How does your company incorporate a patient focus into drug/biologic development?
Open-Ended Response

Dedicated division with remit for patient centric DD.

We have a dedicated team and then collaborate directly with them

not yet established a systematic approach to incorporating the patient's perspectives and preferences into the development. Started a bit within rare disease
Patient preference team

through inter trial patient interview

we have a dedicated department looking into aspects of patient centric drug development; for us: an increased usage of COAs and PROs
Involvement of patient representatives in clinical development planning
We use more patient related clinical outcomes in our phase III trials, but personally think we can do more and better.

Review of clinical development plans, protocols, study operational plans, choice of eCOAs/PROs, sharing results, patients sharing the burden of disease and what it feels like, patient Q&A sessions, patient videos, contribution to explaining the disease burden e.g. regulatory and reimbursement dossiers, involvement in advisory boards where permitted.

collaborate with selected patient advocacy groups on patient experience and protocol review

We develop some therapies that are individual treatment by definition.

Inclusion of Real world data, adaptive and innovative trial designs

Not sure anything systematic is done, nor how / at which stage. I saw it envisioned to address a challenging situation by patient perspectives on benefit/risk. Otherwise of course, QoL and various PROs in phase III trials.

- collaboration and involvement of patient association (review of protocol, organising patient talk for collaborators...)

Patient interviews. It is being discussed to have patients reviewing the protocol, but I am unsure if it has taken place.
Use of PROs, Digital Biomarkers, etc. Presentations from patients to report about their situation

Has one of your development programs been impacted positively or negatively by the clinical outcome and endpoint development process (e.g., Clinician Reported, Patient Reported. Digital), and what did you learn?
Open-Ended Response

In general, requirements around validation are often perceived as a hindrance and may lead towards using accepted endpoints

no

Example of pivotal study with primary endpoint being PRO and clinical important difference not well understood
too much resource spent on it for a low impact.

question unclear

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Yes, many disease areas being pursued have eCOAs/PROs as primary or co-primary estimands. Various new tools are in development and being validated to help better define how a new therapy could improve the course of a disease and/or QoL/symptoms. Digital healthcare has enabled more efficient tools for patients to give feedback on key clinical measures. Any new tool and/or platform has pro's and con's that need careful consideration, requires early planning, and needs to embrace the diversity of patients which differs by disease setting.
Endpoint development is critical and expensive. You always learn a lot, but my biggest takeaway is that it is very easy to get scammed by startups. Some cross industry collaboration would help distribute the risk
We listen to the patient perception and the burden involved by the treatment. We are discussing burden reduction and label update with FDA and EMA.

no

Unvalidated digital endpoints used for PoC and failing at regulatory consultation by lack of team ownership to investigate and question the endpoint. One learning: proper endpoint validation may require cross -industry consortia and efforts.

...

DHT have been implemented / are being implemented in individual programs.
Huge effort to implement and validate. DHT companies are not stable.

People are not good at recognizing cognitive biases!

What are the most significant challenges that you face within your statistical organizations to work with clinical trial teams to develop clinical outcome assessments and endpoints ?
Open-Ended Response

Our Outcomes Research colleagues are well informed in these topics, and we have one Statistics SME to support the collaborations. Key is understanding the regulatory expectation.

Change management of perception (soft science) to relevant part of the value determination and positioning of a new therapeutic

lack of understanding of the requirements from regulators in term of development and validate

lot of discussions , not clear plan of what is mandatory, nice to have, many stakeholders

established COAs and PROs do not meet needs regarding development objectives and compound specifics

Changing portfolio and corresponding change in focus

at the moment it is not easy to establish MCID for new scales. Using distribution and anchor methods is rather new.

Until recently the eCOA/PRO experts were part of a different organisation but that has recently changed. Having these experts in a Biostats organisation has led to many improvements and enhanced collaborations across line functions.

The assumption that something is automatically valid (and does not require separate validation). That cost already mentioned is a big hurdle

Not enough access to the patient him/herself.

Balancing endpoints that matter most to patients (e.g., quality of life, function) with those that are acceptable statistically and scientifically. Cross functional communication

Often lack of early integrated reflection on what it really takes to validate an endpoint, to enable a sound quantitative strategy.

this topic is new for clinical trial teams. They still rely on external expertise or waiting for proposal coming from consortium (but they do not work internally on this topic)

Time

High expectations and hige uncertaintiy around use of DHT

Regulatory acceptability

Do you rely on outsourcing vendors to (a) recommend which Clinical Outcome Assessment / Digital Health Technology (COA/DHT) are fit for purpose, (b) develop and validate COA/DHT, or (c) analyze data from COA/DHT in clinical trials for presentation to health authorities?
Open-Ended Response

For clinical endpoints generally not, for questionnaire-based endpoints yes this work would be done in collaborations with vendors, most particularly b and c.

a mixture

yes

Mixture - both

yes

partially yes, but not handled by our department

partly
No

We partner with vendors but also have internal expertise. We do a mix of internal and external-led eCOA/DHT strategies, validation and analysis. We value the expertise in specialised vendors in this space.

I've seen a mix of insourcing and outsourcing. Neither is perfect.

no we don't

Better not, vendors rarely have relevant regulatory experience and quantitative background to enable success

yes for developing DHT

yes to all three

No, internal experts and dedicated group for COA/DHT are established.

No

Have you considered insourcing some of these activities, and do you believe internal statisticians could or should lead some of these activities? Which skill sets do you have within your organizations and which skill sets do you need?
Open-Ended Response

We would see statisticians as collaborators but not the obvious leaders for this work; outcomes research colleagues are more likely to lead this.

we are adopting a hybridize model currently (int/ext)

basic understanding and skills are present in the organization for having a dialog with vendors but more is needed but we can lead these activities

Yes but not the preference if we could increase internal resources to cover it

Yes, we have considered this. We have started building up the resources and skills needed.
yes
Not considered so far. Statisticians should consider to be drug developers with a quantitative background, rather than consider themselves as technical skilled people with a focused view.
Already insourced and there is an overlap in skills sets but having a group of specific experts makes a difference and adds value.

We have a lot of experts, but often lack support from upper management to expend the resources to collect the data (even if outsourcing ends up being more expensive).
I believe the internal team should at least be in position of providing an efficient oversight, which means first that the internal team is involved, secondly that they have the aptitude to understand what is important or not for the patient. This is why direct access to the patients could be an very important condition.

Cytel statisticians are well-positioned to lead due to their strong quantitative foundation, especially in: Adaptive trial design Bayesian modeling Simulation-based planning Complex estimand definition
Yes, statisticians should play a central role. They need to open up to endpoint development skills and concepts.

yes as we do not have experience internally in developing COA/DHT (we only have statistical expertise in validation of the psychometric properties of scale)

We have an inhouse anchor and statisticians supporting, but the main part of the work is outsourced and relies on external expertise.
Internal experts and dedicated group alread exist or being hired

N/A