Highlights and Summary of Part 12 Webinar:

Public Awareness of Clinical Research and the Path to Diversity in Clinical Trials

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COVID-19 has affected awareness, perceptions and understanding of clinical research for the general public. How may future understanding of participation in clinical research be affected by the pandemic? How will the lessons we're learning and re-learning about healthcare disparities during this pandemic affect future trials? How can sponsors and sites ensure appropriate representation in COVID-19 clinical trials?

Featured speakers:

1 **Annick de Bruin**
Director of Research Services, The Center for Information and Study on Clinical Research Participation (CISCRP)

2 **Edith P. Mitchell, MD, MACP, FCPP**
Clinical Professor of Medicine and Medical Oncology; Director, Center to Eliminate Cancer Disparities at the Sidney Kimmel Cancer Center; 116th President of the National Medical Association

Lindsay McNair, MD, MPH, MSB, *Chief Medical Officer, WCG,* moderated.

This is the 12th in **a series of WCG webinars** that address the coronavirus-related challenges facing the clinical trial industry. You can find links to this webinar and an array of COVID-19 resources on our **WCG Insights Program** page.

Note: Before the presentations began, WCG Chairman & CEO, Donald A. Deieso, PhD, discussed the current protests, racism and the need for greater diversity in clinical trials. His remarks are included at the end of this summary.

Public Awareness & Understanding of Clinical Research: The Center for Information and Study on Clinical Research Participation

1 **Annick de Bruin**
Director of Research Services, The Center for Information and Study on Clinical Research Participation (CISCRP)

CISCRP is a non-profit organization dedicated to educating and informing the public, patients, medical and research communities, and the media and policymakers about clinical research, and the role that each play in the clinical research process.

2019 Baseline Perceptions and Insights Study (n=12,451)

The purpose of this global study was to identify trends in the public's views on clinical research, in terms of the risk they perceive, the benefits they perceive, what information they might need to make a decision to participate, and what information and participation elements are important to them if they decide to enroll in a clinical trial. Of the total respondents, 29% were clinical trial participants.

A 2020 Mini Survey Focused on COVID-19 (n=500)

We focused on the U.S., the U.K., France, Italy and Germany. Among the respondents, about 18% had clinical trial experience, 12% had experienced or are currently experiencing symptoms of COVID-19 and 9% had been tested.

How well do you understand what is meant by the term "clinical research study," also known as "a clinical trial?"

In the mini survey, self-reported understanding is generally high, with 44% of North Americans and 35% of Europeans answered they understand "very well"; 12% of North Americans and 10% of Europeans answered, "not very well" or "not at all well." This is very much in line with what we found in our baseline 2019 study.

Superficial knowledge: However, when you dig a little bit deeper, and you assess that knowledge, you find it's largely superficial.

Lack of knowledge: Many didn't know where research was conducted, for example or couldn't name an agency that oversaw the safety of clinical trials.

Misconceptions persist: In the 2020 mini survey, more than 60% said they believe a COVID-19 treatment

or vaccine will be developed in under a year. Once developed, 64% think it will be less than a year before people can start receiving it.

Awareness: In terms of awareness, the way we assess awareness in this smaller COVID-19 study, as in our larger baseline 2019 study, is that we ask individuals if they remembered seeing or hearing about a clinical research study that was looking for volunteers in the past six months. Nearly half (47%) said no, and 15% did not remember. These proportions, again, line up with what we saw in our larger study.

Safety: In the mini study, 78% said they believe clinical trials are somewhat or very safe. Again, this is very much in alignment with what we saw in our global baseline study. The typical concerns among those people that did not think clinical trials were safe were the side effects, symptoms could get worse, they didn't know enough about clinical research, or they don't trust pharmaceutical companies.

Willingness to participate: The majority (61%) would be willing to participate in a COVID-19 clinical research study. Many of the reasons why they were interested in doing so were lined up with the baseline global study, and most were altruistic. However, as we all know, this does not necessarily translate into participation.

Lack of trust: We saw this again in our mini COVID-19 survey, where trust in pharmaceutical companies was somewhat lower than in other stakeholders in the clinical research enterprise, such as government organizations, research center sites and regulatory agencies. In particular, from the baseline global study, we saw that trust was an issue. This highlights the need for transparency, education and partnership. We also saw that the level of trust among those who have participated in clinical trials is much higher.

Changes in Trials

The subgroup currently enrolled in non-COVID clinical trials (n=38) identified the changes they have experienced. Use of telemedicine (42%) and a move to virtual clinic visits (34%) topped the list, followed by suspension of the study (26%). Other changes include home medicine delivery (21%), the use of smartphone apps (21%) and fewer in-person visits (11%).

Something to think about going forward: What types of reassurances will these volunteers need to proceed with their participation?

Barriers to Participation

We've known and the literature has shown, and this has held true, that the doctor is a critical channel in terms of increasing participation.

The large baseline survey asked, *If you knew your primary care physician or specialist was conducting the clinical research study, how much of an impact, if any, would this have on your willingness to participate?*

Overall, 54% indicated they would be more willing to participate, while 42% said it wouldn't make a difference. Only 3% said it would make them less willing to participate. Among Black respondents, 66% said they would be more willing to participate.

This attitude reflects responses to another question: *How should people best learn about the clinical research process and where to go to find clinical trials?* Again, physicians top the list--but that's not the primary place where people learn about trials, so there is a gap there.

Respondents--particularly among underrepresented communities--identified other sources. For example, the survey found that patient advocacy groups and patient support groups are big resources. Educational programs in schools or colleges might also provide channels to educate people about clinical research.

Online Peer Communities

Online peer communities offer opportunities to reach underserved communities, based on responses to: *How interested would you be in discussing and getting advice on participating in a clinical research study with peers in an online patient community?*

Overall, 30% said they would be "very interested." But among Hispanics, that jumps to 42%; among Blacks, 40%.

At CISCRP, we hear this a lot through our patient advisory board program as well, when we speak directly to patients. People would turn to an online patient community to get advice, and particularly among underrepresented communities.

Legacy Burdens

Again, sticking with the baseline study, respondents who had participated in a trial were asked, *How burdensome was each of the following?*

Traveling to the study clinic topped the list, with 29% identifying it as somewhat or very burdensome, followed by length of study visits (21%) and undergoing diagnostic tests (21%).

In response to a question about how long it took to travel to a clinic, 56% indicated they had to travel over 30 minutes one way.

No Single Solution

Many organizations are moving to decentralized clinical trials. To that end, the baseline survey asked how they would feel about various models:

- Collect your own data at home, using technology.
- Nurse comes to your home for all the study visits, and you might speak to your study doctor via telemedicine.

- Hybrid: Some visits could be conducted at home and some at the clinic.

The responses revealed that no one size fits all. The takeaway: What we need to think about is that everybody has an individual life and responsibilities, and it's important to provide options so clinical research participation can be accessible and minimally burdensome to everyone.

Considerations Moving Forward

Educational initiatives are more important than ever to inform and increase trust: There's so much information out there, and a lot of misinformation, it's so much more important than ever to inform and increase trust among the public and patients and get the facts out there. So, working together to get that done is critically important.

The doctor/patient relationship is critical to help increase participation in clinical trials.

The pace of adoption of new technologies, including telemedicine, has accelerated: This is something we need to leverage now and going forward.

No one size fits all: Everyone has different responsibilities and lifestyles. In making clinical trial participation accessible, it's crucial to have options.

Reassurance matters: It's important to reassure those currently enrolled in ongoing trials about the safety of their data and their physical safety--i.e., how sites are following COVID-19 guidelines. Just showing them and reassuring.

2

Edith P. Mitchell, MD, MACP, FCPP
Clinical Professor of Medicine and Medical Oncology; Director, Center to Eliminate Cancer Disparities at the Sidney Kimmel Cancer Center; 116th President of the National Medical Association

We need equity in health in this country.

It is so important that we address and correct the contributing factors to the disproportionate outcomes in healthcare and for overall outcomes for patients from underrepresented minorities and overall higher mortality rates in these communities.

We must eliminate all of the contributing factors to poor outcomes. Not only is it ethically the right thing to do, but it is the best thing for people and the best thing for our country.

Disparities in COVID-19

COVID-19 is disproportionately affecting people of color in the United States. We've seen reports backing this from Chicago, from New Orleans, Philadelphia, Detroit and many other cities. We must be aware of what it looks like and why it's happening.

When we look at previous and historically human-related data, what we find is that this is not new: There have been many disparities identified for diverse populations, contributing to outcomes in this country: hypertension, kidney disease, heart disease, diabetes, you name it. So, with the COVID-19 pandemic event, we find that again: poor outcomes.

A **recent** report shows that African-American individuals, and those of African descent, contribute enormously to the overall COVID-19 death rates. The latest overall COVID-19 mortality rate for Black Americans is 2.4 times as high as the rate for Whites and 2.2 times as high as the rate for Asians and Latinos.

Ochsner Health *reported in New England Journal of Medicine* that African Americans had twice the death rates in New Orleans, and this has been recorded in many other cities as well.

If you calculate the deaths from COVID-19 in this country, what you find is that, although African Americans comprise 13% of the population, they have double the number of deaths across various age groups from COVID-19. So again, these are areas that we not only have to talk about, but we've got to fix, and it's not only for COVID-19, which is a big challenge for us now, but we've got to fix the other contributing factors that allow such numbers to exist.

COVID-19: Why is There Disproportionate Impact?

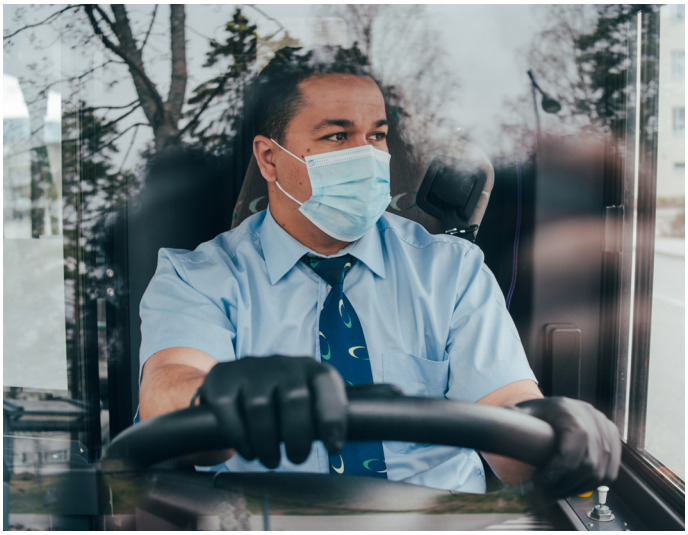
So, why is there disproportionate impact among communities?

Work: More people of color are "essential workers," working during the pandemic and being exposed to the public. They are the bus drivers, those who clean the hospitals, etc., and are therefore working during this pandemic episode. They're exposed to the public at greater rates. Often, they have no access to PPE and other protective gear. So, exposure is greater in minority communities.

Multi-generational households where there are multiple age groups in the family, perhaps grandparents, uncles, aunts and older individuals who are at risk in the home and therefore harder to actually isolate.

Lack of access to healthcare: The are many reasons for this.

- **Inadequate**--or no--health coverage: Many Black people work for companies that do not provide coverage.
- **Lack of trust:** Many individuals from minority communities are hesitant to seek care because of distrust in the healthcare system--a distrust rooted in history.
- **Tend to be sicker when presenting for care** and therefore need more intensive and involved care.
- **Testing access:** Less access to COVID testing sites, therefore not allowing for testing and appropriate isolation practices.



Higher prevalence of disease processes that we know are leading to COVID-19 complications (e.g., cancer, end-stage renal disease, COPD, hypertension).

Misinformation: One popular myth is that black skin protects individuals from COVID, and that's just not true. Therefore, we have to get rid of a lot of misinformation.

Example: Navajo Nation

In the Navajo Nation, there are fewer healthcare institutions with resources that are able to care for individuals with COVID-19. There's a lower rate of testing and a lower rate of treatment and therefore a lack of access to care. The Navajo Nation has surpassed New York State for the highest COVID-19 infection rate in the United States.

Underrepresentation in Trials

Minority communities must be represented well in clinical trials. Currently, they are not.

So how do we ensure there is representative enrollment of minority patients into clinical trials?

- **Discuss diversity as a study priority;** don't just assume that it will happen based on patient demographics.
- **Develop a formal diversity strategy for recruitment** that taps into local community organizations and other trust bearers to help disseminate trial awareness and accessibility information.
- During site selection, **identify and work with institutions that serve the underrepresented communities and have research infrastructure** (e.g., in Philadelphia, Jefferson Health System and Temple University Hospital).
- **Develop programs for special populations:**
  - Geriatric populations
  - Multilingual targeted recruitment plan for minority communities that emphasizes unequal risk and the importance of empowered solutions including participating in clinical trials
  - Other groups, including cancer patients (e.g., NCI COVID-19 in Cancer Patients Study)

Beyond COVID

We can carry this work in the COVID era into other studies:

- **Proactively pay attention to representative enrollment**
- **Work with institutions and investigators who make diversifying clinical trials a priority,** and who create diversity enrollment plans for studies
- **Build relationships** with minority-based health organizations, community groups and other knowledgeable stakeholders: This is not something that just happens. Engaging communities must be planned and must be planned prior to completion of the study; build relationships with minority institutions, minority health organizations, community groups, faith based and churches.
- **Consider developing multilingual recruitment materials**
- **Work with organizations who can give early advice** and communicate about your study (e.g., Cobb Institute of the National Medical Association and other organizations with a history of engaging underrepresented minorities).
- **Include patients and care providers in early conversations** to understand barriers to enrollment, living with the disease and other areas that may inhibit protocol participation.

Wrapping Up

We must use the awareness of the disproportionate impact of COVID-19 and the need for research representation to bring awareness to the larger issue of ensuring diversity in all clinical research. But we already knew about many of the factors, including high rates of uninsured and underinsured, lack of trust and other contributing factors. We not only need to talk about them now: We need to fix them. And that includes making sure every person in this country has some insurance and good access to healthcare. And therefore, we can prevent a number of these problems.

In addition, we need to ensure that our clinical trials for COVID-19 therapies enroll appropriately representative populations. That means those individuals who have higher mortality rates, so we can change the current standings and the current statistics.

We need to leverage this increased awareness of the disproportionate impact of COVID-19 on minority populations and the need for research representation to bring awareness to the larger issue of ensuring diversity and equity in all our clinical research.

Questions from Audience

Questions for Annick

Annick de Bruin
Director of Research Services, The Center for Information and Study on Clinical Research Participation (CISCRP)

&

Questions for Edith

Edith P. Mitchell, MD, MACP, FCPP
Clinical Professor of Medicine and Medical Oncology; Director, Center to Eliminate Cancer Disparities at the Sidney Kimmel Cancer Center; 116th President of the National Medical Association

Q **Ms. de Bruin, you indicated that about 61% of respondents were willing to be in a COVID-19 research study and about 39% were not. Was that result surprising? And how does that compare to when you asked the much more general question about willingness to participate in clinical trials?**

A

de Bruin: It actually wasn't surprising. And like I mentioned, it lines up with our larger baseline study in terms of their interest in participating generally in a clinical trial. When we asked the question in the larger study, the proportion was actually higher in terms of those that were willing. I think there's just a lot of unknowns surrounding COVID-19. And I think that's why the proportion generally was a little bit lower than what we see in our global studies.

I think people are generally concerned about the risks and taking chances with their health. They might be concerned about vaccines in particular and maybe getting COVID-19 from the vaccine or they may be concerned with the side effects, or effectiveness of vaccines in general. And I think it just really highlights the opportunity and importance of educating people about these vaccines and how clinical trials for vaccines specifically might work and how vaccines work in general as well.

Q

Dr. Mitchell, we've had a couple people respond that they would be interested in increasing diversity in their studies, but when they select investigators for clinical trials, they select them based on past performance and performance metrics. So how are they going to get diverse investigators they're relying on performance metrics to select investigators, and there aren't a lot of minority investigators in that pool, which means they're not generating a lot of performance metrics? How do we break that cycle?

A

Mitchell: We recognize that there are fewer minority investigators, and one of our efforts is related to increasing the number of physicians and other clinicians from minority communities. While African Americans, for example, account for 13% of the population of the United States, African-American physicians only account for 4%.

So, we are developing programs with the Association of Medical Colleges, which is the medical school administrative unit. Most of the Black physicians in this country have graduated from four medical schools that are historically black.

Consequently, we are working with other institutions to increase the number of minority medical students; that is true of other disciplines such as pharmacy and nursing, as well.

One of our major efforts is increasing the number of minority investigators and investigators who understand minority populations. So not only are we working to increase the number of investigators from underrepresented minority communities, but also increasing the number of other individuals

who understand minority communities, who know how to speak to others, and how to interact with individuals from underrepresented minority communities.

Truly, we are tackling the problem head-on. And as I say, 360 degrees, making sure that we're looking at all of the components contributing to the disproportional number of minorities in clinical trials, but also the disproportionate death rates in minority communities. So, we're addressing it from every aspect of those contributing factors, trying to ensure that we have equity in clinical investigations and clinical trials, but also advantages and opportunities for treatment of these processes. For individuals with core insurance or no insurance, these people have to make a decision regarding, "Do I buy my medicine, or do I buy food for my family?" Increasing access to care for individuals is also a major part of what we're doing across the country.

Q **Dr. Mitchell, are you aware of any efforts to collaborate with historically black colleges and universities to train physicians to be interested in and supportive of clinical research?**

A **Mitchell:** Oh, absolutely. There are a number of studies where there is involvement and not only involvement but work with underrepresented minority institutions. And I sponsored an event a few years ago when I was president of the National Medical Association, where I had the presidents of all four historically black medical colleges on a panel to describe this. We also work with the ECOG-ACRIN Cancer Research Group, which is funded by the National Cancer Institute where I co-chair a program of bringing in minority medical students or graduate students to our cancer research programs and introducing them to cancer research, introducing them to individuals who are experts in cancer research so that we are creating communication.

And the National Cancer Institute, and I should say the National Institute of Health, not only through the NCI but through its 27 institutes, NIH is really engaged with increasing the number of minority researchers who can therefore participate in the clinical trials and other NIH-supported research.

Introductory Remarks

Donald A. Deieso, PhD
WCG Chairman & CEO

The topic of this webinar, Diversity in Clinical Trials, has the most poignant backdrop with what is occurring in our nation as a reaction to the murder of George Floyd. People throughout the world are repulsed by the video recording and are demonstrating and demanding long overdue changes not just to our criminal justice system, but to the underlying cause, racism.

As the largest ethics company in the world, WCG stands in support of those who are peacefully demonstrating for change. After too many years of ignoring the corroding effects of racism on black and brown communities, let's hope that as a nation convulses in anger and frustration over the tragic loss of George Floyd, true and lasting change will occur.

If you are like the employees of WCG, you want to do something now. Since few of us can directly change the U.S. criminal justice system, we must make our contribution in another way. Let me suggest a pathway. Everyone at WCG, and all of us on this webinar, have a strong commitment to improving public health through the development of new drugs and devices, a significant contribution you are making to saving and improving lives for all people.

When the topic of diversity in clinical trials arises, too often it is in the context of meeting regulatory requirements, less on the need to conduct scientifically responsible and inclusive trials. While it is unquestionably good public policy to drive such inclusion, effecting good science must be our primary motive. One cannot develop effective and safe cures if a segment of the population is underrepresented in the clinical trials.

New drugs must be tested and evaluated for all people, irrespective of racial or ethnic background. Because it is easier to recruit white participants does not make it good science. There was a time, and many of you can remember, when women were excluded as participants in clinical trials for fear of reproductive consequences. Many drugs in use today had as their participants white males only.

Consider the COVID-19 mortality of Black Americans exceeds that of white Americans by 2.4 times. This result may be explained by relatively poor healthcare and associated serious underlying conditions, but irrespective of the cause, which is a subject to itself and worthy of considerable public policy debate, it certainly makes clear the greater need for increased diversity in clinical trials.

So, as we begin this exciting webinar on ways to increase diversity of trial participants, let us be reminded that we can contribute meaningfully to the national trauma by setting our standards and expectations of higher participant diversity not because FDA requires it, but because it is good science, and it's the moral thing to do.