Ethics/Regulatory Call with Dr. DeBar's Demonstration Project - PPACT
Date: May 31, 2013
MINUTES

Participants:

☒	Jeremy Sugarman (Johns Hopkins)	☒	Natalie Thurman (Kaiser Permanente)	☒	Jerry Menikoff (OHRP)	☒	Josephine Briggs (NIH)
☒	Rob Califf (Duke)	☒	Lori Jennings (Kaiser Permanente, HI)	☒	Julie Kaneshiro (OHRP)	☒	Linda Porter (NIH/NINDS)
☒	Lynn DeBar (Kaiser Permanente)	☒	Melanie Plaut (Kaiser Permanente, IRB)	☒	Catherine Meyers (NIH)	☒	Valery Gordon (NIH)
☒	William Vollmer (Kaiser Permanente, NW)	☒	Ashli Owen-Smith (Kaiser Permanente)	☒	Wendy Weber (NIH)	☒	Jonathan McCall (Duke)
☒	Lindsay Kindler (Kaiser Permanente)	☒	Aileen Uchida (Kaiser Permanente, HI)	☒	Sarah Carr (NIH)	☒	Tammy Reece/Cheri Janning (Coord Center)
☒	Sandy Heinz (Kaiser Permanente, NW)	☒	Ivor Pritchard (OHRP)	☒	Sarah Duffy (NIH/NIDA)	☒	Monique Anderson (Duke)

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. DeBar gave an overview of the Pain Program for Active Coping and Training (PPACT) trial, a pragmatic trial that aims to test the effectiveness of a primary-care-based collaborative care intervention for adult patients with chronic, non-cancer-related pain who are receiving long-term opioid therapy. The intervention will involve: 1. A comprehensive intake evaluation with periodic re-evaluation (evaluations performed by a behavioral health specialist or nurse case manager, physical therapist, and a	

	chart-based medication review by a pharmacist); 2. Group coaching sessions (led by the behavioral health specialist, nurse case manager, and/or physical therapist); and 3. Interim case management contacts (performed by the behavioral health specialist or the nurse case manager). • The trial will take place in the Kaiser Permanente NW (KPNW), KP Georgia, and KP Hawaii health plans. • Trial design: 2-arm cluster randomized trial with 200 primary care clusters. o Arm 1: Routine administration used in KP centers. o Arm 2: Intervention. • Eligible participants will be identified through the EHR. Clinicians interested in the study will be given a list of their eligible patients and can assess whether a given patient is an appropriate study candidate. • Invitation/informational letters will be mailed to eligible patients; these letters will be signed by their primary care clinicians. The letter will include all required elements of informed consent, including a clear statement of the option to opt out of the study by calling the provided study telephone number. The letter will also state that study staff will follow-up with patients within 1 week if they have not called to opt out.	
Minimal risk	• Each component of the intervention is currently available to KP members as a separate resource within the respective healthcare systems. The intervention to be tested coordinates these services by organizing them into a single program within primary care and applying an interdisciplinary approach to systematically coordinating patients' use of these services. Patients not randomized to the intervention will continue to receive treatment as usual. • The intervention is not expected to pose any additional risks. • Teleconference participants expressed that the study seemed to meet criteria for a determination of minimal risk. OHRP	

	representatives expressed the opinion that it would be reasonable for an IRB to reach the conclusion that the study is minimal risk.	
Consent (patient and physician)	• Oral consent and oral review of HIPAA elements will be sought from all participants enrolled in the study. A request will be made to IRBs for a waiver of documentation of informed consent and an alteration of HIPAA privacy rule authorization (no signature). The study interviewer will obtain oral consent from prospective study participants via telephone call. During the conversation, the interviewer will indicate that each element of informed consent and HIPAA privacy guidelines/study use of health data has been reviewed with the KP member by checking the requisite element within the patient record in the study electronic tracking system. It is felt that obtaining oral rather than written consent is an appropriate consent procedure because intervention activities involving coordination of clinical care services are already available to most KP members and study participation is expected to pose minimal risk. Further, because the intervention is embedded directly in primary care clinics and conducted in partnership with participating patients' primary care providers, in the event that a patient's symptoms significantly worsen during the intervention, that patient's clinician will be immediately contacted by a PPACT intervention team. • Clinicians will receive an informational letter detailing the study. Their participation will imply consent. • No objections or concerns were raised by the group regarding the waiving of documentation of informed consent.	
HIPAA	• Dr. DeBar believes the criteria for 45 CFR 164.512 are satisfied and waiver of HIPAA is acceptable; no concerns were mentioned. • Because written consent will not be obtained, the investigators are seeking alteration of the privacy rule. Patients will be informed that their data are being used for research.	

Monitoring and oversight	• All NIH clinical trials require a data and safety monitoring plan, which must be approved by the primary NIH IC prior to study implementation. • The safety plan currently involves EHR monitoring of all study participants every 6 months to identify deaths and hospitalizations. • If a safety event occurs, a chart review will be completed by an independent KP clinician in that specific KP region and by an independent medical monitor to determine whether the event was related to the study. • Currently there is no DSMB identified and the group agreed that a DSMB was not necessary.	• The study team will identify an independent monitor entirely independent of the study team and health care systems. Linda Porter noted that NINDS will work with the project to identify this person and ensure that resulting monitoring processes are compliant with the appropriate NIH and NINDS policies.
Issues beyond the PPACT trial	• None noted.	
Conclusion of meeting	• Follow-up needed, as noted in action items.	• A case study will be written to provide guidance for others on the process and value of open dialogue with regulators.

SUPPLEMENTARY MATERIAL FOR PPACT TRIAL

Pain Program for Active Coping and Training (PPACT)

PPACT Study Overview

The PPACT study is a NIH-funded pragmatic trial that aims to test the effectiveness of a primary care based collaborative care intervention for adult patients with chronic no-cancer pain on long-term opioid therapy. The intervention will involve (1) a comprehensive intake evaluation with periodic reevaluation (evaluations performed by a behavioral health specialist *or* nurse case manager, physical therapist, and a chart based medication review by a pharmacist), (2) group coaching sessions (led by the behavioral health specialist, nurse case manager, and/or physical therapist), and (3) interim case management contacts (performed by the behavioral health specialist or the nurse case manager). The trial will take place in Kaiser Permanente NW (KPNW), KP Georgia, and KP Hawaii health plans.

Specific Aims for UH2

Aim 1: Conduct a diagnostic/developmental analysis to identify patient, primary care provider (PCP) team, and system factors important to implementation success by interviewing health plan administrators, PCPs, pain management specialists, and patients in each of the health plans.
Aim 2: Ensure adequacy of electronic medical record/information technology infrastructure and quality clinical data to conduct pragmatic trial.
Aim 3: Prepare and repackage intervention manuals, materials, and training approach to maximize utility for use by broad range of allied health professionals (e.g., nurse case managers, behavioral specialists).

Specific Aims for UH3

Aim 1: Conducting a cluster (clinic) randomized pragmatic clinical trial in 200 primary care clusters across the three KP health plan settings (Hawaii, Northwest, Georgia) to compare the effects of the multidisciplinary biospsychosocial intervention to usual care on

- patients' pain symptoms, pain-related functioning, and satisfaction with health care services
- patients' use of health care services including receipt of opioid medication
- the cost of the program and economic impact of the intervention. As cost considerations will be important for the translatability of this project, articulating the cost impact for health plans will be an important aspect of the dissemination.

Aim 2: Conduct process and implementation evaluations to understand, describe, explain, and enhance intervention Reach (to diverse patients), Effectiveness, Adoption, Implementation, and Maintenance. Guided by the PRISM implementation and sustainability model, we will:

- Conduct in-depth face-to-face interviews with patients and staff participating in the intervention and potentially impacted health plan administrators to obtain and understand their experiences, beliefs, and perspectives about the intervention.
- Regularly collect and share process and implementation information, including preliminary results of qualitative interviews, process measures, and preliminary outcomes with participating health plans to support improvements in implementation and quality of care.

Aim 3: Create, refine, and disseminate an implementation guide for the collaborative care pain intervention based on findings from Aims 1 & 2 and perspectives from key informant interviews of administrators and staff at federally funded safety net clinics that may serve as future dissemination-implementation sites.

Assessment of Risk. Each component of the intervention is currently available to KP members as separate resources within the healthcare systems. The intervention to be tested coordinates these services by organizing these resources into one program within primary care and utilizing an interdisciplinary approach to systematically coordinate the patients' use of these services. Patients not randomized to the intervention will continue to receive treatment as usual. All patients' pain symptoms and pain-related functioning; patients' use of health care services including receipt of opioid medication; and the cost of the program and economic impact of the intervention will be evaluated.

Recruitment (see diagram at the end of this document for a schematic of this process)
We review the recruitment process below because refinement of this process during this prepatory year has led us to shift from proposing a waiver of written or oral consent for both our intervention and usual care participants (which was approved by the KPNW IRB for the UH2 pilot), to proposing that we will request IRB approval for a waiver of signed informed consent and an alteration of privacy rule authorization (HIPAA) (no signature) as described in the "Consent Process and HIPAA" section below.

Eligible participants will be identified through the EMR. Primary care providers (PCPs) will be provided a list of eligible patients who are on their panel so that they have the opportunity to opt-out any patients they think are not suitable for the intervention or to add patients not on the list whom they feel should be included. This list will be accompanied by an information letter that includes all elements of informed consent for the PCP. The PCP's response to the study team approving the patient list or identifying un-suitable patients will constitute PCP consent to participate. Brief chart reviews will be conducted for those patients selected by the clinicians as suitable for the intervention to ensure that they are eligible.

Eligible patients will then be mailed invitation/informational letters, which will be signed by their PCP. The letter will include all elements of informed consent including a clear statement of the option to opt out of the study by calling the provided study telephone number. The letter will also state that the study staff will follow up with patients within a week if they have not called to opt-out. The CHR study staff will then attempt to contact by phone those patients who do not opt out. The call will reiterate the overall goals of the project and oral consent will be obtained at this time. Up to a maximum of 10 patients per PCP will be consented in this manner; any additional eligible patients for a given PCP will not be recruited.

Randomization
Following this process, study staff will create revised lists for each PCP that only include patients who consented to be in the study, and as necessary PCPs with small panels will be clustered together so that all PCPs or PCP clusters have between 6 and 10 consented participants (this is a target range and might vary slightly in practice). Patients will then be cluster randomized at the level of PCP (or PCP cluster) to receive either the collaborative care intervention or treatment as usual. We anticipate that this process will results in approximately 500 randomized patients in KPGA and KPHI, and about randomized 1500 patients in KPNW.

Consent Process and HIPAA
Patients: We will seek to obtain oral consent and oral review of HIPAA elements from all participants enrolled in the study. In order to do this we will request from our IRBs a waiver of signed informed consent and an alteration of privacy rule authorization (HIPAA) (no signature). When a study interviewer obtains oral consent from a prospective study participant over the telephone, the interviewer will indicate that each element of informed consent and HIPAA privacy guidelines/study use of health data have been reviewed with the KP member by checking the requisite element within the patient record in

the study electronic tracking system. This will help ensure that each element of informed consent and HIPAA privacy guidelines/study use of health data have been thoroughly reviewed with all prospective participants. We believe that obtaining oral rather than written consent is an appropriate consent procedure because intervention activities involve the *coordination* of clinical care services already available to most KP members (e.g., physical therapy, behavioral services, nurse case management, and pharmacy) and therefore the intervention will likely cause no more risk of harm than what already exists for patients undergoing usual care treatment for chronic pain. While many patients with chronic pain may have received brief trials of one or more of the services included in the intervention (e.g., nurse case management, work with a behavioral specialist, access to physical therapy) this program serves to coordinate such services in a manner that may best enable patients to reduce pain-related disability and work with their PCPs and other health plan providers to identify the most appropriate and effective care for their condition. Some patients participating in the intervention are expected to have worsening pain and/or other physical or emotional problems during the study period. However, these are risks inherent in the population and would occur whether or not they were enrolled in the study. We do not believe that the risk of adverse outcomes is heightened as a function of being enrolled in the study. Further, because the intervention is embedded directly in the primary care clinics and conducted in partnership with participating patients' primary care providers, in the event that a patient's symptoms significantly worsen during the intervention, their PCP will be immediately contacted by a PPACT intervention team member and their PCP will work with the patient to identify and provide appropriate care. This is consistent with the standard of care provided at Kaiser Permanente.

Randomization occurs at the level of the PCP (or small groups of PCPs); therefore individual patients will not be randomized. Our consenting process with patients will be consistent with that used for various clinical interventions used throughout the health plan. We will employ an informational brochure akin to a clinical consent (approved by KPNW IRB and satisfying the criteria of 45 CFR 46:116 for waiver of written informed consent), followed up by a phone call to verbally reiterate the elements of informed consent and gain oral consent to ensure patients are aware of the potential risks of any particular intervention and alternative care available to them within the health plan as well as our intention to collect personal health information from the electronic medical record for study-related evaluation. We will employ this informational brochure and verbal discussion of informed consent rather than a traditional research written informed consent; rationale for this is described below. Essentially this will let patients know that because the health plan is continuing to improve services for their members including for those members with chronic pain on opioids, KP clinical staff in partnership with the study will be evaluating participants' pain and functioning throughout their participation in the study and this information will be entered into the patients' medical chart to help guide their PCP and other health care providers in the patients' care.

For the pragmatic trial, data will be assessed and recorded in accordance with regular clinical care (either in the intervention arm or the comparison usual care condition), and subsequently extracted by our research staff from EMR and administrative databases in each of the Kaiser Permanente health plans participating in the study. As such we will request a waiver of consent to use computerized records to collect assessment data for the trial. We believe that the assessment portion of the pragmatic trial clearly satisfies the criteria of 45 CFR 46:116 for waiver of informed consent. Those criteria are:

- *"The research involves no more than minimal risks to the subjects"* – The only risk to participants from this procedure is violation of confidentiality, which we protect against.
- *"The waiver or alteration will not adversely affect the rights or welfare of the subjects"* – Research use of records will have no effect on insurance coverage, access to care, or eligibility for any benefit from participating health systems. The various HMO regions

already routinely permit the use of EMR records for research purposes without member consent.

- *"The research could not practically be carried out without the waiver or alteration"* – It would not be possible to meet in person with all PPACT participants to obtain written consent (forecasted to be up to 2,500 patients across the three KP regions).

Finally, patients will be informed that group sessions may be recorded and shared with supervising staff to evaluate the quality of services the patient is receiving and to help the PPACT providers and the health plan understand how to best improve services for health plan members. A signed release of information will be obtained for the potential recording of groups. Should a patient not be willing to sign the release of information, the group they are assigned to will not be audio recorded.

Primary care providers: PCPs will be provided an informational letter, which will include all elements of informed consent. The PCPs response to the study team approving the recruitment of their patients will constitute consent for their participation. We believe that this is an appropriate consent procedure given the minimal risk to the PCP posed by the study. Benefits to the PCPs who are randomized to the intervention arm of the study will include assistance with managing their patients with chronic pain who are on opioids, who are often patients who utilize primary care services at a greater capacity. The PCPs in the intervention arm will be provided with a comprehensive assessment of their study patients, recommendations by the intervention team, and templates for communicating with those patients who present with challenging communication styles. By participating in the study, they will be asked to meet with the PPACT intervention team and then communicate by telephone with their patients in PPACT at 3 time points in the study; baseline, mid-program, and end of program. The goal of these PPACT meetings and patient telephone appointments will be to review goals set and progress made in the program. Our hope is that creating communication around goals and progress will promote a more positive dynamic between patient and provider.

All PCPs participating in the trial regardless of which study arm they are randomized will have the benefit of the study supporting quarterly collection of patient reports of pain intensity and functional impairment using the instrument (Brief Pain Inventory) selected by Kaiser Permanente for the purpose of monitoring function among patients with chronic pain. Clinical guidelines support assessing pain and functioning regularly for patients on long term opioid therapy, therefore such assessment should support participating PCPs in their work with patients. Participating providers, regardless of study arm, are free to refer their patients to any pain-related services they deem warranted.

Data & Safety Monitoring Plan (DSMP). The intervention aspect of this study is based on best available evidence and constitutes a reorganization of currently available clinical services. Accordingly, we do not foresee that the intervention will introduce risks above and beyond standard clinical care of these patients. Nonetheless, patients with complex chronic pain conditions have the potential for clinical outcomes that constitute serious adverse events. While such events would not likely occur as a consequence of study participation, there is still a clear obligation to investigate and respond appropriately to these events. Consequently, we will implement a safety monitoring plan based on those used successfully in other, similar interventions.

The safety plan will involve EMR monitoring of all study participants every 6 months to identify whether either of the following serious adverse events occur:

- Death
- Hospitalization

If an event occurs, a chart review will be completed by an independent KP clinician in the specific KP region to determine if the event was study related. In addition, the review of the adverse events will involve experienced clinicians on the investigative team (Drs. DeBar, Deyo, Keefe, and Kindler) and be reported to the KP CHR IRB associated with the patient's site. The relative occurrence of these events among the treatment as usual participants and intervention participants will also be monitored to determine if these events are occurring at a significantly greater rate in the intervention arm. This analysis will be completed by the statistical co-investigator, Dr. Vollmer.