Department of Veterans Affairs

Memorandum

September 26, 2013
From: Dr. Charlene Weir
To: OMB Staff

Dear OMB,

We appreciate your review of this work. As you are probably aware, all research projects go through exhaustive scientific review by the funding agency and by the local VA scientific review committee. In addition, the governing body of the University of Utah Institutional Review Board does an extensive review to ensure that we are in compliance with Human Subjects and ethical considerations. This review board provides the legal coverage for research projects done at the SLC VA.

Those areas of review have been well covered. The processes in place for scientific review are comprehensive and done by experts in the field, to ensure that the research completed is of scientific quality and exceeds all ethical requirements.

Because of the time delays in OMB review, we have lost the funding to complete the survey as described. As a result, we are going to limit the study population to 1,000 patients. We no longer have money to support staff to work on the project in the scope planned earlier.

Here is our response to your questions.

A.2. This response addresses the "by whom" but not the "how" or the "for what purposes." Please provide more information on these two aspects of the information collection. What are the major research questions that this study was designed to address? A literature review was mentioned in A.16; can a copy of this be provided to us?

We suggest that you read the IRB protocol (attached) as it explains the overall purpose (the important areas are in yellow). This protocol was developed from the original funding proposal. The IRB does the reviews with a panel of experts who focus on Human Subjects, but also assesses the basic logic of the design and rationale for procedures.

The procedures listed in the IRB are intended to comprehensively cover everything we might do. IRB does not REQUIRE that we accomplish everything described and the scope can be limited but not expanded. Researchers are granted some autonomy in

deciding what specific actions to pursue because of their expertise and experience. We include procedures that we MIGHT do order to get pre-approval, so the activities described are broad. OMB approval and available funding determine our actual sample size and procedures for this study. Below are the aims:

Aim 1. Identify the barriers and facilitators to adoption of a POCR research innovation program. Assess the perceptions and attitudes of patients, providers, staff and administrators regarding POCR program.

Aim 2. Produce guidelines for VHA regarding implementation of POCR.

Aim 3: Develop and implement a survey to quantitatively assess providers' and patients' beliefs and perceptions about a perspective POCR program. Explore moderators of attitudes and beliefs, including age, gender, and geographic location among others variables.

Besides the literature review in the IRB protocol, we are providing you with another review taken from our report to the scientific funding agency.

LITERATURE REVIEW

Patients

Engagement of patients in clinical studies is challenged by the need to balance patient participation with the ethical standards of informed consent. Integrating informed consent at the point of care under clinical states of equipoise becomes even more challenging. Lessons can be learned from the research literature in shared clinical decision-making, patient preferences, and the engagement literature of patients in their own healthcare, quality improvement and patient safety. Clinical decision making is perceived by patients as "shared" in which they are able to demonstrate expertise in gaining clarification on their condition, participate in the process of care and negotiate with their provider on specific aspects of their care.[5]

Identifying and integrating patient preferences for involvement in research is key to recruitment and to ethical informed consent. However, prior studies have identified significant limitations in patient's decision-making understanding of the research process. Patients often do not understand the purpose of the consent process itself.[6] Specifically, several studies and a review have noted patient's limited understanding of the purpose of randomization.[7, 8] Most patients appear to have a good technical understanding of randomization, however, they might not think random choice is necessarily compatible with a choice that is in their best interest. They might even view it as unethical for a physician to suggest randomization.[9]

Secondly, patients had a difficult time accepting equipoise. One study found that more than half of the patients could not believe that a provider would really be unsure of which treatment to suggest.[8] Another study found that most patients did understood equipoise, but if they found randomization unacceptable, they were much less likely to enroll.[7]

Variables predictive of patient enrollment include education, prior experience and cognitive capacity. Vulnerability, either due to physical or psychosocial conditions, may be a particularly important consideration for enrollment. This finding has implications for the impact of POCR on the patient-provider relationship and the time needed to adequately address patient concerns.

Negotiating the consent process is similar to other areas where patient preferences have to be incorporated into care decisions. Patients exhibit a range of responses from passivity to autonomy in their willingness to participate.[1] Determining the particular state of willingness to participate by the patient also impacts the amount and type of information the patient may seek about his/her condition.

And finally, several studies have been published examining ethical issues relating to consent, enrollment and the definition of equipoise. Bromage et al[10] described the growing need for autonomy dominating biomedical ethics and that this principal must be assessed in the clinical context of other principles. The contextual factors that they assert must be considered include "the invasiveness of the procedure, equipoise and the importance of the patients' values." Rodrigues et al[11] argue that the differences between clinical care and research must be thoroughly explained in order to protect the rights of patients and that there has to be clear-cut equipoise in outcomes across the physician, patient AND investigator.

1. Benbassat, J., D. Pilpel, and M. Tidhar, *Patients' preferences for participation in clinical decision making: a review of published surveys.* Behav Med, 1998. **24**(2): p. 81-8.
2. Bower, P., et al., *Patient preferences in randomised controlled trials: conceptual framework and implications for research.* Soc Sci Med, 2005. **61**(3): p. 685-95.
3. Elwyn, G., et al., *Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices.* Br J Gen Pract, 2000. **50**(460): p. 892-9.
4. Little, P., et al., *Preferences of patients for patient centred approach to consultation in primary care: observational study.* BMJ, 2001. **322**(7284): p. 468-72.
5. Moreau, A., et al., *What perceptions do patients have of decision making (DM)? Toward an integrative patient-centered care model. A qualitative study using focus-group interviews.* Patient Educ Couns, 2012. **87**(2): p. 206-11.
6. Akkad, A., et al., *Informed consent for elective and emergency surgery: questionnaire study.* BJOG, 2004. **111**(10): p. 1133-8.
7. Mills, N., et al., *Perceptions of equipoise are crucial to trial participation: a qualitative study of men in the ProtecT study.* Control Clin Trials, 2003. **24**(3): p. 272-82.
8. Robinson, E.J., et al., *Lay conceptions of the ethical and scientific justifications for random allocation in clinical trials.* Soc Sci Med, 2004. **58**(4): p. 811-24.
9. Robinson, E.J., et al., *Lay public's understanding of equipoise and randomisation in randomised controlled trials.* Health Technol Assess, 2005. **9**(8): p. 1-192, iii-iv.

10. Bromage, D.I., et al., *Improving informed consent in percutaneous coronary revascularisation.* EuroIntervention, 2012. **8**(1): p. 146-54.

11. Rodrigues, H.C., A.J. Oerlemans, and P.P. van den Berg, *[The need for uncertainty in clinical research. Equipoise].* Ned Tijdschr Geneeskd, 2011. **155**(49): p. A3846.

12. Hummers-Pradier, E., et al., *Simply no time? Barriers to GPs' participation in primary health care research.* Fam Pract, 2008. **25**(2): p. 105-12.

Please provide more information on how you plan to "use the social media site Facebook to recruit participants." –

We are no longer making those plans as our recruitment strategies are limited due to the delay in beginning the project. All participants will now be recruited via email, mail, and phone calls (please see attached IRB protocol).

A.8b. Please include the names of the representatives from the Boston VA medical Center and the faculty at the University of Utah.

The names of our Boston collaborators are listed below. In addition, the names of the individuals in the original approved funding budget are listed. Others listed on the budget worked on the Focus Groups only.

Boston Maverick Group
- Louise Fiore, MD, Executive Director MAVERIC, POCR Principal Investigator
- Ryan Ferguson, Program Manager, MAVERIC
- John Hermos, MD, Regulatory Advisor, MAVERIC
- Pat Woods, Study Nurse/Project Manager

VA Research Representative
- Theresa Gleason, Senior Program Manager, VA CSR&D

Local Staff and Researchers
- Charlene Weir, PhD, RN, Principal Investigator
- Jorie Butler, PhD, Co-Investigator
- Brian Sauer, PhD, Co-Investigator
- Robyn Barrus, MS, Project Manager
- Deborah Hoffman, Research Assistant
- Lacey Lewis, Research Assistant
- Sophia Lu, PhD, Data Analyst

A.10. Is any assurance of confidentiality being given to respondents (if so, it must be backed up by a statute). The cover letter refers to answers being kept "secret," but it is not clear what this is supposed to mean. Was a PIA done for this collection?

The University of Utah and VA Institutional Review Board, that has the salutatory authority to cover research projects for Human Subject Review, extensively reviewed this proposal. We have complied with their rules for confidentiality and privacy in that review. These include the security measures described in the attached IRB protocol for data collection and storage. Our institution has adopted those rules for privacy and confidentiality (including data security procedures). Our VA Privacy Officer reviews every IRB application as part of our local scientific review. In addition, we all have undergone extensive required training in that regard.

The language "kept secret" was designed to meet a 6th grade reading level and was approved by our research office as being appropriate.

A.14. The annual cost to the Federal Government, according to the OIRA worksheet, is $0. Please include the grant funding, staff time, and any other resources that are needed to conduct this collection, even if the funds were already allocated.

The original funding for the project was $425,000 for a one-year study that included focus groups for providers and patients as well as a national survey for both of those groups. Attached is the original approved budget.

A.16. Please provide the time schedule for this collection and reporting of the results.

Our original time frame was for one year. The delay in this component of the project was due to delays in achieving OMB approval.

If we receive OMB approval, we will begin data collection within a few weeks and expect to finish data collection within 3 months. Data analysis will take another month.

B.1. What is the sampling frame for this study? Is the study being conducted only at the one site? This appears to be a 2 X 3 design, but it wasn't clear from our conference call whether low utilizers were be included in the study; please clarify. Also please clarify the rationale for the 3 age groups and what research questions/hypotheses are driving the comparisons that you plan to make by age and utilization status (as noted earlier, these should be in A.2).

We are randomly sampling from all veterans from a national database (VINCI). We are

measuring their age in order to do internal comparisons across age groups. We believe that age makes a difference in attitudes toward research, but that question is exploratory. It is relatively standard in survey research to explore the moderating effects of certain demographic variables, such as geography, age and gender.

It is our goal and the goal of the funding agency to include only those who use the VA sufficiently to have some experience with the institution. We did a data pull of visits per veteran and 65% of those veterans who have been to the VA at least once in the last 3 years have at least 3 visits in the last 2 years. We feel completely justified in that cutoff as we want to include those individuals who know the VA and since 2 visits per year is the recommended time frame for primary care, we saw this cutoff as a minimum figure. Of course, the mean the number of visits was much higher.

B.1. It was noted that: "In order to achieve a response rate of 2,000, 4,000 patients will be invited to complete the questionnaire." However, A.12 lists 8,000 respondents; please make these consistent. What is the basis for the anticipated 50% response rate?

As noted above, we no longer have the funds available to conduct the survey as described. We failed to meet the deadline that we informed you about. Now, the number of patients we will attempt to contact is limited to 1,000 with the hope of getting a response from 500-600.

Survey response rates vary and the true response rate is unknown. A 50% response rate for surveys is a good estimate. The National VA Westat survey achieved 66.7%, but the effective coverage rate was 38.8%. As you can see, estimating response rates is a very difficult. We actually do not know what it will be. Here are some websites that discuss the issue. Also, if you want to learn more about the topic, the work done by Don Dillman and explained in his book, Tailored Design Method.

http://www.practicalsurveys.com/respondents/typicalresponserates.php

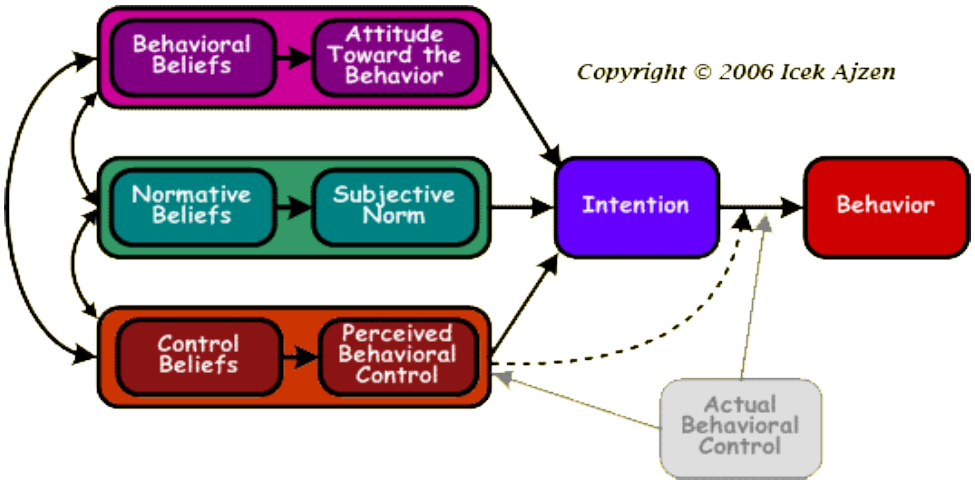
http://www.va.gov/SURVIVORS/docs/NVSSurveyFinalWeightedReport.pdf

B.2a Please clarify *how* the 4,000 patients invited to participate will be selected?

The procedures are described in detail in the approved IRB protocol and since that is the currently approved process, we believe that you will have the most confidence in getting it from that source. It is attached and the relevant procedures are highlighted in yellow.

B.2b Are you planning exploratory or confirmatory factor analyses? What constructs is survey designed to measure? Please identify specific items intended to measure each construct.

The constructs were adapted from Theory of Planned Behavior and our prior focus groups. The Theory of Planned Behavior manual is attached. The recommended and well-accepted procedure is to use qualitative work to identify the exact content regarding beliefs and attitudes and compose items based on the general constructs of: Normative Beliefs (what others think of us doing the action), behavioral beliefs (attitudes towards the expected outcomes) and control beliefs (self-efficacy and/or general control beliefs). We focused on expected outcomes as derived from the focus groups and direct attitudes only. We were going to conduct a factor analyses, but because of a now small sample size, the data analysis will be descriptive only with some correlations within subgroups.



http://people.umass.edu/aizen/tpb.diag.html

B.3. During our call, telephone follow up was mentioned, but it's not described here. Is telephone follow-up still part of the nonresponse follow-up plan? Please describe this in Part B.

Yes, we are going to do a phone call. Please see the approved IRB protocol.