INCREASING PATIENT PARTICIPATION IN CLINICAL TRIALS

PANEL 2

Compensation for Research Participation

One of a series of live panels from the WCG Patient Advocacy Forum in Washington D.C. in October, 2019

Introduction

Historically, IRBs have been worried about compensating participants in clinical trials. But in the last couple of years, that thinking has evolved partly due to the urging of patient advocates, partly because regulators are having a new appreciation for the role of compensation in research studies. This discusses compensation and reimbursement for participants and caregivers, as well as paying patients and advocacy groups for their assistance.

These discussions have been significantly edited for clarity and length.

The Panel

MODERATOR

David Borasky

VP of IRB Compliance
WCG

PARTICIPANTS

Elisabeth M. Oehrlein

Senior Director
National Health Council

Jeanne Regnante

SVP, Community Education and Chair
Diverse Cancer Communities

Leslie Hanrahan

SVP, Lupus Foundation of America

David Borasky

SACHRP (Secretary's Advisory Committee on Human Research Protections) dug into the topic of patient compensation, knowing there was this history of reluctance on the part of sponsors and others to offer compensation. The committee looked carefully at the issue and began to break it apart. And at the end of the day, what it said was, "Don't worry about it." You know, it's really going to be rare that we have a significant ethical issue when it comes to paying research participants. It's hard to coerce somebody by saying, "I'm going to pay you a lot of money to be in this research study." SACHRP also said, people have the autonomy to make decisions for themselves. There's nothing wrong with saying we're going to reimburse your costs, to compensate you for your time for being in this research study. What has been each of your experience(s) with patient compensation?

Leslie Hanrahan

I've been the vice president for research and education of the Lupus Foundation of America for about 13 years. I feel like I have a unique position. I've been a patient in three clinical trials. Through the years, I've worked on the patient recruitment side at an organization working with the FDA, locating patients for clinical trials, doing outreach and education. But since I've been at the Lupus Foundation, my perspective has completely changed.

When I worked at the trial recruitment firm, we really didn't think about advocacy organizations and compensation, but they weren't talking to us about it either. So when we were starting to work on a study with

"When I worked at the trial recruitment firm, we really didn't think about advocacy organizations and compensation, but they weren't talking to us about it either."

—LESLIE HANRAHAN

a company, we tried to really learn everything we could. In the early 2000s, we would go to a nonprofit whose experts were giving us their time and offer a small donation. And they would take it and give us an enormous amount of time, expertise, experience and access, which is an incredible value.

It was an interesting experience moving to a nonprofit organization and sitting on the other side of that. Lupus is an interesting disease. I think at the time there were companies just starting to be interested in Lupus clinical trials.

We've had one FDA-approved treatment for Lupus for the past 50 years. Everything else is used off-label. Once these companies started coming to us, it was our duty and our job to help them - it was part of our mission. But it's also a resources issue, for us as an organization. I thought, I am really lucky to be here now because I can take my knowledge from my other side and bring it over here.

It was hard in the beginning to be able to be compensated fairly for all those amazing things - access, expertise, trust, etc. We are the source for information. So it's the right place to be.

But the issues of compensation and value, I think all of us are still wrestling with what's the value and what's the right compensation. We want to do all we can, that's why we're there. We say "yes" even when we really don't have the right resources to do it, because that's who we are, why we're there. But it's a very, very difficult topic. I know Lupus

"The issues of compensation and value, I think all of us are still wrestling with what's the value and what's the right compensation. We want to do all we can, even when we really don't have the right resources to do it."

—LESLIE HANRAHAN

Foundation of America and other organizations are wrestling with it.

Elisabeth M. Oehrlein

At the National Health Council, we're building some tools; specifically, we're developing a fair market value calculator. It's not to figure out how to compensate research participants, but rather patients and patient organizations who are participating in guiding drug development. Now with patient-focused drug development, we know that patients and patient groups are playing an increasing role in helping to design clinical trials, helping to ensure materials are at the right health literacy level for a particular population, helping to recruit. For all these different activities that patient organizations and individual patients are participating in, neither the research community nor the patient community really knows what appropriate compensation rates are.

Another barrier to meaningful patient engagement in drug development is legal agreements. At the National Health Council, we're often asked to do consulting work or to help with different projects. Sometimes we'll get a contract that's 60 pages long just to do the equivalent of $1,000 of work. And we're a staff of 20, without a legal staff. For us to have a lawyer look at that contract on our behalf could cost $1,000. So we've been developing—with an international group—some legal templates that would be plain language and adaptable for patient engagement.

Another aspect of the work we're doing is developing guiding principles. This involves helping the community think about topics

"Another barrier to meaningful patient engagement in drug development is legal agreements... we've been developing some legal templates that would be plain language and adaptable for patient engagement."

—ELISABETH M. OEHRLEIN

such as how reimbursement differs from payment or compensation. We've been interviewing our members as well as nonmembers. We've conducted about 60 interviews so far to help us develop these tools - people from industry, from research, nonprofit organizations, and from the patient community.

We've been sort of a central gatherer of this information about existing standard operating procedures different companies have, what rates different patients or patient groups are charging, and even the activities patient groups are being asked to do. We're developing all these different pieces into what will be a fair market value calculator for clinicians or researchers. It will be an Excel calculator that we'll update every couple of years to make sure it's current.

Jeanne M. Regnante

The Diverse Cancer Communities Working Group is informed by data and focuses on best practices to optimize access to care, treatment, and inclusion in clinical trials for racial and ethnic minority patients. Underserved populations in cancer have said this is a strong group because our membership includes 10 pharmaceutical companies focused on cancer innovation, patient organizations, and a number of academic medical center leaders who are focused on and committed to making a difference in the lives, treatment, and care of patients.

We do know there are disparities in care, and I think this is important to understand throughout the cancer continuum. Clinical trials are just one aspect of that. That's why this area is so complicated.

"We do know there are disparities in care, and I think this is important to understand throughout the cancer continuum. Clinical trials are just one aspect of that. That's why this area is so complicated."

—JEANNE M. REGNANTE

We try to focus on understanding and shining a light on what does work. We asked the question, "Where are the Cancer Centers in the United States which are able to successfully improve racial and ethnic minority recruitment? Who are their leaders and what are they doing?"

We interviewed 14 leaders in eight centers across the United States. First, these center leaders don't have to do anything about engaging the community. They have the trust of the community partners with whom they engage.

They ask everybody who is eligible for a clinical trial to come in. If someone doesn't have insurance, the center will get the insurance. They make sure the sponsors compensate them for logistical support to help and offer that support to anybody coming into the trial.

They do a great job of reaching out to primary care physicians who are trusted providers for patients.

It's not one thing: It's several things.

We also talked about cost directly to patients in clinical trials, especially as it relates to underserved populations, innovation, and other areas. I want to share with you some high-level data points:

First, lower-income patients are less likely to be asked to be in clinical trials, suggesting that insurance status or a lack of understanding about who is going to pay plays a role.

"Lower-income patients are likely to be asked to be in clinical trials, suggesting that insurance status or a lack of understanding about who is going to pay."

—JEANNE M. REGNANTE

Also, lower-income patients are most likely to be concerned about costs of being in a trial, particularly older women and families with young children.

We recently conducted a survey with our working group members and industry leaders. In terms of compensation, we asked, What are you doing in the area of reimbursement and compensation in clinical trials and when are you doing it?

Overall, the industry is in the early adoption stage regarding standardizing reimbursement to patients in general for any reason.

A lot of the responses came back with "it depends" and "it's not standardized." There are differences in terms we use: compensation, logistical support, standard-of-care costs, patient assistance; there's little consistency. What everybody does agree on is that it's a check or a credit card that goes to the patient which allows them to participate in a trial. No company said they had a standard model or calculator they applied to trials for such payments.

Everybody agrees a clinical trial shouldn't cost patients. I'd say that's a good place to be. It's clear they believe out-of-pocket costs should not be a barrier to participation.

Big pharma says 83% of the time reimbursement depends on the trial, the disease area, or the stage. Most said rare diseases are an exception. Several said institutions should ask, some companies that

"Everybody agrees a clinical trial shouldn't cost patients. I'd say that's a good place to be. It's clear they believe out-of-pocket costs should not be a barrier to participation."

—JEANNE M. REGNANTE

patients need to ask. Some companies said requests are handled mostly by exception, and the request goes to the company's internal clinical trial monitor.

Many companies reported they ask sites to come up with a budget. But sites said they don't have the manpower to do this. I think this is really important. Even though pharmaceutical companies might ask for a budget from a site for compensation or logistical support, sometimes the site doesn't respond because there's no manpower to adjudicate the requests. We need to do a better job operationally at the sites to make sure they can collect information and validate the request from patients, and then pay the patients on time.

David Borasky

Are we doing enough in terms of compensating the caregivers?

Leslie Hanrahan

There's a large population of patients who are children, so the burden feels huge. My organization thinks about it quite a bit, but we really don't have a great answer. It goes back to the discussion about reimbursing for missed days at work. How do you handle that? We find ourselves talking about trial design. The system is kind of broken; if we can fix that, then all the other things kind of come along with it.

I don't think we've asked caregivers enough, to be honest. I think it's an untapped community we need to do more with, to understand better, in general.

"Even though pharma companies might ask for a budget from a site for compensation or logistical support, sometimes the site doesn't respond because there's no manpower to adjudicate the requests."

—JEANNE M. REGNANTE

Jeanne Regnante

When you go to a physician—especially a specialist—you know you're going to be spending a long time there. You need somebody with you to listen and ask questions with you and I wonder if that's any different with clinical trials. I'm thinking about a scenario where a child is in a clinical trial and their mom used to drive them; there are several study visits and the long lab tests that need to happen over time.

The National Institutes of Health (NIH) recently sent out an announcement about a trial where they were recruiting obese children. It involved a screening visit and about eight follow-up visits over a year's time. I looked at the bottom of the page and there, in big bold letters, it said "compensation." Good for the NIH. They told folks upfront what was required, what compensation they were offering - $100 dollars for screening and $830 for all follow-up visits. That money is going to the caregiver. I think that is appropriate: We should think about compensation in the context of caregiving.

Elisabeth M. Oehrlein

Developing these tools has spurred so many interesting conversations, of course. One was about compensating children. Depending on the situation, it might not be ethical to compensate the child. So we reached out and asked "How are companies doing this? How are different patient groups tackling this?"

What we learned is, some type of family compensation would come into play. And again, we're talking here about engagement in terms of trial

"They told folks upfront what compensation they were offering... That money is going to the caregiver. I think that is appropriate: We should think about compensation in the context of caregiving."

—JEANNE M. REGNANTE

design or those types of aspects. But in terms of who are the different types of patients. Certainly one of the variables for that is patients who are accompanied by a caregiver. That's one of the aspects that's also incorporated into the tools we're developing as well.

Audience Member

I work with Parent Project Muscular Dystrophy and we published a paper this year on the burdens of clinical trials. Muscular Dystrophy is a rare disease and it's primarily a pediatric disease. That influences my comments.

Clearly a child does not go into a clinical trial without a caregiver. Frequently in a rare disease that involves considerable travel—and there're usually siblings—so who compensates? So there's compensation and there's reimbursement. It's two separate issues. Reimbursement should be upfront. It isn't always.

You're expecting people to put on it their credit card - the cost for this travel. Sometimes that's not a possibility. That limits the pool of people who are interested in the trial. And some of the trials, particularly as we're looking into gene therapy, are often moving to the site. You might need to live there for six weeks. How do you uproot your family?

My son was in a trial starting 15 years ago, and in the beginning, my advocacy group had to give a grant to the company to get travel paid for. But no advocacy organizations should be paying for travel. That should be coming out of the sponsor's pocket. It's become better

"Some of the trials, particularly as we're looking into gene therapy, are often moving to the site. You might need to live there for six weeks. How do you uproot your family?"

—AUDIENCE MEMBER

over the last 15 years. But it is a huge burden, to think about the parents, the child enrolled, the siblings, and how that impacts the whole family.

Elisabeth M. Oehrlein

We live here in D.C. and right down the street from NIH, and both my children volunteer at the Children's Inn. I've talked to some of the parents; their room and board are taken care of. But there's that time away from work; some of those parents had to decide whether to stay at their job or not. That's a real consideration.

Audience Member

I don't want to completely lose sight of the fact that caregivers can also be for adults. I'm from the Bladder Cancer Advocacy Network, and our population tends to skew older. We have adult children of patients who are taking time out of work to get their loved one into a trial or even into treatment. That's also something that needs to be considered. I don't want to just focus on parents taking care of their children and the burden that goes along with that.

Leslie Hanrahan

We've been collecting case studies about where the impact is when you engage patient communities in designing trials. We've seen so many interesting examples where there were assumptions made. For example, that the participants wouldn't want to have all the tests right off the bat - that they would want to have them spread out over a long period of time. That would involve multiple site visits.

"Their room and board are taken care of. But there's that time away from work; some of those parents had to decide whether to stay at their job or not. That's a real consideration."

—ELISABETH M. OEHRLEIN

By convening focus groups of patients at the front end and asking, "Would this be a deterrent for you for actually participating?", we know of sponsors that have been able to redesign the clinical trials and avoid amendments. This probably lessened the recruitment burden and probably also lessened the bias towards certain populations being able to participate. That's certainly one way of approaching it, to make sure from the very front end when designing the trials, that we're thinking about these things.

Is transportation needed? I know there are all kinds of interesting examples now of ride-share services being contracted to bring patients to the pharmacy, or to bring patients in for a routine doctor visit. We need to think about some of those novel ways of just getting patients to be able to participate.

Audience Member

I'm a colon cancer patient currently going through clinical trials. I have had one offer of compensation through one of the clinical trial groups. I was initially told I would get coverage for one trip and one overnight stay. But I never heard, never received anything, and every time I had a discussion with a nurse navigator at this treatment site, I got a very wishy-washy response. Does the patient have any recourse?

David Borasky

We occasionally get calls from people in research studies who are having exactly that sort of issue. That should be spelled out somewhere in the consent document. Ideally it speaks to what the

"I never heard, never received compensation, and every time I had a discussion with a nurse navigator at this treatment site, I got a very wishy-washy response. Does the patient have any recourse?"

—AUDIENCE MEMBER

amount is, what's covered and what the anticipated plan is for making the payment. When it's in the consent form it's easy. Someone can call the IRB. We call the research site first and try to figure out, is this a site problem? A sponsor problem? And then escalate it as necessary. But to us, once that promise is made in the consent form, and the more explicit it is, the better. Our leverage is somewhat limited. We can't literally make them write a check, but often it does motivate them to act and complete that cycle.

Jeanne Regnante

There is something pharmaceutical companies can do around informed consent. Pharmaceutical companies are already getting input from patients on study feasibility and study design. I think pharma is really starting to do that well. As part of that engagement with patients, ask them about what should the compensation model be? And get that input into the consent as part of that process.

You don't have to create a separate process. You're already asking patients questions, so ask them about compensation as part of the informed consent. And make sure it is appropriate for the patient population that is being recruited. Ask them for that because they're the experts on what you should do.

"You're already asking patients questions, so ask them about compensation as part of the informed consent. Ask them because they're the experts on what you should do."

—JEANNE REGNANTE

Audience Member

I'm going to switch gears just a little bit and talk about big data. I'd like to understand your thoughts on the idea that everyone should be getting compensated for any type of data that's being shared for clinical research.

David Borasky

It's an interesting question. I think it's going to be tricky and I think we all have tons of data out there. Everything from our Amazon shopping to spitting into tubes. I think often you do that without even recognizing how it might be used, and many people and places are trying to commercialize all the data they have. I don't really have a good answer about how the compensation should be contemplated or handled in that aspect though.

Elisabeth M. Oehrlein

This is not National Health Council's position, but I've been thinking a lot about this lately. Thinking about when there's a co-insurance or something like that and an insurance company will then sell the data. So if I'm a patient and I'm paying a 20% co-insurance, maybe I should own 20% of that data and maybe when that data that gets sold to a pharma company, I should be getting a reduction in premiums, or a reduction in something, for the fact it was sold and I own part of that. Not just because it was my experience, but because I actually paid money toward that. That's nothing official, but certainly something I'm starting to have some internal discussions at the NHC about. Also, what would something like that even look like? And how could that be scaled?

Jeanne Regnante

I think there's another aspect of this subject we need to be mindful of and that is the influence of policy. There are 48 states in the country where Medicaid does not reimburse the standard of care costs when a patient is in a clinical trial. Now think about that. If the patient wasn't in

"There are 48 states in the country where Medicaid does not reimburse the standard of care costs when a patient is in a clinical trial. Now think about that."

—JEANNE REGNANTE

a clinical trial, they would be reimbursed for standard of care costs and our patients, they need support.

The American Society of Clinical Oncology is driving a change in policy around this. Please advocate and have your organizations advocate for that work. It's being driven mostly by the cancer community. The other aspect of this I think we need to be mindful of, and I'm not too sure I know the answer to this question, when a patient is compensated, whether it's reimbursement for hotel rooms, or gift cards, or meals, is that taxable? Is it taxable income? And I think it's not clear. And you know, if I were a patient and I knew that being in clinical trial, I was going to get $1,000 for being in this trial and 30% of it wasn't going to be mine at the end of the day, and I needed to report it, depending on your situation, I might say no. So there needs to be a real hard look at some policy implications of what it is we're trying to do. Basically, the disparity will remain for a lot of patients, that there's a huge underlying risk.

Elisabeth M. Oehrlein

I can build a little bit upon this because this has also come up during our conversations about fair market value and the principles. We do need clarity on this topic because if you're receiving compensation, you may potentially no longer qualify for Medicaid or some other benefits. Even not too much compensation depending on your situation. So that's one of our principles: It needs to be very clear this is something that should be discussed and upfront and transparent - eligibility could be affected depending on the compensation.

"If you're receiving compensation, you may potentially no longer qualify for Medicaid or some other benefits... this is something that should be discussed and upfront and transparent."

—ELISABETH M. OEHRLEIN

Audience Member

If the pharmaceutical industry pays the investigators a certain amount of money for the patients, wouldn't it fall upon the investigators to pay the patients? Or do you think the patients have to be individually paid first, from the pharmaceutical industry?

Leslie Hanrahan

I think it should come from the investigator, to be honest. But then I think there needs to be standardization across sites, across studies, stating that the money needs to be used in a specific way. I've been in three different studies and three different situations in terms of reimbursement. In one study, I knew they just used the money a different way. So that's alarming. I do think there is some responsibility that the industry must put in place in terms of how the investigators use the funds. I don't think the money should come from the companies. When patients talk to companies about their disease, in order for them to get reimbursed for their time, they have to give the company their social security number. And we've had people turn it down because they don't want to give that type of information, for a myriad of reasons. I don't think it should come from the company at all.

"I think compensation should come from the investigator... I think there needs to be standardization across sites, across studies, stating that the money needs to be used in a specific way."

—LESLIE HANRAHAN

David Borasky

To add to that, my opinion would be that at least the company has the leverage. So you know whether at the end of the day the money's coming from the company, whether the vehicle is the site setting it up. If the sponsor is hoping compensation will contribute to recruitment and retention, it seems like they should be using their role as sponsor

to say they have an expectation that participants in our trials are going to be fairly compensated or reimbursed, or whatever the right language is. But we expect that to happen. And then sites would build it into their contracts and their plans with a sponsor.

Jeanne Regnante

I just want to put an exclamation point on something now. This is a capability that we need to make sure is paid for at the site. So they might need to be compensated for our half of FTE just to do this work, to understand what the need is and make sure that individuals are compensated consistently with what was agreed to. Just because we asked the site to do it and provide a budget, doesn't mean that actually happens. I mean you have to make sure the sites have the ability to do that and they have the headcount to do that. And I'm not sure that exists.

"Just because we asked the site to compensate patients and provide a budget, doesn't mean that actually happens. You have to make sure the sites have the ability to do that and they have the headcount to do that."

—JEANNE REGNANTE

Key Learnings

Improve representation of lower income communities by ensuring fair participant compensation

Socio-economic status is a considerable barrier to participation. We see that lower income patients are less likely to be asked to be in clinical trials, with insurance status or a lack of understanding about who is going to pay for treatment playing a large role. It goes both ways, as lower-income patients are the most likely demographic to be concerned about the costs of participating in a trial.

Overcome barriers to participation by compensating patient caregivers

Compensation for caregivers needs to become standard practice. The importance of caregivers in clinical trials cannot be overstated, with many patients depending on caregivers to be able to participate in a study. Time-off from work and travel are financial burdens often considered for patients, but we cannot forget that caregivers are also experiencing those financial hardships.

Enhance participation in clinical trials by considering the long-term financial impact of research participants, caregivers, and families

Compensation for patients and caregivers can help relieve the burden of trial participation, but trials that require patients to live on-site for extended periods deserve further consideration. In many cases, adult patients and caregivers need to weigh the reality of leaving their jobs to participate in a study, or even uproot their families. Further examination

Key Learnings continued...

of how to overcome these potential financial burdens is essential to improving participation for live-in studies.

Establish a standardized patient compensation model by increasing study team bandwidth

Sponsors need to set clear expectations and standardizations across studies and sites about how the money is to be used. Though sponsors may be upfront with their expectations of investigators and sites—it may not always happen. Sponsors need to make sure study teams have enough bandwidth to be able to dedicate resources to budget management and making sure patients are compensated in accordance to set expectations.

Acknowledge patient input to improve compensation model

With growing evidence of success—conducting focus groups to gather patient input is becoming standard procedure when it comes to improving feasibility and study design. It may be time to follow the same formula and consider including the patient perspective when building a fair compensation model.

Visit the WCG Institute to read additional discussions from the Patient Advocacy Forum

GO TO THE INSTITUTE