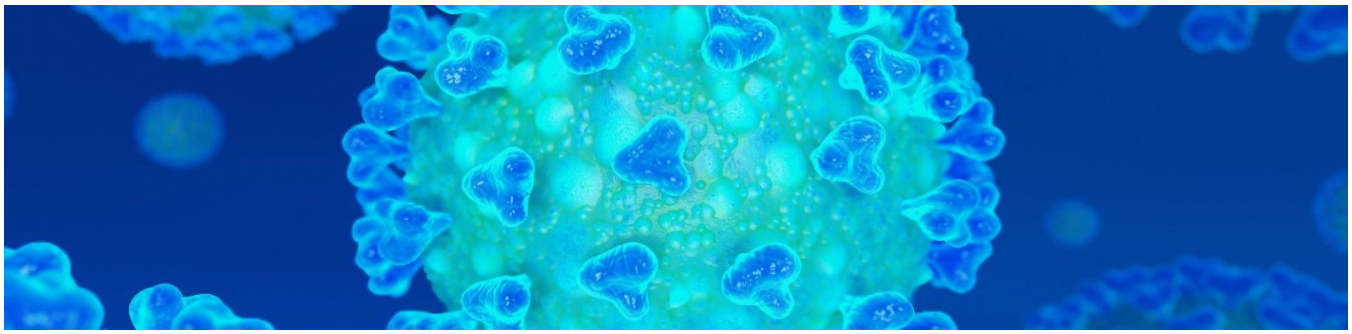
Adjusting to Remote Monitoring During COVID-19: Working Smarter & Safer

Lessons Learned from a Virtual Town Hall held on April 3, 2020



COVID-19 ramifications on trial conduct continue to evolve at an astounding pace, requiring rapid adaptation, mitigation, and innovation. Now that the shock has worn off and we have a better picture of the pandemic's impact on our industry, it's time for us to get creative and find a path forward. At Halloran, we believe the most valuable way to start that journey is by working together to forge ahead. We recognize that there is no one-size-fits-all solution to addressing the impacts of our trials, but the more knowledge we can share, the faster we can get products to patients who need them most.

On April 3rd, 2020, as part of Halloran's Virtual Town Hall series, industry colleagues convened to discuss issues and solutions specifically related to accelerating the uptake of remote monitoring (RM), conducting monitoring activities that were previously conducted on-site, (not to be confused with centralized monitoring) in the wake of COVID-19. From logistics to operations, to systems and processes, the considerations are endless when adapting monitoring to take place off-site. As we begin to chart out our next steps around business continuity, we must leverage our collective knowledge and experience. This write-up captures the key questions and answers from our 3rd Halloran Virtual Town Hall.

Getting started – general considerations

Q: I want to implement remote monitoring (RM) at my company – where do I even begin?

- Sponsors built **site assessment checklists** inclusive of questions around geographic RM regulations, study and protocol requirements, and site-level capabilities to help them evaluate site RM readiness. Sponsors already piloting RM were able to **condense 6 months of work into a span of a few days** to get their RM processes in flight.

    - Important elements to consider include external EMR access / relevant local regulations to allow it, technology ecosystem, local lab availability, protocol/procedure complexity, etc.

- Fortunately, regulatory authorities are **loosening restrictions on external EMR access**, reducing the red tape our industry faced under normal circumstances.

- Training is a key success factor. **Trainings should be lean, quick, and delivered to small audiences at multiple timepoints.** This makes it easier to address questions, ensure quality instruction, and foster better learning overall.

- Site coordinators and investigators are short on time and maybe working across multiple studies. Therefore, **coordinating communications across sites** is critical. We recommend limiting to one sponsor contact to ensure a successful collection of updates and implementing smoothly into operations.

- **Step by step high-level RM process**, mapped out for deployment:

    1. Identify available options by conducting an RM assessment via Site Assessment Checklist, local regulations, and site-specific policies
    2. Update study documents as needed, and set up storage
    3. Train internal team, external sites, and subjects
    4. Execute on remote monitoring

Q: What are the considerations for uploading documents to secure shared file areas (SFAs) (i.e. Box, SharePoint)?

- Secure SFA platforms provide coordinators a **secure place to redact and upload documents** for monitors to review remotely.

- **Assumptions**: sites have scanning ability, wifi is accessible (remote EMR access is a perk)

- **Focus on uploading documents related to 1) study safety and 2) study efficacy**. Safety is the primary focus at this time (i.e. lab tests, imaging reports, any documents directly linked to primary study endpoints, safety data/reports).

- Informed consent forms (ICFs) may require minor language updates on procedural updates. **However, generally, ICFs don't need procedural updates** for RM. Participants should be informed of any procedural changes via letter, memo, or other documents. See WCG IRB for some practical FAQs on this topic.

    - If considering implementing virtual consenting, discuss the process with sites/institutions and refer to local guidelines to determine if local agencies should be notified. Also, note that the process and implementation plan should be documented in the monitoring plan addendum.

- Contract updates are generally minor and easy to achieve as **sites have been willing to collaborate** to swiftly make necessary changes. It's important to **maintain central documentation** of these changes, especially when sites are used across multiple studies. This ensures info distribution control, as well as internal sponsor alignment, so sites are not bombarded with contract updates and sponsors are aligned internally on required changes to contracts and budgets.

Q: Should we be making changes to existing Monitoring Plans? If yes, what should we focus on?

- RM requires minor **edits/an addendum to your Monitoring Plan.** Addendums should spell out what the new plan is, why the new plan is in place, how to react appropriately, where to upload documents, naming

conventions, access permissions, how the remote visit will be documented (i.e. if using something other than the trip report template, etc.)

- Another way to document RM process changes is to make an **overarching Note to File (NTF)** citing that COVID-19 may require deviations from the Monitoring Plan, that deviations will not threaten patient safety, and that the Monitoring Plan will be reconciled upon return to normalcy (predetermined date).
- Record any deviations as COVID-19-related, including missed visits, ensuring they're trackable, and ensure they're easily extractable at the end of the study. Specific deviations associated with COVID-19 will need to be summarized in the clinical study report. Refer to FDA's guidance on clinical trials during COVID-19 and EMA's guidance on points to consider on implications of COVID-19 on ongoing clinical trials for further information on maintaining documentation and recording deviations.

Q: What should we consider for patients who require complex or invasive procedures that are not possible to administer remotely (i.e. transfusions, lumbar punctures, blood draws, etc.)?

- RM processes for complex procedures must be executed on a **case-by-case basis** and consider geography, procedure frequency, procedure type, out-of-window threshold, patient status/history, etc.
- When necessary, **collaborate with sites to identify local labs/clinics** that can perform the procedure. We have seen sites being very cooperative in this regard.
- **Document the occurrence of local lab procedures in a trackable, extractable format** and location. Do not worry about normal ranges and other details. In the Monitoring Plan addendum, spell out how/when you will retrospectively reconcile the data, and how this will be captured in EDC.
- General Sponsor should also adjust their approach to **invoicing for missed procedures** to include payment for missed minor/low-cost procedures and negotiating invoicing of missed complex/expensive procedures during follow-up visits.

Implementing RM visits

Q: Telemedicine / virtual monitoring visits are becoming more commonplace in pandemic operations – what should we consider when implementing such measures?

- Map out all available **options for remote data access** upfront such as:
    1. Direct electronic medical record (EMR) access
    2. Video visits (Webex, Zoom, telephone, etc.)
    3. Documenting uploads to Box or another compliant document sharing tool
    4. Faxing / scanning / emailing
    5. e-source solutions
- **Take a tiered approach to planning RM visits:**
    - Do you aim to conduct a video/telephone visit?
        - If yes, make sure you're prepared by creating a detailed worksheet that includes steps to guide the clinical research associate (CRA) through the execution and documentation of monitoring visit activities.
        - If no, ask yourself if the EMR externally accessible?

        - If no, ask yourself is it feasible to communicate and share documents using encrypted emails or secure SFAs?
    - If yes, leverage these solutions to conduct an RM visit; conduct source data verification (SDV) with a focus on safety data.
- A newly coined industry term, **"offsite interim monitoring visit (OIMV)"** (or tele-MV) describes remote monitoring visits during which digital "over the shoulder" monitoring activities replace in-person interaction.

Q: Remote data access is a notable obstacle – how can we use the demands of remote clinical trials to set our industry's data access standard going forward?

- A success story that we are hearing from sponsors has been with an **eSource platform** as it has made things seamless for entry, integration, and access, which are important in crises like COVID-19.
    - Data is entered in real-time via tablet and transfers are scheduled daily, rendering **data integrated and accessible on the same day it's collected.**
    - **Data visualization provided standards and efficiency** across teams: 80% of the data criteria were the same across studies, data were more focused on clinical trial endpoints.
    - **Challenges**: CRO agreement to work in the Sponsor's systems, change management, training.
    - **Assumptions**: Accessible wifi, sites adhere to data safety and security best practice, sites understand the importance of daily data entry, ability to train all personnel with system touchpoints.
    - **Results:** Drastically decreased # necessary monitoring visits (case study: visits decreased from 30% to 40%)

Enduring innovation

Q: What COVID-19 innovations could (and should) outlast this pandemic?

1. **Increased real-time data access**
2. **Remote access to EMRs**
3. **Telehealth/virtual solutions**

For many companies, COVID-19 is becoming the impetus for digital transformation and that's not a bad thing. Despite the devastation, disruption, and sadness that has spread across the globe with COVID-19, we've seen remarkable camaraderie in our industry. These conditions have compelled us to act as *one* collaborative industry with *one* shared goal: to get life-saving therapies to patients in need. We must carry forth this mindset even after COVID-19 has run its course and reference these learnings to propel us forward. As a participant noted at the closing of our Town Hall, together we will make our trials **smarter and safer!**

-

We have offered some valuable links to additional key Guidance Document links are listed below. However, we recommend visiting these health authority websites often as they are updated frequently as new information becomes available.

FDA Guidance on Conduct of Clinical Trials of Medical Products during COVID-19 Pandemic Last updated March 27, 2020

EMA Guidance on the Management of Clinical Trials during the COVID-19 (Coronavirus) pandemic

EMA Guidance on Points to consider on implications of Coronavirus disease COVID-19) on methodological aspects of ongoing clinical trials

MHRA's Guidance on Managing Clinical Trials During Coronavirus (COVID-19)

UK's NHS COVID-19: Guidance for sponsors, sites, and researchers (v2.2 26 March 2020)

U.S. Department of Health & Human Services Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

Please also reference our previous newsletters here for more information and be on the lookout for our future virtual town halls as we continue to learn more to share.

Please reach out to us if we can help in any way or would like to be included in any of our upcoming town halls.

CONTACT US

Laurie Halloran, CEO | lhalloran@hallorancg.com
Greg Dombal, President & COO | gdombal@hallorancg.com
Paola Murphy, Chief Client Officer | pmurphy@hallorancg.com
Katie McCarthy, Chief Development Officer | kmccarthy@hallorancg.com
Sheila Gwizdak, VP, Quality | sgwizdak@hallorancg.com
Kim Raymer, VP, Regulatory Affairs | kraymer@hallorancg.com
Jason Milovanovic, VP, Clinical Development | jmilovanovic@hallorancg.com

GIVE US A FOLLOW

Halloran CONSULTING GROUP

266 Summer Street, 8th Floor
Boston, MA 02210
hallorancg.com | 617.648.7879