ACRO
ASSOCIATION OF CLINICAL RESEARCH ORGANIZATIONS

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Office of Science and Technology Policy
Executive Office of the President
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1650 Pennsylvania Avenue
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RE: ACRO response to Office of Science and Technology Policy (OSTP) Request for Information: *Clinical Research Infrastructure and Emergency Clinical Trials*

The Association of Clinical Research Organizations (ACRO) represents the world's leading clinical research and technology organizations. Our member companies provide a wide range of specialized services across the entire spectrum of development for new drugs, biologics, and medical devices, from pre-clinical, proof of concept, and first-in-man studies, through post-approval and pharmacovigilance research. ACRO member companies manage or otherwise support a majority of all FDA-regulated clinical investigations worldwide. With employees engaged in research activities in 114 countries, the member companies of ACRO advance clinical outsourcing to improve the quality, efficiency, security, and safety of biomedical research.

ACRO thanks OSTP for releasing this important RFI on *Clinical Research Infrastructure and Emergency Clinical Trials*. ACRO is pleased to provide the following feedback.

Recommendations

In the early stages of the COVID pandemic, the United Kingdom established a scientific committee, the Scientific Advisory Group for Emergencies (SAGE) to provide scientific and technical advice to support government decision makers during emergencies. Taking a capacity management approach, this group prioritized scientific review to determine which trials had the best chance to be productive, which in turn sped up the clinical trial process. We could mirror this effort in the United States. In addition, the development and use of a platform trial protocol specifically to accommodate multiple vaccines directed at the same target would be a much more efficient use of patients and resources. Utilizing a similar approach to the I-SPY trials would enable efficiencies in time, cost, and resources.

The need for an expert group to review emergency clinical trial protocols was illustrated by an April 2021 article in *Nature*[1] by Janet Woodcock and Kevin Bugin of the Food and Drug Administration (FDA). Their analysis suggested that an overwhelming majority of COVID treatment trials—as much as 95 percent—were designed and executed in such a way that not enough patients were enrolled and thus the trials were not statistically

[1] Janet Woodcock and Kevin Bugin, *Trends in COVID-19 therapeutic clinical trials*

powerful enough to produce meaningful results. To prevent the “wasting” of trials and trial participants, ACRO strongly believes that a high-level scientific committee, with rapid decision-making capability, charged with rationalizing an emergency research portfolio and avoiding an abundance of under-powered clinical trials, should be established. The utilization of platform protocols should also be governed by this committee. This scientific and technical committee to a US emergency response should be composed of experts from government, academia, public health organizations, and industry (inclusive of pharma, technology, and clinical research organizations) in roughly equal numbers.

An approach that could greatly help trial enrollment would be to utilize data analysis across geographies and therapeutic areas and to develop a national database or a collection of databases of potential trial participants. Sponsors and clinical research organizations (CROs) have access to a number of datasets for which appropriate use arrangements could be established. The Centers for Medicare & Medicaid Services (CMS) holds a significant amount of health data that could be leveraged towards this effort as well, as do private health insurers. With guardrails required by HIPAA in place, and a commitment across the health system to offering individuals opt-in opportunities to consent to the use of their data for research purposes, while securing such data from unauthorized access or disclosure, development of national databases or collaborative arrangements for use of a collection of databases of both identifiable and de-identified data for research use is entirely possible.

Similarly, data bank models, such as the UK Bio Bank can make real time review of data accessible to investigators under an agreed-upon governance structure, providing an ability to amend ongoing studies, and increasing the likelihood of success.

Many of the questions in the RFI address research networks. It is ACRO’s recommendation that the US lean heavily on existing sites and networks during an emergency. By existing sites and networks, we are referring to both those created or funded by NIH and the many private-sector research sites that supplement industry trials. A robust infrastructure of sites currently exists, and the government should coordinate with and include them in capacity planning and fund programs that address research gaps in historically underrepresented communities. Networks cobbled together during a crisis are unlikely to be successful and therefore time should be spent, before the next inevitable emergency, shoring up existing networks—whether federally funded or private—and investing in new ones where needed.

The use of already existing networks is particularly important when considering pediatric patients and other vulnerable and displaced populations. As we have seen throughout the COVID-19 pandemic, these populations are most adversely affected. Therefore, existing networks already “at the ready” would help to best deliver trial interventions.

Consistent with NIH policy and FDA recommendations, any sites/networks that do not agree to the use of a single IRB should be ineligible for funding or selection in the event of an emergency. Any networks participating should be required to use protocol templates, emergency master agreements, and encouraged to use remote technologies and services to grow their capacity. Additionally, the traditional concept of the research site as a clinic- or hospital-based physical entity, should be enlarged to include the use of home-based and/or other remote study locations to facilitate patient recruitment, retention, and diversity, all of which are acutely impacted during biomedical emergencies. Decentralized trial activities and elements, which the FDA widely embraced during the COVID pandemic, should be extensively applied to advance trial conduct in future emergencies.

One hurdle that ACRO members came up against during the COVID-19 pandemic was the availability of laboratory and other medical supplies. Many investigators and research organizations had trouble accessing lab supplies due to the volume of research testing going on across vaccine and treatment trials in addition to clinical diagnostic testing. In several countries CROs and research sites were not included on the lists of organizations given priority access to those supplies, which caused delays throughout a number of trials. Amending such lists in the future to stipulate that investigators and approved research organizations should have access to laboratory and other medical supplies, on the same priority level as clinical diagnostic testing and treatment facilities, would help to mitigate such delays, but only if production capacity is expanded. Equally important is the need to maintain and expand “warm base” manufacturing capabilities for supplies and equipment that are likely to be needed by both clinical testing and treatment facilities and by research facilities during future emergencies and that were in short supply for both types of facilities during the pandemic.

The questions in section 2 of the RFI relate to improving diversity and equity. One way to do this is to review private sector initiatives for new models of embedding research in the US healthcare system and particularly locational that serve underrepresented communities. Industry has been building research structures into communities, so that trials are more accessible and the time/travel burden on patients is lessened. Among these efforts are partnerships with health care clinics—companies with broad reach like CVS and Walgreens—and the provision of home health nurses and the use of telehealth services to support routine safety assessments. Embedding research into healthcare delivery systems, including hospitals, group practices, community clinics, and home health agencies is paramount.

Lastly, we would put forward a policy recommendation that the US consider a national ‘license’ or other recognition for Principal Investigators (PIs) and nurses to preempt state law during the period of a federal public health emergency declaration in order to address problems created by state licensure of healthcare providers that were observed during the COVID pandemic. This emergency national license would be targeted specifically to PIs and nurses engaged in clinical research and not available to

healthcare providers only providing regular clinical care. The Nurse Licensure Compact (NLC) program already in place in the US could be a model. A number of ACRO members have recounted instances during the COVID pandemic where trials were delayed or canceled due to state licensure issues. This proposed solution would be extremely helpful for closing gaps in the use of home health evaluations and interventions as part of an ongoing clinical trial. Note that the issue of cross-state licensure also impacted the delivery of telemedicine across state borders during the pandemic but was significantly remedied by altered reimbursement models.

Conclusion

Thank you for this opportunity to provide feedback on the Clinical Research Infrastructure and Emergency Clinical Trials RFI. If we can provide additional details or answer any further questions, please do not hesitate to contact us.

Respectfully,

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