



Introduction to Policy Recommendations

These 33 Policy Recommendations are the result of over 2 years of collaboration between over 300 stakeholders drawn from public, private, and nonprofit sectors. These Policy Recommendations, however, are not the culmination of the EDICT Project, as the EDICT Team is committed to disseminating these Recommendations in the hopes of achieving actual policy change. The release of these Policy Recommendations, then, signals the initiation of the ‘dissemination phase’ of the EDICT Project.

We encourage readers to review the more detailed explanation of the EDICT Policy Methodology, contained in the Policy Methodology Document (also on this CD). Simply by way of Introduction, however, EDICT participants identified root causes of barrier to participation in nine distinct areas, which areas they viewed as opportunities for policy change. Those nine areas were:

1. Allocation of research dollars;
2. Insurance coverage for costs associated with clinical trials;
3. Professional education;
4. Public education;
5. Community participation;
6. Participant navigation;
7. Industry sponsorship;
8. Publications; and
9. Regulatory climate.

These Policy Recommendations have been the subject of an extensive revision process that began in earnest in September 2007. At that time, the EDICT Team held a Core Leadership Conference, which constituted a “soft launch” of the Policy Recommendations. Subsequently, in December 2007-January 2008, the EDICT Team conducted three “Waves” of review with both internal EDICT members and targeted external stakeholders. The EDICT Team then sought input from the public, as a reflection of both the inclusive deliberation process and the EDICT Team’s own research that revealed that more community involvement led to stronger recommendations.

Though these Recommendations are not “drafts,” our Policy Methodology leads us to believe that the policy revision process is ongoing, even as we enter the ‘dissemination phase.’ We therefore encourage critical feedback, and we look forward to continuing and deepening our collaboration with all those who work to ameliorate disparities in clinical trials.





Table of Contents

Policy Recommendation 1.1 --Allocation Strategy – Federal Research Priority

Policy Recommendation 1.2 -- Institute of Medicine Study

Policy Recommendation 1.3 -- State Health Plans

Policy Recommendation 2 -- Insurance Coverage

Policy Recommendation 3.1 -- Clinical Research Education

Policy Recommendation 3.2 -- Medical Education On Disparities (LCME)

Policy Recommendation 3.3 -- Graduate Medical Education

Policy Recommendation 3.4 -- Continuing Professional Education

Policy Recommendation 3.5 -- IRBs

Policy Recommendation 4.1 -- Mandates

Policy Recommendation 5.1 & 5.2 -- Community Participation

Policy Recommendation 6.1 & 6.2 -- Participant Navigation

Policy Recommendation 7.1 -- Industry Partnerships

Policy Recommendation 8.1 -- Publications

Policy Recommendation 9.1 -- NIH Revitalization Act of 1993

Policy Recommendation 9.2 -- Reinvigoration of the FDA Modernization Act

Policy Recommendation 9.3 -- Requirements for Culturally and Linguistically-
Appropriate Clinical Trials

POLICY RECOMMENDATION

1.1- Allocation Strategy – Federal Research Priority

Background

Diseases that are high incidence, high mortality, and feature high disparities ought to take the highest priority for public sector funding of clinical research ([Figure 1](#)). Nevertheless, there is evidence that diseases (e.g., liver cancer) which feature high disparities and high case fatality rates are significantly [underfunded](#).¹

Part of the problem is that the public and private sectors are essentially investigating the same disease areas.² It appears that economic considerations dictate policy in the private sector and political considerations dictate policy in the public sector. Moreover, the influence of such considerations in their respective sectors are unchecked by any defined, accepted standards for allocations.³

This approach to allocation of resources leaves many populations underrepresented in clinical trials. This is all the more problematic because many underrepresented populations bear a disproportionate burden of *disease*.

Policy Recommendation

Because allocation policy is integral to eliminating disparities in clinical trials, the EDICT team recommends that:

All federal agencies that fund clinical research give the highest priority for their clinical research investments to diseases with large disparities and high case fatality rates in racial and ethnic minorities, socially and economically disadvantaged populations, and others bearing the greatest burden of disease.



Intended Audience

The intended audiences for this policy recommendation are the U.S. Congress and federal agencies that fund clinical research, as it is they that set allocation policy for public sector funding of clinical research.

Rationale

Private firms have little incentive to allocate significant funds to research on low incidence/high case fatality/high disparity diseases. This is because such a disease simply does not sicken enough people to enable a pharmaceutical, medical device, or biotechnology company to earn a return on its capital investment.

Absent public sector funding, populations suffering from such diseases will not benefit from clinical trials. Accordingly, allocating public monies to the conduct of clinical research is crucial to ensuring that those who suffer from such diseases receive the benefits from clinical research.

Figure 1

Proposed EDICT Funding Priorities for Clinical Trials Accrual by Sector, Disparity, Incidence, and Mortality (Case Fatality)

Sector/ Degree of Disparity	High Incidence/ High Prevalence ¹	High Incidence/ High Mortality	Low Incidence/ High Case Fatality ²	Low Incidence/ Low Mortality
Public				
High Disparity	+++	+++++	++++	++
Low Disparity	++	++++	+++	+
Private				
High Disparity	++++	+++	+	+
Low Disparity	+++++	+++++	+	+

Funding Priority: + Lowest ++ Lower +++ Medium ++++ Higher +++++ Highest

¹ High Incidence/High Prevalence diseases reflects that while many people get the disease (e.g., local and regional breast cancer) many survive with it because of early detection and/or access to state of the art treatment.

² Low Incidence/High Case Fatality rate diseases reflect a situation where the overall incidence and mortality may be relatively low, but virtually everyone who is diagnosed with the disease will die of it in less than 5 years (e.g., liver cancer).

POLICY RECOMMENDATION:
1.2 –Institute of Medicine Study

Background

Diseases that are high incidence, high mortality, and feature high disparities ought to take the highest priority for public sector funding of clinical research (Figure 1). Nevertheless, there is evidence that diseases (e.g., liver cancer) which feature high disparities and high case fatality rates are significantly underfunded.⁴

Part of the problem is that the public and private sectors are essentially investigating the same disease areas. It appears that economic considerations dictate policy in the private sector and political considerations dictate policy in the public sector.⁵ Moreover, the influence of such considerations in their respective sectors are unchecked by any defined, accepted standards for allocations.

This approach to allocation of resources leaves many populations underrepresented in clinical trials. This is all the more problematic because many underrepresented populations bear a disproportionate burden of disease.⁶

Intended Audience

The intended audience for this policy recommendation is Congress.

Policy Recommendation

Because identifying and eliminating duplicative funding is integral to eliminating disparities in clinical trials, the EDICT team encourages the U.S. Congress to

- (a) **request that the IOM conduct a study to investigate duplication of clinical research funding among the public, private and not-for-profit sectors; and**
- (b) **request that IOM recommend strategies for eliminating duplication and promoting coordination.**

If the IOM were to conduct this study, the results could lead to a more equitable allocation of resources, which in turn may ameliorate some of the disparities in clinical trials that result from duplicative funding of clinical research.

Rationale

The priority status high incidence/high case fatality diseases enjoy in terms of clinical research funding has an unintended consequence: funding for specific research projects is often duplicated among the public, private, and non-profit sectors. The efforts of public advocacy organizations also contribute to this problem, as the most active and influential advocacy groups are often effective in ensuring increased or sustained funding for research consistent with their respective missions.⁷

To minimize such duplication, the Team recommends that the Institute of Medicine undertake a partnership with public sector funders to (1) identify areas of duplicative research and (2) to recommend strategies for eliminating duplication and promoting coordination.

The IOM is particularly well-positioned to participate in such a partnership because they released a report in 1998 entitled “Improving Priority Setting and Public Input at the National Institutes of Health.”⁸ This report surveyed the informal processes through which NIH allocated funds for biomedical research. As one of the few associations that has produced a detailed report on priority-setting for research, the IOM possesses sufficient background to identify and eliminate duplicative allocations. Moreover, because the IOM is well-respected by all manner of stakeholders and is considered an important voice in health policy in general, its participation in such a partnership would increase the level of success.

Figure 1

Proposed EDICT Funding Priorities for Clinical Trials Accrual by Sector, Disparity, Incidence, and Mortality (Case Fatality)

Sector/ Degree of Disparity	High Incidence/ High Prevalence ¹	High Incidence/ High Mortality	Low Incidence/ High Case Fatality ²	Low Incidence/ Low Mortality
Public				
High Disparity	+++	+++++	++++	++
Low Disparity	++	++++	+++	+
Private				
High Disparity	++++	+++	+	+
Low Disparity	+++++	+++++	+	+

Funding Priority: + Lowest ++ Lower +++ Medium ++++ Higher +++++ Highest

¹ High Incidence/High Prevalence diseases reflects that while many people get the disease (e.g., local and regional breast cancer) many survive with it because of early detection and/or access to state of the art treatment.



² Low Incidence/High Case Fatality rate diseases reflect a situation where the overall incidence and mortality may be relatively low, but virtually everyone who is diagnosed with the disease will die of it in less than 5 years (e.g., liver cancer).

POLICY RECOMMENDATION
1.3 - State Health Plans

Background

While some state health plans include information on clinical research and clinical trials, few address them in detail. Such focus is difficult because, at the state level, there are a number of stakeholders with divergent views and competing priorities.

Some states recognize the importance of the elimination/reduction of health disparities and have included appropriate language in their state health plans to encourage the implementation and development of programs.⁹ However, few have encouraged the recruitment and retention of racial and ethnic minorities, socially and economically disadvantaged populations and others that bear the greatest disease burden into clinical research/trials as a strategy to eliminate/reduce health disparities.¹⁰ Securing state resources in implementation and allocation could exert a particularly significant effect on disparities in clinical trials.

Policy Recommendation

Because state health plans' attention to disparities in clinical trials is crucial to elimination of such disparities, the EDICT team recommends that:

State, municipal, and federal policymakers work with states as they implement state health plans to increase accrual and retention in clinical research of racial and ethnic minorities, socially and economically disadvantaged populations, and others who bear the greatest disease burden.

Intended Audiences

The intended audiences for this policy recommendation are state, federal, and municipal policymakers including governors, state health officials, legislators, and mayors.



Rationale

Most clinical trials do not take place in academic clinical centers.¹¹ Two-thirds of phase III trials occur in community settings, which makes state health plans an important source for policy on clinical research. Thus, there is reason to believe that disparities in clinical trials could be reduced if state health plans focused on such disparities and recommended allocation of resources intended to eliminate them.

POLICY RECOMMENDATION

2.1-2.4 – Insurance Coverage

Background

Because costs associated with clinical trials are often a concern for participants, the existence of insurance coverage for clinical trials may act as a barrier to participation in clinical trials. For example, a study of NCI-sponsored cancer treatment trials found that uninsured patients represented only 5.4% of all clinical trial participants.

¹²

Even when participants have insurance, some private third-party payers do not cover the full costs associated with participating in the clinical trial.¹³ Though few studies have addressed the question outside of the context of cancer, the cancer studies have shown that the cost for a patient to take part in a clinical trial is not necessarily any more expensive than it is for the patient to receive standard care.¹⁴

Moreover, as is the case in general with barriers to clinical trials, the problems of cost and out-of-pocket expenses may affect underserved populations with greater frequency or intensity than populations already proportionately represented in clinical trials.¹⁵ As such, enhancing information flow regarding the extent of insurance coverage for clinical trials is integral to ameliorating disparities in clinical trials.¹⁶

The cost to conduct the clinical trial is not adequately reimbursed on the public side to support the clinical trial. Even if people do have insurance coverage this issue will still hamper accrual. Furthermore, the seemingly obvious solution – to enact mandates that would require insurers to reimburse for costs associated with clinical trials – is flawed for several reasons. First, any state mandate would be preempted and hence inapplicable to any ERISA plan.¹⁷ Thus, any such mandate would have a limited impact in ameliorating the problem. Second, imposing coverage mandates tends to frustrate insurers' ability to assess risk, which may result in higher premiums that would have a disproportionate impact on many of the same underserved populations who face disparities in clinical trials. For these and similar reasons, several advocacy groups recently abandoned their efforts to advocate for such mandates, and the EDICT Team joins them in believing that other policy approaches are more fruitful.

Policy Recommendations:

Because the lack of insurance coverage is a significant barrier to increase the opportunity for members of underserved populations to participate in clinical trials, the EDICT team recommends that:

2.1 - Business groups such as the National Business Group on Health (NBGH) and the CEO Roundtable on Cancer:

- a) request that their member companies provide coverage for clinical trials in their healthcare plans; and
- b) encourage their member companies to document the extent of benefits and communicate those benefits to employees with regard to participation in clinical trials.

2.2 - Health insurance or employee benefits related trade or business groups such as NBGH, Society for Human Resource Management (SHRM), America's Health Insurance Plans (AHIP), CEO Roundtable on Cancer and the NBGH request that their member companies enhance benefit managers' knowledge regarding coverage for clinical trials.

2.3 – Centers for Medicare and Medicaid Services (CMS) adopts policies that:

- a) develop a reporting mechanism to gather and disseminate information on state coverage for clinical trials in Medicaid and SCHIP programs; and
- b) encourage state Medicaid and SCHIP programs to adopt policies that are consistent with the policies of Medicare clinical trials coverage.

2.4 – Congress expressly authorize CMS to adopt policies that link coverage of clinical trials to sponsors' and research teams' certification that the protocol contains specific plans and demonstrated capacity to ensure appropriate inclusion and representation of populations underrepresented in clinical trials.

Intended Audience

The intended audiences for these policy recommendations include trade and business groups that influence insurance and benefits policy, such as the National Business Group on Health (NBGH), CEO Roundtable on Cancer, Society for Human Resource Management (SHRM) and America's Health Insurance Plans (AHIP), as well as the U.S. Congress and CMS. The NBGH is a non-profit organization representing large employers' interests on health care and health policy. Most of its clients are Fortune 500 companies and large public sector employers. The CEO Roundtable on Cancer is comprised of corporate executives from major American companies who work to develop initiatives to prevent, diagnose and facilitate access to best available treatments for their employees. SHRM is the world's largest professional association



devoted to human resource management and employee benefits; AHIP is a national association representing approximately 1300 U.S. health insurers. Finally, the Centers for Medicare and Medicaid Services (CMS), as the federal agency chiefly responsible for managing Medicare and Medicaid, is a prime mover in setting policy on reimbursement and coverage.

Accordingly, these organizations are important stakeholders in the policy discourse on insurance coverage and clinical trials, and their actions on coverage will clarify trends and practices on the issue. For the same reason, implementation strategies should focus on these stakeholders.

Rationale¹⁸

Given the complexity of health insurance coverage in general, there is reason to suspect that even people who do have insurance coverage may not know whether their policies include benefits for clinical trials. Thus, policy recommendation 2.1(a), urges trade associations like the National Business Group on Health, the CEO Roundtable, SHRM and AHIP to encourage member companies to clarify the extent of coverage for subscribers for benefits connected to clinical trials. Policy recommendation 2.1(b) follows up by urging the same associations to encourage greater transparency between employers and employees regarding the extent of coverage.

Because insurance benefit managers may lack knowledge of the scope of clinical trials and the extent to which coverage is extended to subscribers, policy recommendation 2.2 urges the relevant trade associations to encourage its member companies to take action intended to enhance benefit managers' knowledge regarding coverage for clinical trials.

Because Medicaid varies from state to state, and also because CMS is a prime mover in shaping reimbursement policy in both public and private markets, policy recommendation 2.3 urges CMS to adopt policy designed to increase collective understanding on Medicaid coverage for clinical trials. CMS's national coverage determination as to Clinical Trials Policy has already garnered significant attention regarding the need for Medicare reimbursement of costs associated with clinical trials,¹⁹ and features of Medicaid coverage are an important complement. Unfortunately, no comprehensive data exists on the latter, and CMS is in the best position to make the collection and analysis of such data a priority.

Finally, in the summer of 2007, CMS announced several Reconsiderations of its 2000 Clinical Trials Policy. These Reconsiderations proposed adding a self-certification process which entities would be required to satisfy in order for benefits to extend to participants in clinical trials sponsored or conducted by said entities. One of the items in the self-certification process would require entities to demonstrate a plan for recruiting and retaining members of underserved populations in clinical trials. The EDICT Team was and remains a strong supporter of the proposed changes. Though CMS ultimately decided to maintain the status quo for the time being, recommendation 2.4 reflects the EDICT Team's continuing belief that tying Medicare coverage for clinical trials to researchers' demonstrated and specific plans for ensuring



appropriate inclusion is integral to eliminating disparities in clinical trials. Moreover, if Congress were to expressly authorize CMS to adopt such policies, that would reaffirm the congressional commitment to appropriate inclusion embodied in the Revitalization Act.

Further details on the proposed Reconsiderations, including copies of all public comments issued by the EDICT Team in this issue, are available on the EDICT website.²⁰

POLICY RECOMMENDATION:
3.1 - Clinical Research Education

Background

Federal regulations require all investigational teams who conduct research with federal funding take human subjects research training. However, many academic medical centers and research institutions have viewed these regulations as a floor rather than a ceiling, and, in any case, only 30% of clinical trials are federally funded.²¹ Thus, these centers and institutions have responded to the need for supplemental training by creating their own education programs on the ethical and legal conduct of human subjects research.

While such programs typically cover the responsible conduct of clinical research, it is rare that such programs explain the current state of disparities in clinical trials. Nor is it common for training programs – whether intended to satisfy regulatory or institutional requirements – to address means of ameliorating these disparities. Because clinical research educational programs are so widespread, they represent attractive sites for introducing educational requirements and learning objectives related to disparities in clinical trials.

Policy Recommendation

Because the elimination of disparities in clinical trials is unlikely to occur without educating investigators on the ethical and scientific advantages of reducing disparities, the EDICT team recommends that:

Institutions that mandate research training experience include modules that

- (1) address the existence and current problems regarding disproportionate representation of underserved populations in clinical trials;**
- (2) explain why the amelioration of disparities in clinical trials constitutes both good science and good ethics; and**
- (3) suggest practical strategies for recruiting and retaining members of underrepresented populations in clinical trials.**

Rationale

Presumably, many academic medical centers and research institutions mandate clinical research education that emphasizes the responsible conduct of scientific research because of an understanding that such education promotes both ethics and science. As numerous authorities explain, the research enterprise in general founders without sufficient public trust that human subjects research will be conducted in accordance with ethical precepts. That public trust is part and parcel of high-quality science, because erosion of that trust makes human subjects research infinitely more difficult.

Nowhere is this dynamic more evident than in the current problems regarding disparities in clinical trials, in which a variety of populations are underrepresented in clinical trials. One of the most commonly cited barriers to increasing members of such populations' participation is mistrust in the research enterprise in general.

Without educating investigators on the current problems regarding these disparities, progress is rendered far more difficult because it is the investigators who have the means to design studies with built-in measures designed to increase enrollment of members of underrepresented populations. Education of investigators should also explain why increasing such participation is not simply an ethical imperative, but produces better science insofar as a subject population that displays such disparities will not resemble the targeted patient population, whether that population is the general public or a specific community. Finally, such education can suggest practical strategies for recruiting and retaining members of underrepresented populations in clinical trials, thereby equipping investigators with the needed tools.

Institutions that already mandate such research training are exceptionally positioned to supplement these programs with modules specifically designed to ameliorate disparities in clinical trials.

POLICY RECOMMENDATION
3.2 –Medical Education On Disparities (LCME)

Background

Students are graduating from medical school without sufficient knowledge of how health care disparities are manifested in clinical research. Formal research training—especially clinical research training—is scant in medical education curricula, and medical schools’ curricula that address health care disparities are frequently limited and offered as electives. Opportunities to participate in clinical research projects that enroll underserved patient populations are designed without sensitivity to cultural, linguistic, and other patient concerns, and model interdisciplinary teamwork is rare. And the effects of the “hidden curriculum” and medical students, interns, and residents often undermine educational efforts to address physicians’ behaviors and attitudes that contribute to health care disparities in clinical research.

Policy Recommendations

Because enhancing education of students, investigators, and other professionals is vital to ameliorating disparities in clinical trials, the EDICT team recommends that:

The Liaison Committee for Medical Education amend standard II.B.2, which addresses education regarding clinical research, so as to include specific learning objectives related to the manifestations of health care disparities in clinical and translational research; and

Rationale

Part of the difficulty in ameliorating disparities in clinical trials is that those professionals who are positioned to mollify the problem often lack understanding of both the problem and potential remedies, while those who understand the problem and means to ameliorate it are often ill-positioned to do so (i.e., they may not participate in clinical research). OT 3’s mission is largely directed to the former problem. The hope is that by enhancing the ways in which professionals are educated, more and more of those who conduct clinical trials will apprehend the widespread disparities in clinical trials, as well as their responsibility and their ability to effect change. While this recommendation addresses medical education, the EDICT Team believes that an analogous recommendation would be appropriate for accreditation bodies that credential health professionals. Medical students and trainees are targeted here at least in part because physicians remain the most likely party to be principal investigators.



While leaders in medical education are beginning to address the holes in medical curriculum regarding biomedical research in general, any attempts to do so which do not include specific learning objectives regarding disparities in clinical trials are suboptimal. Medical school and allied health school faculty and curriculum “managers” need to be given the mandate and the tools necessary to design, evaluate, and implement curricular interventions that address clinical research skills and the topic of health care disparities. Preceptors, residents, and principal investigators with responsibility for students’ education also need to be trained to effectively teach these curricula.

Finally, given the importance of the “hidden curriculum” in educating students, new physicians must be given the opportunity to shadow physician-scientists in clinical research that model practices for eliminating disparities. Revising the LCME standards so as to specifically mandate education regarding disparities in clinical trials offers one tool for building into medical education awareness of the problem as well as capacity for redressing it.

POLICY RECOMMENDATION –
3.3 - Graduate Medical Education

Background

Residents are crucial to the goal of eliminating disparities in clinical trials because they are often a patient’s first source of information regarding clinical trials. Educating residents that increasing proportionate representation in clinical trials makes for better science and for better ethics and is therefore a core element of the EDICT project.

In graduate medical education for residents, there is little to no formal training about clinical trials in general or disparities and the need for diversity in clinical trials recruitment. In 1999, the Accreditation Council for Graduate Medical Education (ACGME) endorsed general [competencies](#) for residency training.

In theory, several of the generic competencies overlap concern for increasing recruitment and retention of minority and other under-represented groups for clinical trials. However, none of the terms “research,” “clinical trials”, “minorities”, or “disparities” appear among either the short or full versions of the competencies. For that matter, the ACGME Core Competencies do not include specific requirements for training in understanding and interpreting research or criteria for evidence based research as, for example, maintained by the U.S. Preventive Services Task Force [criteria](#) for evidence based medicine.

Over the past seven years, the ACGME has developed a variety of tools to help implement as well as assess the Core Competencies, including materials on evidence based medicine and cultural competence, to cite only two that could impact recruitment of patients to clinical trials. It is therefore reasonable to incorporate materials on diversity and disparities in clinical trials research into the existing framework of the Core Competencies.

Policy Recommendation

Because provider education is vital to ameliorating disparities in clinical trials, **the EDICT team recommends that residency training programs incorporate the following elements into the formal curriculum of their programs:**

- **The existence of disparities and the need for diversity in clinical trials;**
- **Basic principles of research as they impact evidence based medicine as well as the acceptability and appropriateness of research findings for diverse populations;**
- **Awareness of available clinical trials for which their patients, especially those from underrepresented groups, may be eligible;**

- **Awareness of how lack of cultural competence impacts both patient care and recruitment to clinical trials;**
- **Awareness of Culturally and Linguistically Appropriate Services (CLAS) Standards as they impact both patient care and clinical trials recruitment.**

Rationale

Physicians in practice are a cornerstone for referral and recruitment to clinical trials. Physicians in practice tend to consider as priorities those categories of medicine to which they were exposed in their training. However, because neither residents nor physicians in practice receive systematic or consistent training in the issues related to disparities and the need for diversity in clinical trials recruitment, these concerns are not salient as they provide patient care, even when it would be appropriate to engage patients in discussion about appropriate clinical trials for which patients may be eligible. Because residents also are primary teachers in the clinical context of medical students' training, it is equally important for them to both model and reinforce culturally and linguistically appropriate approaches to patient care and clinical trials research.

POLICY RECOMMENDATION

3.4 - Continuing Professional Education

Background

Health professionals are crucial to the goal of eliminating disparities in clinical trials because they are often a patient's first source of information regarding clinical trials. Educating health professionals such as physicians, nurses as well as other members of the health care team that increasing proportionate representation in clinical trials makes for better science and for better ethics is a core element of the EDICT project.

For example, in continuing medical education (CME) for physicians in practice, there is little to no formal training about clinical trials in general or disparities and the need for diversity in clinical trials recruitment. Physicians also do not receive such training during residencies. In continuing medical education ("CME"), neither the Accrediting Council for Continuing Medical Education (ACCME), nor the American Academy of Family Physicians (AAFP), which maintains a separate CME accreditation process for family physicians, specifically address issues related to diversity or disparities in clinical trial recruitment. However, nothing precludes raising these issues in appropriate CME contexts.

Policy Recommendation

Because education is vital to ameliorating disparities in clinical trials, the EDICT team recommends that continuing professional education providers incorporate the following elements into their programs:

- **The existence of disparities and the need for diversity in clinical trials;**
- **Basic principles of research as they impact evidence based medicine as well as the acceptability and appropriateness of research findings for diverse populations;**
- **Awareness of available clinical trials for which their patients, especially those from underrepresented groups, may be eligible;**
- **Awareness of how lack of cultural competence impacts both patient care and recruitment to clinical trials;**
- **Awareness of the OMH Culturally and Linguistically Appropriate Services (CLAS) Standards as they impact both patient care and clinical trials recruitment.**

Rationale

Health professionals in practice are a cornerstone for referral and recruitment to clinical trials. Physicians, nurses and other health professionals in practice tend to consider as priorities those categories of medicine to which they were exposed in their training. However, because health professionals in practice do not receive systematic or consistent training in the issues related to disparities and the need for diversity in clinical trials recruitment, these concerns are not salient as they provide patient care, even when it would be appropriate to engage patients in discussion about appropriate clinical trials for which patients may be eligible.

POLICY RECOMMENDATION:

3.5 - IRBs

Background

Institutional Review Boards (IRBs) are often referred to as “gatekeepers” for the conduct of biomedical research involving human subjects. They are federally mandated under the National Research Act of 1974 and [45 C.F.R. § 46](#) *et seq.* Virtually all research involving human subjects, whether publicly or privately sponsored, must earn IRB approval

Unfortunately, IRBs often lack the training needed to recognize how disparities may manifest themselves in a research protocol and what the scientific and ethical implications of those disparities might be. For example, they may be ill prepared to review a research protocol with a complete understanding of the extent to which disparities may affect the enrollment of a racially and ethnically diverse cohort of participants. Moreover, the [Belmont Report](#) indicates that justice, construed primarily as fairness in subject selection, is a key principle in rendering human subjects research ethical. IRBs are indispensable in invigorating this third principle of the Report.

Policy Recommendation

Because education of IRBs is crucial to ameliorating disparities in clinical trials, the EDICT team recommends that

- (a) the Association for the Accreditation of Human Protections Programs (AAHRPP) include the requirement that IRBs receive training in health care disparities in general and disparities in clinical trials in order to qualify for accreditation.**
- (b) the Office of Human Research Protections (OHRP) issue policy guidance materials designed to enhance IRBs knowledge as to inclusion of underrepresented populations in clinical trials.**

Intended Audience

The [AAHRPP](#) is the accreditation body for IRBs both in the U.S. and globally. Accordingly, if they were to adopt standards for IRB accreditation that required IRBs to demonstrate both awareness of disparities in clinical trials and the need to ameliorate them, IRB behavior all over the world could conceivably be changed.

In addition, while IRB accreditation is currently voluntary, [OHRP](#) is the federal body most directly involved with federal oversight of IRBs. As such, any policy guidance issued by OHRP directed at IRBs would be likely to generate substantial buy-in.

Rationale

Despite the criticism directed at the IRB system in the past few years, it nevertheless remains an integral player in clinical research for the simple reason that no protocol involving human subjects may be conducted without IRB approval. While privately-sponsored clinical research is often excluded from statutory and regulatory requirements that govern research funded with public monies, *all* research involving human subjects must receive IRB approval under 45 C.F.R. § 46 *et seq.*

Because IRBs act as gatekeepers for clinical research, their awareness of the widespread disparities in clinical trials is crucial. If IRBs are unaware of the scope of the problem as to disparities, they are unlikely to exercise their authority in ways that will ameliorate disparities in clinical trials. IRBs themselves serve an educative function in some sense inasmuch as they perform educate investigators and research teams on the ethical and legal requirements for permissible human subjects research. Educating IRBs on the scope of the problem of disparities and on ways of increasing participation by underserved populations is therefore a way of simultaneously educating academic health center administrations, commercial funders of clinical research, and central or commercial review boards.

As to AAHRPP, it is a fairly new organization that has, as its founding members, credible and influential organizations who support the accreditation of IRBs (e.g., AAMC, FASEB, etc.). The AAHRPP has accredited a significant number of IRBs all over the world, including academic and commercial review boards (thereby reflecting the global character of clinical research). The AAHRPP conducts site visits and evaluations to reinforce its accreditation policies.

Accordingly, if the AAHRPP were to adopt accreditation standards relating to disparities in clinical trials, it could have significant impact in educating both IRBs and other major players (academic health centers, investigators, private sponsors, etc.) on the issue of disparities. Such awareness is a necessary first step to ameliorating disparities in clinical trials.

However, because AAHRPP accreditation is currently voluntary, federal involvement could prompt key policyholders to move swiftly in making mandatory IRB training on disparities in clinical trials. As such, there is a role for OHRP to play in setting policy on this issue. Issuance of OHRP-sponsored materials designed to train IRBs on disparities in clinical trials is a key component of policy change as to IRBs.

POLICY RECOMMENDATION:

4.1 - Mandates

Background

Two of the primary barriers to increasing participation in clinical trials are mistrust and lack of awareness of clinical trials. Such mistrust is particularly prevalent among underserved populations, many of which, sadly, have sound historical reasons for such mistrust. As to lack of awareness, one survey found that 80% of respondents were unaware that they were eligible to participate in a clinical trial related to their illness.²²

One possible means of ameliorating both mistrust and lack of awareness is enhancing educational opportunities regarding clinical trials for the public. Notwithstanding the legitimate basis for some underserved populations' mistrust of clinical trials, many persons may also harbor various fears and misconceptions regarding clinical trials.²³ These fears could be assuaged with effective education. Moreover, the obvious remedy for the general lack of awareness of clinical trials is to increase such awareness via enhanced education.

While almost half of all states require that insurers cover the costs associated with clinical trials, and CMS announced in 2000 that it would reimburse such costs, there is no concomitant mandate regarding public education of clinical trials.

OT 4.1 Policy Recommendation

Because educating the public on the clinical trial process is integral to ameliorating disparities in clinical trials, the EDICT team recommends that

- (1) all states that mandate insurance coverage for costs associated with clinical trials should also mandate these companies provide to each member**
 - (a) educational materials; and**
 - (b) information about the benefit separate from any other communication (i.e., a policy coverage book);**

and

- (2) CMS adopt policy designed to ensure that all Medicare beneficiaries receive**
 - (a) educational materials; and**
 - (b) information about the benefit separate from any other communication (i.e., a policy coverage book).**

Rationale

Both federal and state governments have recognized the importance of ensuring insurance coverage for clinical trials. Approximately 20 states have enacted laws requiring insurers to cover reasonable costs associated with clinical trials. Similarly, the Medicare clinical trials policy has mandated such coverage as to Medicare since 2000, and CMS expressly considered expanding coverage in its 2007 reconsideration of its Clinical Trials Policy.

Nevertheless, neither the relevant state laws nor the Medicare clinical trials policy contains any express requirements regarding education for the respective beneficiaries. This is significant because patients' lack of awareness regarding clinical trials is a significant barrier both to general participation in clinical trials and to members of underserved populations' participation.

Accordingly, these policy recommendations fill an important hole in the state and federal policies by requiring educational materials be provided to relevant beneficiaries. Attaching the educational requirements to pre-existing mandates will ideally ease implementation and enhance impact, particularly as applied to the Medicare clinical trials policy.

POLICY RECOMMENDATION

4.2 - Community Outreach – Sponsors

Background

Two of the primary barriers to increasing participation in clinical trials are mistrust and lack of awareness of clinical trials. Such mistrust is particularly prevalent among underserved populations such as women, the elderly, and racial and ethnic minorities. Sadly, many of these populations have sound historical reasons for such mistrust. As to lack of awareness, one survey found that 80% of respondents were unaware that they were eligible to participate in a clinical trial related to their illness.²⁴

One possible means of ameliorating both mistrust and lack of awareness is enhancing educational opportunities regarding clinical trials for the public. Notwithstanding the legitimate basis for some underserved populations' mistrust of clinical trials, many persons may also harbor various fears and misconceptions regarding clinical trials.²⁵ These fears could be assuaged with effective education. Moreover, the obvious remedy for the general lack of awareness of clinical trials is to increase such awareness via enhanced education.

Finally, information on clinical trials and the clinical trial process is available but is often underutilized, and may also be written in such a way that the average individual cannot understand it.

Intended Audience

Given that there is a pressing need for enhanced public education regarding clinical trials, it makes sense that those stakeholders who organize and sponsor clinical trials are well-positioned to effect change. Accordingly, this policy recommendation targets such sponsors, whether they be public, private for-profit, or non-profit actors.

4.2 Policy Recommendation

Because enhancing patient and public understanding of clinical trials is integral to ameliorating disparities in such trials, the EDICT team recommends that all sponsors of clinical trials require:

- (a) **the development and implementation of culturally appropriate recruitment and retention plans with an additional focus on community education provided in appropriate languages for non-English and limited-English speaking populations.**

Such plans should reflect the cultural and ethnic diversity of the populations at the sites to simulate the local recruitment and retention of appropriate numbers of racial and ethnic minorities, women, and other and medically underserved patients as trial participants.

- (b) **that all local clinical trial teams convene a community advisory “recruitment and retention committee” to inform, evaluate, and advise on participation of underserved populations.**

Rationale

It is striking that in spite of the general consensus that mistrust and lack of awareness are significant barriers to clinical trial participation, organized, systematic efforts to enhance patient and public education are infrequent. Increasing such participation among underserved populations is particularly important insofar as many underserved populations (*e.g.*, women, the elderly) bear a disproportionate burden of disease. Enhancing education as to clinical trials may increase participation in general both by simply increasing awareness of clinical trials and by promoting trust between subjects and researchers.

However, these goals are also essential to ameliorating disparities in clinical trials. This is because both mistrust and lack of awareness of clinical research constitute significant barriers to increasing members of underserved populations’ participation in clinical research. One way of increasing both the utilization and the quality of such education is to encourage sponsors of clinical research to require all research teams seeking funding include in their protocols specific communication plans for educating members of underserved populations.

This process should be based on evidence-based research or promising practices so as to increase the likelihood of successful communications. Furthermore, continued and future funding should be made dependent, in part, on evaluation of the outreach/education methods, thereby further ensuring evidence-based practice. The EDICT Project’s BackPack research, which is intended to assess best practices in reducing disparities in clinical trials, may facilitate the identification of best practices regarding public education.

Inclusion, participation of the underserved in clinical trials can ultimately reduce cost and resources necessary to conduct population-relevant clinical trials and accelerate enrollment into these trials.

POLICY RECOMMENDATIONS

5.1 & 5.2 – Community Participation

Background

There is a disconnect between research institutions and the communities where they conduct clinical research. Part of that disconnect is cultural and systemic. Clinical trials are part of the larger picture of clinical research. We believe that communities must be involved in the entire clinical research process. To be effective, involvement with communities must begin before a trial and continue after the trial is completed. This in turn results in less robust knowledge and less effective options for segments of the population. We define “community” as “those whose well-being is likely to be affected by the conduct of the research.” *From Building Community Partnerships in Research, Recommendations and Strategies, Report to the President from the Secretary, Health and Human Services, February 1998.*

Authentic community participation (as opposed to representation) in the clinical trial process is rare, which tends to exacerbate disparities in clinical trials and outcomes. Such disparities result in research findings that may not be applicable or generalizable to all segments of the population. This in turn results in less robust knowledge, less effective clinical outcomes, and fewer options for segments of the population.

Several significant factors result in minimal community participation in clinical trials.

First, there is insufficient gender, racial and ethnic diversity among clinical researchers, compounded by a lack of understanding of context on the part of researchers. Researchers typically lack critical contextual data about the communities that will assure a more community-specific design. While information about quality of life exists, it is often discounted because it is qualitative and not quantitative. The data explaining what it is like to live in a particular underserved community exists, but is rarely sought and when identified it is often discounted. This is both because it is qualitative and because members of the research community do not see the need to consider cultural and community norms in clinical trials. Researchers may acknowledge these limitations exist however, they are not reflected in the actionable results published.

Second, there is a failure to disseminate clinical research findings to those who participated in the trial and to the community as a whole. This is perceived as disrespectful and diminishes the value of its investment. This promotes distrust and perpetuates the barriers to community participation.

Third, clinical studies fail to provide for the creation of infrastructure within the community to support residents over the long term. Building ongoing capacity in the community is important both to increase community participation and to eliminate disparities in clinical trials.

The collective experience of the team confirms that community participation in clinical research is critical and will contribute significantly to the elimination of disparities in clinical trials.

Policy Recommendations

5.1

*Because increasing community participation is crucial to eliminating disparities in clinical trials, the EDICT Team recommends that **public and private sector sponsors** require:*

1. All proposals for clinical trials considered for funding to demonstrate methods and measures to ensure meaningful community participation throughout the clinical trial process.
2. All proposals for clinical trials considered for funding to include a detailed plan to build community capacity for understanding and supporting clinical research. (For example, these might include an ongoing participant navigation program, community training and education as well as equipment, facilities, and other resources that enhance access to healthcare services.)

5.2

*The EDICT Team further recommends that **community organizations and individuals**, as equal partners in the process, should:*

1. Develop and implement plans to actively disseminate information about research outcomes, new policies, and new knowledge to community members.
2. Develop ongoing relationships with individual investigators and with research institutions to promote meaningful dialogue that ensures community involvement.

Rationale

To enroll and retain appropriate representation in clinical trials, a new system of community engagement and representation is required. A system that includes

community-based participatory research principles will leverage the expertise, experience, and motivation of “those whose well-being is likely to be affected by the conduct of the research.” These principles include:

- Recognizes community as an unit of identity
- Builds on strengths and resources within the community
- Facilitates collaborative, equitable involvement of all partners in all phases of the research
- Integrates knowledge and intervention for mutual benefit of all partners
- Promotes a co-learning and empowering process that attends to social inequalities
- Involves a cyclical and iterative process
- Addresses health from both positive and ecological perspectives
- Disseminates findings and knowledge gained to all partners
- Involves long-term commitment by all partners.²⁶

There are multiple reasons to incorporate community-based participatory research principles in clinical trials.

1. Community participation can increase each community’s readiness and willingness to participate in the clinical trials process when grassroots community members are engaged in the decision-making process at all levels and phases including the planning and implementation stages. Helping people to become informed and educated about the clinical trials process is essential to recruitment and retention of participants.
2. Participation can help build trust between the community and researchers where mistrust often exists. This is particularly important given the documented abuses of human subjects.
3. It builds greater understanding of the clinical trials process and the contributions communities can make in bringing new treatments to the public.
4. Enhanced community participation results in increased opportunities for community members to assume more meaningful roles in the entire clinical trials process.
5. Community participation promotes individual retention in trials because participants are better informed and have the support of the community. In such circumstances, participants’ commitment would be motivated by the desire to make a contribution to the health of their community.
6. Community members with experience in the clinical trials process can help identify what research needs to be done as well as assist in the planning and implementation of clinical trials.

These policy recommendations will strengthen the relationship between the community and the full research system; ameliorate distrust that exists in the community; ensure the dissemination of clinical trial results to all segments of the community; and significantly contribute to successful, representative clinical trials.

POLICY RECOMMENDATIONS

6.1-6.3 – Participant Navigation

Background

Participant²⁷ navigation is a relatively new concept for clinical trials. It is increasingly important in addressing the system barriers presented by our fragmented health care system. Simply navigating the various elements of clinical trials – meeting screening and lab appointments in different places, taking time off of work, arranging child care, etc. – constitutes a significant barrier to participation in clinical trials for underrepresented populations.

These populations include rural families, people with disabilities, the elderly, women, children, as well as various racial and ethnic minorities. Participant navigation is wholly service-oriented, and is inherently flexible because navigators must respond as (1) different professionals to the needs of (2) different communities who may need (3) different services with (4) different time/schedule commitments. Ultimately, participant navigation is crucial to eliminating disparities in clinical trials because the subject may well associate the clinical trial with the navigator (rather than with the investigator, study coordinator, project manager, etc.)

Policy Recommendations

6.1

Because high-quality participant navigation is essential to ameliorating disparities in clinical trials, the EDICT team recommends that institutions and providers of continuing education:

- (1) institute basic training for participant navigators;**

6.2 and 6.3

and that institutions and sponsors of clinical research:

- (2) ensure that entities that conduct clinical trials demonstrate that they have the capacity to deliver participant navigation services; and**
- (3) encourage research protocols to include specific participant navigation plans. Such plans should include implementation schemes that reflect collaboration and input from existing navigators and community representatives with input from patients.**

Intended Audiences



Because participant navigation services may represent a crucial liaison between investigators, subjects, and communities, the EDICT Team 6's recommended policies are addressed to multiple audiences.

As participant navigation training is sorely needed, policy recommendation #1 encourages certifying/accrediting bodies like the Joint Commission, health professional associations, or state paraprofessional organizations to institute basic training for participant navigators.

Policy recommendations #2 (ensuring navigation capacity) and #3 (encouraging in protocols inclusion of navigation plans) each address public and private sponsors of clinical research, as well as academic, private, and community sites where clinical research is conducted.

Rationale

Policy recommendation #1 addresses the emerging paraprofessional role of participant navigators and the highly diverse backgrounds of persons entering this work. Patient navigators may be healthcare professionals, social workers, cancer survivors or other lay persons from the community. There is a need, therefore, to institute basic training for participant navigators to establish the core knowledge and skills they need. Participant navigation services are vital because the navigator is often the "face" of the clinical trial to the participant. The participant navigator's presence can be critical to recruitment and especially retention of participants from at-risk communities.

Moreover, simply expanding patient navigation services are insufficient to meet the need for several reasons. First, not all participants in clinical trials are patients. Second, failing to draw a macro-level distinction between clinical care and clinical research runs the risk of perpetuating the therapeutic misconception, loosely defined as the conflation of therapy with research.²⁸ Avoiding the therapeutic misconception requires treating navigation through the clinical research enterprise differently in some important senses from navigation through the therapeutic enterprise.

Policy recommendation #2 addresses the need to make the presence of patient navigation services an accepted standard of practice for institutions conducting clinical trials. This recommendation focuses on funding and other incentives to encourage these institutions to build this capacity.

Policy recommendation #3 addresses the fact that participant navigation is often an afterthought in study design and execution. Given the importance of navigation to the participant, it is advisable to include participant navigators in the design of the specific protocol. This practice will enable navigators, along with representatives from at-risk communities, to help the study team develop a navigation plan tailored to the needs of those communities.

POLICY RECOMMENDATION

7.1 – Industry Partnerships

Background

For some time, there has been concern with disparities in the representation of underserved populations in clinical trials. Given that conducting high-quality clinical trials is an enormous task, implementing programs designed to ameliorate these disparities has proven difficult for research sponsors throughout the clinical trials paradigm. As the driving force for 75% of human subjects research conducted around the world, pharmaceutical and biotechnology companies are exceptionally positioned to institute measures designed to ensure appropriate representation in clinical trials.²⁹

In drafting the policy recommendation below, the EDICT Team began with the problem statement that underserved populations are not appropriately represented in clinical trials. The team defined “underserved populations” to include a number of categories including, but not limited to, racial and ethnic minorities, older adults, women, rural populations and persons with disabilities. We note that the efforts that have been made in pediatric studies have resulted in a sea change in how the clinical programs are designed. We believe that the same kind of beneficial effect can be obtained by a focus on underserved populations.

Guiding Principle

The team also adopted a principle for guiding the drafting of research policy by decision makers within the pharmaceutical and biotechnology industries. This principle states as follows: “Unless medically or scientifically contraindicated, clinical trials sponsored by these industries will be designed and implemented with a strategy for inclusion that reflects fully the diversity of the population with the disease or condition of interest.”

The principle applies to studies conducted across the life span. Likewise, this principle can serve as a model of ethical global drug development policy.

Policy Recommendation

Because the elimination of disparities in clinical trials is good ethics, good science, as well as good business, the EDICT team recommends that industrial sponsors adopt policies to ensure that decisions to implement clinical trials will include:

- (1) Assessment of whether a given intervention is targeted to the general population or to specific subgroups within the general population;**
- (2) Requirements of investigators that the subject population include members of underserved communities that correspond to the proportions such communities comprise in the targeted population;**
- (3) Development and selection of investigators with the capability of achieving diversity of inclusion based on the population served.**
- (4) Requirement that clinical trial plan takes account of how the communities affected will receive information and other benefits as a result of the trial.**

Rationale for Policy

A commitment to evidence-based medicine requires being able to define what counts as better evidence and why.³⁰ The team believes that evidence from clinical trials that has representation based on disease prevalence is superior to evidence from trials that lack such representation.³¹ As a recent Endocrine Society White Paper put it, clinical trial data based on studies that lack appropriate representation cannot be presumed to be applicable to “all the key ethnic minorities who suffer a higher burden of these diseases”³² “Scientifically, it makes no sense to develop new treatments among populations of patients who are different from those who will be using them.”³³

In general, the clinical trial should provide evidence of applicability of the intervention across the entire patient population. In other cases, a clinical trial is designed to provide evidence of the effect of an intervention in a specific target population (whether identified by race, ethnicity, gender, disability status, or age). Therefore, clinical trials with diverse representation assure better scientific evidence, which can then be translated into better clinical practice, and provide greater benefit to the public.

The Team recognizes that industry-sponsored clinical trials reflect the realities of globalization. However variations in environment, habits, practices, lifestyle, genetics, nutrition, etc. have the potential to impact responses to medical interventions.³⁴ Accordingly, inclusion of under-represented populations from any specific state, country, or region may not provide crucial information regarding how a given intervention will affect under-represented communities within the U.S. The team also recognizes that race is a social concept with no essential biological definition.³⁵ Despite the global character of clinical research, the best evidence of how a given intervention will work within the American population comes from clinical trials in which the diversity of America is well-represented.



Ultimately, pharmaceutical and biotechnology companies are critical to the success of the overall project to reduce disparities in clinical trials. These sponsors have the authority and the means to mandate representation that can eliminate such disparities.

POLICY RECOMMENDATION

8.1 - Publications

Background

There is consistent evidence that populations that bear disproportionate burdens of disease are consistently underrepresented in clinical trials. Moreover, discussions of diversity, inclusion, and representation in clinical trials are often missing from the subsequently published studies. This is unfortunate because frank scholarly discussion of disparities represents a significant learning opportunity both for the investigators themselves and for the general readership.

While there are uniform requirements regarding biomedical publications from at least two different bodies (the [International Committee of Medical Journal Editors](#), or “ICJME,” and the [World Association of Medical Editors](#) or “WAME”), neither addresses the problem of disparities in clinical trials. In addition, the rationale for eliminating disparities in clinical trials on grounds of social justice, scientific rigor, and business interests has not been made clear to journal editors, academic medical centers, private sponsors of clinical trials, and investigators themselves.

Increasing awareness of the problem of disparities in clinical trials is a first step to eliminating them. Urging enhanced dialogue and analysis of the issue in connection with publications is an important means of raising awareness.

Policy Recommendation

Because publications provide a forum for raising and analyzing disparities in clinical trials, they are integral to eliminating such disparities. The EDICT team therefore recommends that:

the ICMJE and the WAME adopt editorial standards that require investigators to include in their manuscripts analysis of whether the subject population’s demographics correspond to the demographics of the population that bears the disease burden.

Intended Audiences

While a number of different stakeholders have the potential to change behavior in this area, arguably journal editors enjoy the most direct ability to do so. Given that the ICMJE and the WAME set standards for biomedical journals worldwide, they are a key player in implementing policy that could raise awareness and enhance analysis of disparities in clinical trials.

Rationale

While most published studies are products of clinical trials that did not feature appropriate representation, most studies also do not discuss the inclusiveness or lack thereof of the relevant trials. This results in the loss of a significant learning opportunity. At a minimum, frank and open disclosure of a trials' success or failure to recruit and retain subjects who are members of populations that bear the relevant disease burden would increase dialogue and awareness of the widespread disparities within clinical trials.

Moreover, ensuring appropriate representation between the subject population and the population that bears the disease burden would result in higher quality publications. In general, the clinical trial should provide evidence of applicability of the intervention across the entire patient population. In other cases, a clinical trial is designed to provide evidence of the effect of an intervention in a specific target population (whether identified by race, ethnicity, gender, disability status, or age). Therefore, clinical trials with diverse representation assure better scientific evidence, which can then be translated into better clinical practice, and provide greater benefit to the public.

Finally, biomedical journals have been an important source of information and criticism regarding past research abuses. Henry Beecher's famous 1966 article detailing such abuses at major academic centers was a significant stepping stone on the path to formal regulation of clinical research.³⁶ Unfortunately, many of the same populations that are underrepresented in clinical trials are victims of past research abuses. Accordingly, U.S. and global leaders in setting publication standards can play a crucial role in ensuring that the benefits of biomedical research are distributed justly, especially to populations that have been subjected to unethical research in the past.

POLICY RECOMMENDATION
9.1 - NIH Revitalization Act of 1993

Background

The [NIH Revitalization Act of 1993](#) requires applicants for federal research funding to provide a strategy for inclusion of people of diverse racial and ethnic origin and women into clinical trials. While this requirement does force investigators to think about issues of disparities in clinical trials formulate a plan to alleviate some of these disparities, recent data show that most clinical trials are still falling short of their target inclusion percentages and that submitted plans are not always being followed after their initial approval by the Institutes.

Policy Recommendation

Because the NIH Revitalization Act is crucial to eliminating disparities in clinical trials, the EDICT team recommends that:

- (a) – NIH provide for more direct instruction as to what an appropriate inclusion plan should look like in regards to recruitment and retention, and how success of the plan will be evaluated.**
- (b) – Applicable NIH policy should expressly provide for substantial incentives for investigators to implement appropriate inclusion plans.**

Intended Audience

This policy recommendation is intended for both clinical investigators and the National Institutes of Health. The NIH has the wherewithal to change investigator conduct, while Congress is the appropriate Political Actor to change the NIH policy.

Rationale

While the NIH Revitalization Act of 1993 mandates appropriate representation of traditionally underrepresented populations in clinical trials, that mandate has, unfortunately, not translated into measurable improvements. There are many reasons for this difficulty in translation, but the ultimate point is that the Revitalization Act needs to be revitalized. The effect of the Revitalization Act could be substantially increased with better and more specific guidance from NIH that would provide detailed analysis and suggestions on how to implement appropriate inclusion plans.

Moreover, NIH reviewers should more stringently assess submitted plans for their likelihood of achieving the target inclusion and for the appropriateness of the target percentages given the location. The EDICT Team noted the possibility of satisfying the mandates of the



Revitalization Act by attaching direct grant scoring to the merits of the inclusion plan. Incentives should be offered to those proposals which contain superior inclusion plans.

POLICY RECOMMENDATIONS
9.2- Reinvigoration of the FDA Modernization Act

Background

In 1997, the US Food and Drug Administration enacted the guidance, [FDA Modernization Act](#) to standardize collection of race and ethnicity data in clinical trials. However, the FDA guidance “does not address the level of participation of racial and ethnic groups in clinical trials.” It has been posited that the lack of requirements for diverse racial and ethnic inclusion is not consistent with the essential ethical principles of the [Belmont Report](#) (i.e., respect for persons, beneficence, and justice). Moreover, due to the fact that the NIH Revitalization Act mandates that NIH address issues of appropriate inclusion and representation, the FDA has tended to describe the issues surrounding disparities in clinical trials as largely outside of their jurisdiction or ambit.

9.2 Policy Recommendations

Because FDA action is integral to eliminating disparities in clinical trials, the EDICT team recommends that:

- (a) – FDA policy be harmonized with NIH policy to require appropriate racial and ethnic inclusion in clinical trials**
- (b) – FDA implement penalties for non-compliance.**
- (c) – FDA implement incentives for appropriate racial and ethnic inclusion.**

Intended Audience

This policy recommendation is aimed at the U.S. Congress and the Food and Drug Administration.

Rationale

A harmonization of FDA policy with NIH policy pursuant to the NIH Revitalization Act of 1993 could have a significant effect in eliminating disparities in clinical trials. It is possible that an unintended consequence of the Revitalization Act is the perception that ensuring appropriate inclusion is solely NIH’s responsibility. This is untrue because the FDA’s primary objective is to ensure the safety of the nation’s food and drug supply, and there is a growing base of quality evidence showing that introducing drugs into populations whose demographics and comorbidities were not appropriately represented in the clinical trials is at least inadvisable, and at most dangerous. As such, harmonizing FDA and NIH policy on disparities in clinical trials is crucial to crafting a collaborative, informed regulatory approach on the federal level. In



addition, the NIH Revitalization Act applies only to recipients of federal funds. Given that many clinical trials are funded by private sponsors, FDA authority is needed to augment buy-in among stakeholders not subject to the mandates of the Revitalization Act.

While calls for increased penalties should be allocated judiciously, the EDICT Team reached consensus that incentives alone are unlikely to generate buy-in from the relevant stakeholders sufficient to substantially reduce disparities in clinical trials. Accordingly, penalties may be needed to change the policy climate regarding federally mandated inclusion in clinical trials. Such penalties, along with positive incentives for compliance, could conceivably go a long way to reducing the complexity and the ambiguity of two different standards of reducing disparities in clinical trials.

The FDA Director would reconvene the panel that the FDAMA called for with the intention of producing policy designed to ameliorate disparities in clinical trials. Such a policy would ideally perceive such disparities as squarely within the ambit of the FDA and IRBs if we are to follow the lead of the Belmont Report.

POLICY RECOMMENDATION:
**9.3 - Requirements for Culturally and
Linguistically-Appropriate Clinical Trials**

Background

In 2000, the Department of Health and Human Services (DHHS) [Office of Minority Health](#) (OMH) published 14 [National Standards on Culturally and Linguistically Appropriate Services](#) (CLAS) in 2000. The CLAS standards are designed to help health care organizations and individual providers make their practices more culturally and linguistically accessible. The goal is to integrate CLAS standards throughout healthcare organizations in partnership with the local community so that all healthcare consumers receive treatment that is equitable and effective as well as culturally and linguistically appropriate.

CLAS standards are organized according to three themes:

- Culturally Competent Care
- Language Access Services
- Organizational Supports for Cultural Competence.

Within this framework, there are three types of standards with varying stringency:

- CLAS **mandates** are current Federal requirements for all recipients of Federal funds.
- CLAS **guidelines** are recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies.
- CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations.

CLAS Standards are currently not addressed consistently or systematically, if at all, in clinical trials.

Policy Recommendation

All clinical research policy makers (e.g., accrediting bodies, public and private sector funders, as well as healthcare agencies, corporations, institutions, and organizations sponsoring or conducting clinical trials) will formally:

- **Acknowledge their commitment to CLAS standards in their written policies and clinical research guidelines.**
- **Incorporate CLAS standards into their formal professional training, whether for certification or as continuing education.**
- **Distribute the CLAS standards to all researchers and staff engaged in clinical research under their auspices.**
- **Strive for adherence to the CLAS Standards related to**
 - **language access services (Standards 4, 5, 6, and 7).**
 - **diversity of staffing (Standard 2), and**
 - **maintaining a current demographic, cultural, and epidemiological profile of the community for purposes of recruiting and retaining representative participants in clinical trials**

Intended Audience

This policy recommendation is aimed at accrediting bodies such as the Society of Clinical Research Associates (SoCRA), the Association for the Accreditation of Human Protections Programs (AAHRPP), as well as funding agencies such as the National Institutes of Health (NIH), and the Centers for Disease Control (CDC) and regulatory agencies or bodies such as the Food and Drug Administration (FDA) and individual institutions that conduct clinical trials as well as their Institutional Review Boards (IRBs) mandate the adherence to the CLAS standards for clinical trials that they conduct or sponsor.

Rationale

While OMH promulgated the CLAS standards in 2000, little progress has been made in incorporating these standards into the clinical research enterprise. This is despite the fact that several of the CLAS standards are mandatory for all recipients of federal funds. The EDICT Team is aware that the Office of Civil Rights is currently considering whether failure to satisfy the mandated standards qualifies as a violation of applicable civil rights law. Such penalties may be necessary to produce compliance with the CLAS standards, but the EDICT Team is also working with both OMH and the Office of Women’s Health on a project designed to find ways of applying the CLAS standards to clinical trials (“CLAS-ACT”).

The goal of the CLAS-ACT project is to familiarize clinical trials investigators and staff with CLAS standards, and to assess how well CLAS standards are implemented in specific research studies as well as throughout individual agencies, institutions, and organizations. Enhanced application of the CLAS standards into the clinical trials process could contribute significantly to ameliorating disparities in clinical trials by ensuring that interaction and

communications with participants will proceed along culturally and linguistically appropriate pathways.

¹ Jon Kerner, *Barriers to Medically Underserved Peoples Participation and Retention in Clinical Trials*, at 3-4.

² Andrew A. Toole, *Does Public Scientific Research Complement Industry R&D Investment?* Available at <http://ftp.zew.de/pub/zew-docs/dp/dp0575.pdf> last accessed on March 23, 2008. In this discussion paper, Toole addresses the debate of how much public money should be spent on scientific research and on which areas of research should receive funding by asking whether publicly funded research complements private research and development. He concludes that publicly funded basic research is more complementary and thus more important to private industry than publicly funded clinical research. Even so, Moses, et al., found that 43% of the NIH budget was allocated to support clinical research in 1994 and increased slightly to 45% by 2004. See Hamilton Moses, et al., *Financial Anatomy of Biomedical Research*, 294 JAMA 1333-1342 (2005).

³ Franco Sassi, *Setting Priorities for the Evaluation of Health Interventions: When Theory Does Not Meet Practice*, 63 HEALTH POLICY 152 (2003). The author notes that “in most organizations commissioning or undertaking evaluations of health interventions priority setting remains largely an informal process led by power an influence, rather than by systematic and explicit criteria.” Sassi specifically refers to the NIH priority setting process as one that is accomplished “through largely informal and unstructured processes.”

⁴ Jon Kerner, *Barriers to Medically Underserved Peoples Participation and Retention in Clinical Trials*, at 3-4.

⁵ John E. Porter, *Federal Funding and Supportive Policies for Research*, 294 JAMA 1385-1389 (2005).

⁶ Jemal Ahmedin, et al., *Cancer Statistics, 2005*, 55 CA CANCER J CLIN 10-30 (2005) (noting these disparities may result from inequalities in access to and receipt of quality health care and/or differences in comorbidities).

⁷ See, e.g., Rebecca Dresser, “Public Advocacy and Allocation of Federal Funds for Biomedical Research,” *The Milbank Quarterly* 77, no. 2 (1999): 257-27; David Resnick, “Setting Biomedical Research Priorities: Justice, Science, and Public Participation,” *Kennedy Institute of Ethics Journal* 11 (2001): 181-204.

⁸ Institute of Medicine Report, *Scientific Opportunities and Public Needs: Improving Priority Setting at the National Institutes of Health* (Washington, D.C.: National Academy Press, 1997).

⁹ See, National Cancer Institute, *States That Require Health Plans to Cover Patient Care Costs in Clinical Trials* (last updated 3/27/2007) available at <http://www.cancer.gov/clinicaltrials/developments/laws-about-clinical-trial-costs> last accessed on March 23, 2008. The NCI has identified 23 states that have passed legislation that requires a health care plan to provide coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.

¹⁰ *Id.*

¹¹ G. Lightfoot, et al., *Faster Time to Market: ACRP’s White Paper on Future Trends*, APPL. CLIN TRIALS 56-68 (1999); See also M. Lunik, *Clinical Research: Managing the Issues*, 56 AM J HEALTH SYST PHARM 170-174 (1999).

¹² W.B. Sateren, et al., *How sociodemographics, presence of oncology specialists, and hospital cancer programs affect accrual to cancer treatment trials*. 20 JOURNAL OF CLINICAL ONCOLOGY 2109-17 (2002).

¹³ D.P. Goldman, et al., *Incremental treatment costs in National Cancer Institute-sponsored clinical trial*, 289 JAMA 2970-2977 (2003); see also, William B. Farrar, *Clinical Trials: Access and Reimbursement*, 67 CANCER 1779, 1781 (1991).

¹⁴ *Ibid.*; see also M.L. Brown, *Cancer patient care in clinical trials sponsored by the National Cancer Institute: what does it cost?* 91 JOURNAL OF THE NATIONAL CANCER INSTITUTE 818-19 (1999); B.H. Fireman, et al., *Cost of care for patients in cancer clinical trials* 91 JOURNAL OF THE NATIONAL CANCER INSTITUTE 847-53 (1999).

¹⁵ Anjali S. Advani, et al., *Barriers to the Participation of African-American Patients with Cancer in Clinical Trials: A Pilot Study*, 97 CANCER 1499-1506 (2003), concluding that interventions targeting education and income may increase the recruitment minority patients into clinical trials.

¹⁶ G. Marie Swanson and Amy J. Ward, *Recruiting Minorities Into Clinical Trials Toward a Participant-Friendly System*, 87 J. NATL. CANCER INST 1747-1759 (1995).

¹⁷ See, William Pierron, *ERISA Pre-emption: Implications for Health Reform and Coverage*, 314 EBRI ISSUE BRIEF (2008) available at, http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf, last accessed on March 23, 2008. ERISA refers to the Employee Retirement Income Security Act of 1974 which provides the legal framework for the uniform oversight of benefits by employers doing business in any state in the country. This allows multi-state

companies that self-insure to offer consistent benefit packages and reduces the expense of administration. When applied to health benefits such as insurance products which are subject to state regulation, ERISA ; *see also*. Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AMERICAN J OF LAW & MED 251-289 (1997).

¹⁸ OT2 is aware of the fact there is a substantial population that lack insurance (public or private) that these recommendations will be unlikely to help significantly. Yet addressing these larger access to care problems risks swallowing the specific insurance problems OT2's charter defines.

¹⁹ *See, e.g.*, CCH Healthcare Compliance, "Revised NCD Expands Access to Clinical Trials," available at <http://health.cch.com/news/healthcare-compliance/072507a.asp> (last visited August 13, 2007).

²⁰ *See* EDICT Project, www.bcm.edu/edict.

²¹ *See* General Accounting Office, NIH Clinical Trials: Various Factors Affect Patient Participation 1, 4 (1999), available at <http://www.gao.gov/archive/1999/he99182.pdf> (last accessed August 18, 2007); *see also* Hamilton Moses III, E. Ray Dorsey, David H. Matheson, and Samuel O. Thier, *Financial Anatomy of Biomedical Research*, 294 JAMA 1333, 1335 (2005).

²² National Cancer Institute, "Doctors, Patients Face Different Barriers to Clinical Trials," available at <http://www.cancer.gov/clinicaltrials/developments/doctors-barriers0401> (last accessed August 13, 2007).

²³ *Ibid*.

²⁴ National Cancer Institute, "Doctors, Patients Face Different Barriers to Clinical Trials," available at <http://www.cancer.gov/clinicaltrials/developments/doctors-barriers0401> (last accessed August 13, 2007).

²⁵ *Ibid*.

²⁶ Israel, B., Schulz, A., Parker, E., and Becker A., "Review of community-based research: Assessing partnership approaches to improve public health," *Annual Review of Public Health* 19 (1998): 173-202.

²⁷ By "participant" we mean someone who participates in any clinical trial, including prevention trials.

²⁸ The literature on the therapeutic misconception is immense. For starters, see Gail E. Henderson et al., *Clinical Trials and Medical Care: Defining the Therapeutic Misconception*, 4(11) PLOS MEDICINE (2007); T. Lewens, *Distinguishing Treatment from Research: A Functional Approach*, 32 J. MED. ETHICS (2006); Matthew Miller, *Phase I Cancer Trials: A Collusion of Misunderstanding*, 30(4) HASTINGS CENTER REPORT (2000).

²⁹ *See, e.g.*, General Accounting Office, NIH Clinical Trials: Various Factors Affect Patient Participation 1, 4 (1999), available at <http://www.gao.gov/archive/1999/he99182.pdf> (last accessed August 18, 2007); *see also* Hamilton Moses III, E. Ray Dorsey, David H. Matheson, and Samuel O. Thier, *Financial Anatomy of Biomedical Research*, 294 JAMA 1333, 1335 (2005).

³⁰ *See, e.g.*, Kenneth W. Goodman, *Ethics, Evidence, and Public Policy*, 48(4) PERSPECTIVES IN BIOLOGY AND MEDICINE 548 (2005).

³¹ *See, e.g.*, J.G. Ford, et al., *Knowledge and Access to Information on Recruitment of Underrepresented Populations to Cancer Clinical Trials*, Evidence Report: Technology Assessment (Summary), 2005(122): p. 1-11; Giselle Corbie-Smith, William C. Miller, and David Ransohoff, *Interpretations of 'Appropriate' Minority Inclusion in Clinical Research*, 116(4) AM. J. MED. 249, 251 (2004); National Heart Lung and Blood Institute/NIH. Questions and Answers on Inclusion of Minorities and Women in Study Populations. 2002. Available from: <http://www.nhlbi.nih.gov/funding/policies/nhlbigui.htm>.

³² The Endocrine Society, *White Paper: Increasing Minority Representation in Clinical Trials*, at 3, 8 (2007); available at http://www.endo-society.org/publicpolicy/health_disparities/upload/Final%20Color%20White%20Paper%20with%20Endorsers.pdf (last accessed Feb. 6, 2008).

³³ *Id*. Furthermore, a recent article documented the existence of wide variations between clinical trial participants and Medicare beneficiaries in evidence used for Medicare national coverage determinations. *See* Sanket S. Dhruva & Rita F. Redberg, *Variations Between Clinical Trial Participants and Medicare Beneficiaries in Evidence Used for Medicare National Coverage Determinations*, 168(2) ARCH. INT. MED. 136 (2008). Though the effects of this discrepancy have yet to be examined, one can reasonably claim on the basis of this article that the evidence being used to drive coverage determinations is suboptimal.

³⁴ *See, e.g.*, Dorothy Roberts, *Legal Constraints on the Use of Race in Biomedical Research: Towards A Social Justice Framework*, 34(3) AM. J. L. MED. & ETHICS 526, 532 (2006).

³⁵ *Id.*; Lundy Braun, *Race, Ethnicity, and Health: Can Genetics Explain Disparities?* 45(2) PERSPECTIVES BIOL. & MED. 159 (2002); see also Race, Ethnicity and Genetics Working Group, *The Use of Racial, Ethnic, and Ancestral Categories in Human Genetics Research*, 77(4). AM. J. HUM. GENETICS 519-532 (2005).

³⁶ Henry K. Beecher, *Ethics and Clinical Research*, 274 N. ENGL. J. MED. 1354 (1966).