

Ethics/Regulatory Call with Dr. Coronado's Demonstration Project – STOP CRC
Date: May 29, 2013
MINUTES

Participants:

☒	Jeremy Sugarman (Johns Hopkins)	☒	Jerry Menikoff (OHRP)	☒	Wendy Weber (NIH)	☐	
☒	Rob Califf (Duke)	☒	Ivor Pritchard (OHRP)	☒	Josephine Briggs (NIH)	☐	
☒	Gloria Coronado (Kaiser Permanente)	☒	Russ Glasgow (NIH)	☒	Jonathan McCall (Coord Center)	☐	
☒	Sandy Heinz (Kaiser Permanente)	☒	Stephen Taplin (NIH)	☒	Tammy Reece (Coord Center)	☐	
☒	Amanda Petrik (Kaiser Permanente)	☒	Dave Wendler (NIH)	☒	Cheri Janning (Coord Center)	☐	
☒	Julie Kaneshiro (OHRP)	☒	Catherine Meyers (NIH)	☐		☐	

These minutes were circulated to all participants on the call for two rounds of review and they reflect all corrections that were received.

AGENDA ITEMS	DISCUSSION	ACTION ITEM
Review of Demonstration Project	- Dr. Coronado gave an overview of the STOP CRC project, a 2-year, pragmatic, cluster-randomized trial to assess the effectiveness of an automated data-driven, EHR-linked program for mailing fecal immunochemical test (FIT) kits (with linguistically appropriate pictographic instructions and return postage) to patients who are due for colorectal cancer (CRC) screening. - Participating research sites: Kaiser Permanente Center for Health Research (CHR); Group Health Research Institute, and OCHIN. - Participating clinic sites (26) from several community health center organizations affiliated with OCHIN. - Clinics will be randomized to either an intervention or usual care	

	(UC) condition. Intervention clinics will be offered training to deliver the STOP CRC program and track patient outcomes using EHR tools. - Costs and cost-effectiveness of the intervention relative to control (usual care) will be assessed. Secondary outcomes assessed by the study will include differences in CRC screening outcomes (e.g., for Hispanic ethnicity, primary language, poverty, and insurance status). The project will also assess adoption, implementation, potential maintenance, and spread of the program using a mixed-methods rapid assessment process, field notes, and other ethnographic data. - Kaiser Permanente NW IRB is the IRB of record for the pilot study and will be the IRB of record for the phase 2 study. All participating organizations have agreed to cede to KPNW IRB through an authorization agreement. - No concerns were raised regarding the study or the use of a single IRB of record.	
Minimal risk	- The first phase of the research is approved by the IRB as minimal risk (as of October 2012). - The FIT is part of standard clinical care. There are no harms or risks anticipated with increasing screening rates through the proposed intervention. Research data will consist of patient EHR data and information on clinics and providers. All data will be obtained with automated data extractions. Thus, the risk to subjects is minimal and limited to breach of patient confidentiality. Processes have been put in place to minimize this possibility. The study will not constrain the choice of tests or treatments offered to patients. - No concerns were raised about a minimal risk determination for the study.	
Consent (patient and physician)	- Interested in patients' responses to a low-intensity outreach program and limiting the sample to patients who have consented would diminish the generalizability of the findings. - Justification for waiver of consent reviewed and no concerns	

	were raised.	
HIPAA	- The potential study population is large and it is not feasible to obtain HIPAA authorization on all participants. To obtain such authorizations, each patient would have to be contacted. Gathering and retaining contact information poses greater risk to potential participants than does access to EHRs, given the precautions in place. - Only study personnel who have signed a confidentiality agreement will have access to EHR data. Links to identifiers will not be transferred or stored at CHR. - Link to identifiers will be maintained only at OCHIN and will be destroyed after data analysis and manuscript writing is complete. No identifiers or links will be transferred to CHR other than limited data set elements including dates of service. - Dr. Coronado believes that the criteria for 45 CFR 164.512 are satisfied and the waiver of HIPAA is acceptable; no concerns about this were mentioned.	
Monitoring and oversight	- Currently, there is no official DSMB. - NCI does not require a fully appointed DSMB for this type of project. - There is currently no monitoring plan in place.	The study will require a Data and Safety Monitoring Plan, which will be developed by the study team, and approved by NCI prior to study implementation. Although a DSMB would not be required for the trial, independent monitoring of the trial would likely be appropriate, and NCI staff will work with the study team to finalize the Plan.
Issues beyond the STOP CRC trial	None voiced.	
Conclusion of meeting	Follow-up needed as noted in action items.	Case study will be written up to provide guidance for others planning similar trials to facilitate navigation of the ethics and regulatory issues.

SUPPLEMENTARY MATERIAL
FOR STOP CRC TRIAL

Supplementary Material

STRATEGIES AND OPPORTUNITIES TO STOP COLORECTAL CANCER IN PRIORITY POPULATIONS**Overall goal**

The overall goal of STOP CRC is to raise the rates of colorectal cancer (CRC) screening in Federally Qualified Health Centers (FQHCs). We will develop and test a culturally tailored, health care system-based program to improve CRC screening rates in a collaborative network of more than 200 FQHCs, OCHIN. OCHIN's electronic health record system will serve as a novel and robust data source for our study. In Phase I (Year 01), we pilot-tested an evidence-based approach to improving participation in CRC screening in two FQHCs. In Phase II (Years 02–05), we will conduct a comparative effectiveness pragmatic clinical trial, using a mixed-methods approach to evaluate the adoption, implementation, and maintenance of our CRC screening program designed explicitly for FQHC clinics. Throughout the project, we will work with a diverse planning advisory group of clinicians and patients, community representatives, state policy makers, and researchers, using principles of Community-Based Participatory Research.

Phase 1: Aims

Aim 1. Define electronic codes and methods to identify eligible patients and track relevant CRC outcomes.

- a. Define inclusion and exclusion criteria for study participation to identify a set of patients at two pilot OCHIN clinics who are at average risk for colorectal cancer.
- b. Define data sources and refine methods for extracting EHR data on socioeconomic and demographic variables, receipt of CRC screening tests, results, receipt of follow-up care, and diagnoses.
- c. Determine potential moderators of intervention effectiveness—e.g., Hispanic ethnicity, native language, and insurance status—and create codes that can extract EHR data relevant to these moderators.

Aim 2. Use codes and methods developed in Aim 1 to test the feasibility, effectiveness, and cost of an EHR-based, two-arm CRC screening intervention in a subset of 100 patients in the pilot clinic.

Aim 3. Use results from the pilot intervention to prepare a large-scale, cluster-randomized pragmatic trial across 18 OCHIN clinics (see Phase II).

Phase 1: Participating Institutions**1.1 Participating Research sites**

- 1.1.1 Kaiser Permanente Center for Health Research
- 1.1.2 Group Health Research Institute
- 1.1.3 OCHIN

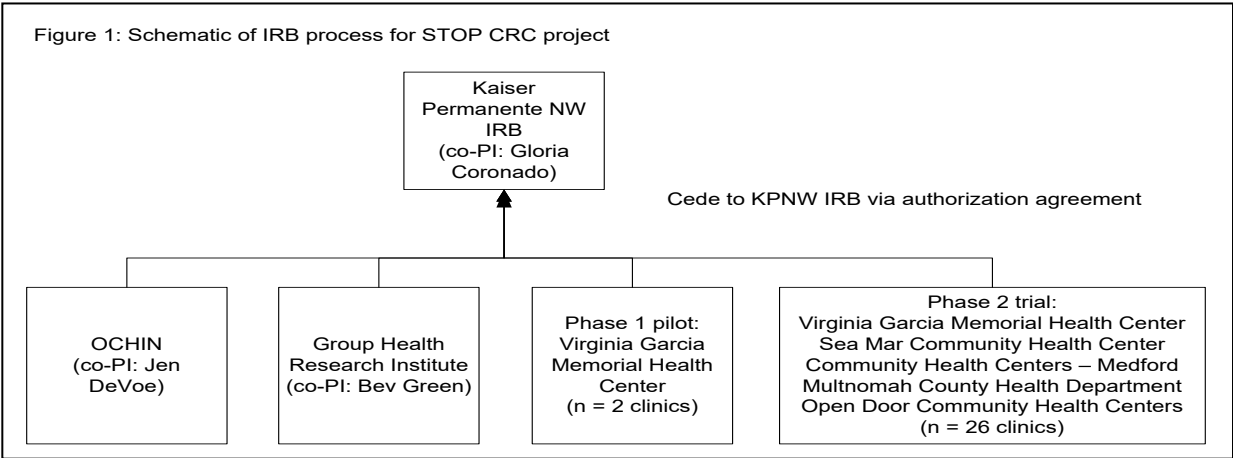
1.2 Participating Clinic sites

- 1.2.1 Virginia Garcia Memorial Health Center

Phase 1: IRB agreements

Kaiser Permanente NW IRB is the IRB of record for the pilot and will be the IRB of record for the Phase 2 study. All participating organizations have agreed to cede to KPNW IRB through an authorization agreement. Figure 1, below, shows a schematic of this arrangement. The Phase 1 IRB is approved as minimal risk (as of October 2012).

STOP CRC: SUPPLEMENTARY MATERIAL



Phase 2: Project Overview

We will conduct and evaluate a two-year pragmatic cluster-randomized trial to assess the effectiveness of an automated data-driven, EHR-linked program for mailing FIT kits (with linguistically appropriate pictographic instructions and return postage) to patients due for CRC screening. We will facilitate a guided process to improve program adoption, reach and effectiveness that accounts for individual clinics' resources, capacity, and preferences. We will do this in 26 FQHCs that meet the inclusion criteria established by the advisory group. We will assess the costs and cost-effectiveness of intervention relative to controls (UC). Secondarily, we will assess differences in CRC screening outcomes; e.g., for Hispanic ethnicity, primary language, poverty, and insurance status. We will assess adoption, implementation, potential maintenance, and spread of the program using a mixed-method rapid assessment process, field notes, and other ethnographic data.

Phase 2: Aims

Primary Aim 1. Assess the effectiveness of a large-scale, two-arm CRC screening program among diverse FQHC patients. The intervention will consist of:

- An automated data-driven, EHR-linked program for mailing FIT kits (with linguistically appropriate pictographic instructions and return postage) to patients due for CRC screening plus a PDSA improvement cycle to further enhance program adoption, reach, or effectiveness.

Primary Aim 2. Assess differences in CRC screening outcomes—e.g., Hispanic ethnicity, native language, poverty, and insurance status.

Primary Aim 3. Assess the costs and long-term cost-effectiveness of the automated program, relative to usual care.

Secondary Aim 1. Assess adoption, implementation, reach and potential maintenance and spread of the program, using a mixed-method rapid assessment process, field notes, and other ethnographic data.

1. Participating Institutions:

1.1 Participating Research sites

- 1.1.1 Kaiser Permanente Center for Health Research
- 1.1.2 Group Health Research Institute
- 1.1.3 OCHIN

1.2 Participating Clinic sites

- 1.2.1 Virginia Garcia Memorial Health Center
- 1.2.2 Multnomah County Department of Health
- 1.2.3 Open Door Community Health Centers
- 1.2.4 Medford Community Health Center
- 1.2.5 Sea Mar Community Health Centers
- 1.2.6 Mosaic Medical Center
- 1.2.7 Cowlitz County Medical Center
- 1.2.8 One Health Center
- 1.2.9 La Clinica del Carino

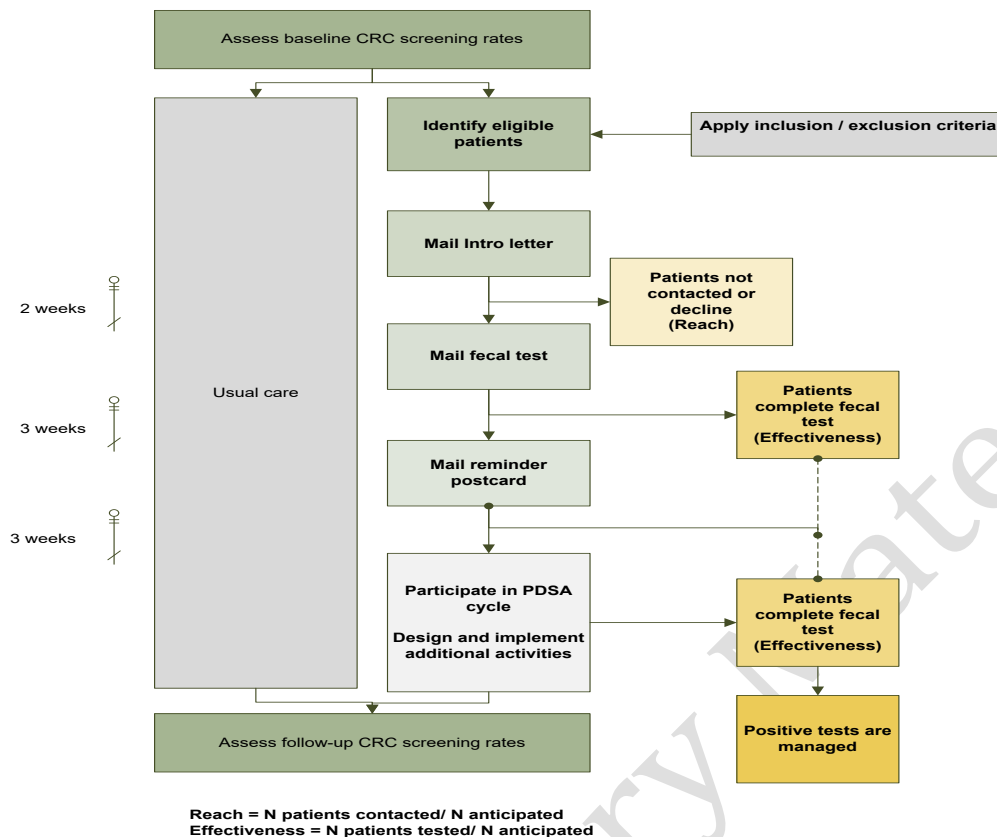
2.1 Study Procedures

Eligible clinics will be randomized to either an intervention or UC condition. Intervention clinics will be offered a training to deliver the STOP CRC program and track patient outcomes using the EMR tools.

2.2 Study Intervention

Our core intervention will consist of a direct mailed fecal test and a PDSA improvement cycle, to enhance program adoption, reach or effectiveness. Figure 2, below, shows a design of the study.

Figure 1: STOP CRC Pragmatic Study Design



Risk & Benefit: Risk Assessment

- 1 * **Risk Classification** - Provide your estimate of the risk classification for this study (select one):
 - 0 Minimal risk: Defined as being not greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological exams or tests.
2. * **Rationale** - Provide your rationale for the classification you have chosen above:
 - 0 Colorectal cancer screening is recommended for our population. We will be targeting our outreach efforts to patients who have not met the recommendations for screening. Therefore, the risk is no greater than the risks ordinarily encountered during the performance of routine exams. Moreover, our program will be administered at the level of the clinic; thus patient consent is neither feasible nor warranted. Our participating Healthcare Systems are enthusiastic about improving their colorectal cancer screening performance metrics and may eventually adopt a system-wide program similar to ours, our study allows for a rigorous evaluation of the program. At the end of the program, all usual care sites will receive implementation guides that will assist them in implementing the program, if desired.

Risk/Benefit Assessment: Risk of Interventions or Interactions

1.0 * **Harm/Risks Description** - Describe the risks, discomforts, inconveniences and potential harms associated with each intervention or participant interaction. Include consideration of physical, psychological, social, economic, legal, and other factors. If data are available, estimate the probability that a given harm may occur, the probable severity, and the potential reversibility:

The Fecal Immunochemical Test (FIT) is part of standard clinical care. There are no harms or risks anticipated with the intervention of increasing screening rates. We will select patient eligible for our program using EMR data on age and previous screening history. We will make no exclusions based on

STOP CRC: SUPPLEMENTARY MATERIAL

race, ethnicity or language. Research data will consist of patient EMR data and information on clinics and providers. We will collect all data with automated data extractions. Extracted data will include demographics, screening history, and co-morbid conditions. We will also track follow-up to diagnostic colonoscopy among patients who screen positive. We will not collect patient-reported outcomes. We will use patient data to assess pre- and post-intervention rates of colorectal cancer screening, adjusted for baseline rates and possible modifiers. Data transferred to CHR from OCHIN will be de-identified.

The program activities in this study are very low risk. Individual subjects will not be contacted or consented for this study. We will not constrain the choice of test or treatments offered to patients. The main risk associated with this study is the loss of confidentiality as access to the medical record will be necessary. Only de-identified information will be transferred to CHR for analysis. All data will be protected in a manner consistent with Kaiser Permanente standards; that is, under password protected and encrypted computers. All data collected from providers and other clinic personnel (for qualitative assessment of adoption, implementation, and maintenance) will be stored in password protected computers.

The research could not practicably be carried out without a waiver of patient consent for the following reasons: 1) our outreach program will be delivered at the clinic level as part of standard clinical care; thus gathering patient consents is infeasible and unwarranted; 2) The large study population of low-income patients with low levels of health literacy makes gathering consents infeasible. Moreover, it would result in inclusion of a subset of patients, threatening the generalizability of our findings; 3) The risk for breach of patient confidentiality increases when subject contact information is maintained for the purposes of contacting patients for their consent. This exceeds the risk of associated with our outreach program; 4) Alternative methods for obtaining consent are infeasible and diminish the generalizability of our findings.

2.0 * Welfare/Safety Description - Describe the welfare/safety precautions that will be taken to minimize risks/harms/discomforts/inconveniences of the intervention(s) and/or participant interaction(s):

We do not anticipate concerns for patient welfare, as the FIT is noninvasive. The study poses no adverse affects on the health, financial, or legal interests of patients as study participation poses only minimal risk. We will not constrain the choice of test or treatments offered to patients. Patients will be under the usual care of their physician during the duration of the project. Patients will receive the results of their screening test, according to usual clinical care. They will also be contacted if they screen positive to assure referral to diagnostic follow-up, consistent with usual clinical care.

Risk & Benefit Assessment: Benefits

1.0 * Describe any potential for direct benefits to research subjects in this study:

Early detection of colorectal cancer could prolong a patient's life and increase their quality adjusted life years. Colorectal cancer is 90% preventable if caught early. Research shows that annual fecal testing reduces mortality by at least 33%. Patients who receive our outreach program may be more likely to get screened and may benefit from years of life saved. Moreover, because colorectal cancer can be prevented (through the removal of polyps), we anticipate preventing cancers and raising awareness of the need for colorectal cancer screening in entire clinic populations.

2.0 * Describe any potential benefits to society:

Understanding effective strategies for improving cancer screening support policies to increase

STOP CRC: SUPPLEMENTARY MATERIAL

screening rates. Fecal testing is shown to be cost-saving; thus programs to improve rates of screening can reduce healthcare-related costs, and prevent colorectal cancer.

Risk/Benefit Assessment: Alternatives

1.0 Alternatives to Participation - If applicable, describe alternatives (research or non-research) that are available to subjects if they choose not to participate in this study, including “watchful waiting” or “no treatment.” Are there therapies, treatments, or other interventions available outside of this proposed research study? If your research will enroll healthy volunteers and involves a medical procedure(s), you must provide a justification for involving normal volunteers in research:

Patients will receive usual care; that is opportunistic screening -- a possible recommendation to receive a colorectal screening during a regular clinic visit.

2.0 * Risk-to-Benefit Relationship of Participation - Describe the risk-to-benefit relationship of participation in the research (relative to non-participation and/or alternatives). That is, what risks are study participants expected to undertake or encounter in relation to anticipated benefits?

The benefit to patients who receive colorectal cancer screening is reduction in mortality from colorectal cancer. This outweighs any possible risks of breach of patient confidentiality.

Risk & Benefit Assessment: Potential Study Subjects Identification

1.0 * State specifically how the potential study subjects will be identified (e.g., clinician referral; analyst review of patient medical records, disease registries, clinician panels, or electronic databases; patient self referral) and who will determine eligibility:

Patients will be identified by analyst review of patient medical records through electronic databases. Analysts at OCHIN will determine eligibility. OCHIN serves as the EMR vendor for the clinics. Staff at participating clinics will then conduct outreach, by mailing introductory letters, FIT kits, and reminder postcards, and additional outreach (may include live phone calls or home visits) as determined by the PDSA improvement cycle and when indicated for patients in intervention clinics. For analysis purposes, a de-identified dataset of patient electronic health records (including dates of visits and procedures) will be provided to CHR. The use and disclosure of this information involves no more than minimal risk to the privacy of individuals, based on:

1) An adequate plan to protect the identifiers from improper use and disclosure

The risk to subjects is minimal and limited to breach of patient confidentiality. To minimize this possibility, confidentiality of data will be strictly maintained through multiple processes, including:

- Limiting who has medical record access to research study staff who have signed a confidentiality agreement, been thoroughly trained, and have adequate knowledge regarding patient confidentiality.
- Limiting what is being accessed by ensuring that the information being extracted from the medical record is well-defined and limited in scope.
- Limiting where records are being accessed by confining access to the performance site, and removing identifiers from data sources.

Secure storage of written and electronic data will be ensured. Only aggregated, group results will be reported in any presentation, publication, or report generated from this research.

2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers

STOP CRC: SUPPLEMENTARY MATERIAL

Link to identifiers will be maintained only at OCHIN and will be destroyed after data analysis and manuscript writing is complete. No identifiers or links will be transferred to CHR other than limited data set elements including dates of service.

3) Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart.

Only study personnel who have signed a confidentiality agreement will have access to medical record data. Links to identifiers will not be transferred or stored at CHR.

4) The research could not practicably be conducted without the waiver

The potential study population is large and it is infeasible to obtain HIPAA authorization on all participants. To obtain such authorizations, each patient would have to be contacted. Gathering and retaining contact information poses greater risk to the subject than access to medical records given the precautions in place. Moreover, as we are interested in patient responses to a low-intensity outreach program, limiting our sample to patients who have consented would diminish the generalizability of our findings.

Patient data is needed to calculate clinic rates of colorectal cancer screening and to conduct analysis that assesses moderators of program effectiveness.