingredient in efforts to improve research outcomes and eliminate health disparities. Partnerships help to build trust in the clinical research process and increase the likelihood that affected communities are invested in and supportive of the research being done. By enhancing community literacy about clinical trials, it is possible to change social norms, so that when a community member receives a cancer diagnosis, s/he is more likely to inquire about clinical trials as an option for treatment.

We recommend that public and private sponsors of phase III cancer clinical trials:

1. Ensure that the institutions/investigators implementing their research protocols have documented: a) ongoing community education about clinical trials beyond any particular trial; and b) outreach activities with community groups, particularly those working to reduce health disparities.

2. Provide technical assistance to facilitate the ability of research sites to successfully implement community partnership, outreach and engagement activities.

3. Demonstrate mutually beneficial, sustained partnerships with existing community infrastructure, such as primary care providers and community-based organizations. These partnerships should engage in outreach and education efforts that inform the community about clinical trials beyond any particular trial. Whenever possible, research sites located in the same geographic area should collaborate in these efforts.

4. Engage in outreach activities with community groups, particularly those working to reduce health disparities, to educate the broader community about cancer clinical trials beyond any particular trial. Whenever possible, research sites located in the same geographic area should collaborate in these efforts.

We recommend that local research sites implementing phase III cancer clinical trials:

5. Expand existing standards for community outreach and research to include community based education and partnerships around clinical trials.

We recommend that the American College of Surgeons’ Commission on Cancer:

5. Expand existing standards for community outreach and research to include community based education and partnerships around clinical trials.
VII. Enhancing Community Interpretation, Dissemination and Implementation of Trial Outcomes

Although traditionally focused on data analysis, conference presentations and peer reviewed publications, there are distinct opportunities for community engagement in the final stage of a Phase III cancer clinical trial. These include better communication of trial results to trial participants, as well as broader use of CR/PAs in the interpretation and dissemination of trial outcomes to the larger community.

We recommend that public and private sponsors of phase III cancer clinical trials:

1. Support studies to identify the most effective strategies for community involvement in interpretation, dissemination and implementation of phase III cancer study results, measured in terms of changes in practice and policy.

2. Partner with private sector organizations, foundations and advocacy groups for the services they provide in interpretation, dissemination and implementation of Phase III study results.

3. Partner with advocacy and community-based groups to set priorities for interpretation, broad dissemination, and implementation of study results, based on importance and applicability. There should be particular emphasis on reaching underserved, minority, LEP, low-literacy, poor and elderly populations.

4. Explore appropriate ways to assist local research sites/local investigators in notifying clinical trial participants about trial results, in lay language and in a timely manner.

As the leader of the National Cancer Program, we recommend that the National Cancer Institute:

5. Conduct research on best practices to communicate aggregate trial results to participants.

6. Conduct an assessment of the ways in which CR/PAs are currently involved in the interpretation, dissemination and implementation of Phase III study findings.

Implementing and Disseminating the Recommendations

The next phase of the Communities as Partners project includes broadly disseminating and communicating these recommendations to stakeholders within the clinical trial system, including:

- **Sponsors of Phase III cancer clinical trials**: NCI and the pharmaceutical industry

- **Those responsible for the design and implementation of phase III trials**: The national Cooperative Groups, industry, and local clinical research sites

- **Oversight and quality improvement agencies**: The Food and Drug Administration, Office for Human Research Protections, AHRQ, and local Institutional Review Boards

- **Accreditation organizations**: The Association for the Accreditation of Human Research Protection Programs and the American College of Surgeons’ Commission on Cancer

For cancer clinical research to achieve its full potential in reducing deaths and disparities, we must explore new approaches to make trials more “accruable” and help communities become more involved in research activities. Indeed, as suggested by experts from the NCI, success in clinical trial accrual “will require sustained, aggressive action, and new partnerships between policymakers, healthcare professionals, professional societies, and underserved communities.” 16 We believe the recommendations advanced in this report, for the first time, effectively guide each of these groups in forging these new partnerships.
Endnotes


8. The National Community-Based Organization Network defines community-based organizations as groups that are “organized by individuals who are directly impacted by the community level problem or issue and who traditionally have had no say in the decisions that govern their lives.” http://www.sph.umich.edu/cbphcaucus/ncbon.html

9. An example would be a representative from a group unrelated to cancer, but whose mission includes improving the health of the community. These would include: Community-based groups such as voluntary and professional organizations, K-12 schools, faith-based groups, housing organizations; representatives from local chapters or affiliates of a national voluntary group such as the NAACP.

10. An example is an individual affiliated with a national or local cancer service group or advocacy organization such as the American Cancer Society, National Breast Cancer Coalition and Leukemia/Lymphoma Society.

11. National research activities for phase III studies include, but are not limited to: Development of research question(s) and trial concept; Design of trial (i.e., rationale, objectives, endpoints, eligibility, schema); Development of consent form; Development of recruitment and accrual plan; Development of requirements for local research team; Participation in Data Safety Monitoring Board (DSMB) activities; Participation in data analysis and interpretation; Participation in dissemination of findings through community networks.

12. Local research activities for phase III studies include, but are not limited to: Participation in decision of which trials local investigators choose to open; Participation in creation of recruitment and retention plans; Participation in community education activities; Participation in Institutional Review Board (IRB) activities; Advisement on trial implementation activities (such as data collection protocols; communication of trial availability, outreach, patient navigation design); Advisement on ongoing communication activities.

13. 24-hour accessible interpretation service, available in many health care institutions.

14. Appropriate grouping may be done by institution or research group; may be classified by disease site, disease stage, type of treatment (e.g., adjuvant, surgical) etc.

15. Standards issued by the Office of Minority Health in the US Department of Health and Human Services that provide guidance on providing culturally competent care to diverse patient populations and enhancing the patient-provider relationship.

About Us

The Education Network to Advance Cancer Clinical Trials (ENACCT) is the only national organization devoted solely to identifying, implementing and validating innovative community centered approaches to cancer clinical trials education.

Community-Campus Partnerships for Health (CCPH) is the only national organization devoted solely to promoting health through partnerships between communities and higher educational institutions, including community-based participatory research, service-learning, broad-based coalitions and other strategies.

The full report, with recommendations and appendices, is available at:

www.communitiesaspartners.org