June 13, 2022

Robert M. Califf, MD
Commissioner of Food and Drugs
Food and Drug Administration
5630 Fishers Lane, Rm 1061
Rockville, MD 20852

Via Electronic Submission: https://www.regulations.gov

Re: Docket No. FDA-2021-D-0789 – Diversity Plans to Improve Enrollment of Participants from Underrepresented Racial and Ethnic Populations in Clinical Trials; Draft Guidance for Industry

Dear Commissioner Califf,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, appreciates the opportunity to comment on the draft guidance titled *Diversity Plans to Improve Enrollment of Participants from Underrepresented Racial and Ethnic Populations in Clinical Trials* (hereinafter draft guidance).

As the largest direct provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies.

**Clinical Trials Diversity Overview**

Clinical trials offer patients with cancer and other serious medical conditions access to ground-breaking research and treatments that may improve quality of life, extend survival, and even prove lifesaving. Barriers to clinical trial participation thwart potential treatment advances, survival increases, and reduction in mortality. Approximately 20% of cancer clinical trials fail due to insufficient patient enrollment (American Cancer Society, 2018). The percentage of adults with cancer that participate in clinical trials ranges between 2% and 8% (Unger et al., 2020). Within this already low percentage of trial participants, data reveals that Black and Hispanic populations represent just 3.1% and 6.1%, respectively, of trial participants (Gavidia, 2020). While Black Americans represent approximately 13% of the population, a 2021 study showed the participation to prevalence ratio of Black Americans in clinical trials of all cancer subtypes had an average enrollment percentage of just 7% (Awidi & Hadidi, 2021). Of importance, the findings of a 2020 study revealed that when offered the opportunity to participate in a clinical trial, more than half of cancer patients do so (Unger et al., 2020). Equally notable, the study found higher (though not statistically significant) rates of participation for Black and Hispanic patients as compared to White patients (Unger et al. 2020). As opposed to providing disparate take-aways, taken together, these findings serve as a compass to guide the FDA and all stakeholders on the need to develop policies and practices that redress the inequities and biases in our current health system so that

all populations, especially racially and ethnically diverse populations, are provided the same opportunity to participate in, benefit from, and contribute to clinical trials.

**CSC's Prior Comments to Reduce Clinical Trial Barriers**

CSC is a leader in promoting policies and practices that ensure equitable access to clinical trials and that break down long-standing barriers that unnecessarily and inequitably exclude or limit people from participating in clinical trials. Our prior comments to the FDA on expanding access to clinical trials include Enhancing the Diversity of Clinical Trial Populations— Eligibility Criteria, Enrollment Practices, and Trial Designs (August 6, 2019), Male Breast Cancer: Developing Drugs for Treatment (October 25, 2019), Inclusion of Older Adults in Cancer Clinical Trials (May 5, 2020), Premenopausal Women with Breast Cancer: Developing Drugs for Treatment (December 7, 2020), and Core Patient-Reported Outcomes in Cancer Clinical Trials (August 9, 2021). These comments identify many of the issues/concerns that limit or influence clinical trial recruitment, enrollment, and retention as well as address considerations and solutions to improve clinical trial diversity. The themes and priorities addressed in our prior comments to improve access to clinical trials include:

- Practice beneficence as defined in the Belmont Report as (1) do no harm and (2) maximize possible benefits and minimize possible harms
- Broaden eligibility criteria
- Limit exclusions to when strong clinical or scientific justification exists
- Include patients who will use the medication, if approved
- Eliminate unnecessary barriers and burdens of participation including, but not limited to, travel costs, travel distance and time, physical and emotional burdens of travel, interference with work, and dependent care obligations
- Reduce the frequency of required visits to the trial site
- Conduct trials in the community setting where most cancer patients receive their care through community providers including rural areas and geographic areas with racially and ethnically diverse populations
- Recruit trial participants in the communities where people live, work, go to school, and play
- Increase the use of telemedicine and other alternate forms of communication to decentralize clinical trials
- Collect and incorporate patient experience data (PED), both the physical and psychosocial impacts of the disease or clinical investigation, in clinical trials to understand patients' needs and concerns to help inform trial design, enhance recruitment, and ensure retention
- Ensure clinical trial resources and materials are understandable, relatable, and culturally appropriate

**Group Comments to Congressional Leaders on Clinical Trial Diversity**

Recently, CSC joined other patient advocacy organizations urging Congressional leaders to take bold steps to improve clinical trial diversity as part of the Prescription Drug User Fee Act (PDUFA) reauthorization. These letters, the first signed by 89 organizations and the second signed by 72 organizations, speak to specific actions that can be taken to increase trial diversity including: 1) greater accountability by *requiring* sponsors to develop and submit diversity plans, 2) sponsors and FDA ensuring action plans of integrity, 3) increased use of decentralized clinical trials and increasing trial

flexibilities, 4) holding public workshops in communities with cross-sector stakeholders, 5) annual reporting by the FDA to Congress and the public summarizing information on diversity action plans, 6) directing federal resources and grants to community-based providers to support clinical trial recruitment and trials conducted at community health centers, and 7) minimizing financial barriers by re-evaluating and expanding permissible costs connected to clinical trial participation for costs related to digital technologies as well as transportation, lodging, and meals for the trial participants and their family members.

**FDA Draft Guidance Provisions**

We appreciate the FDA's recognition of the need to develop plans specifically designed to improve enrollment of participants from underrepresented racial and ethnic populations in clinical trial. As illustrated by our prior comment letters and sign-on letters discussed above, we support significant changes to ensure, as compared to encourage, equitable representation of racially and ethnically diverse populations. We interpret the first three Categories of the draft guidance as providing the high-level parameters for the development of a sponsor's diversity plan. To meet the urgency of the need, we recommend using language that sets forth a clear expectation that trials *will be* designed to include racially and ethnically diverse populations at representative levels.

Section A. of Category #2 on the Scope of medical product development program currently asks sponsors to outline the "expected" geographic locations of the trial or studies and how these aspects of the trial "may" specifically address inclusion of underrepresented racial ethnic populations. We urge this language be strengthened by removing the word "expected" so that sponsors understand their commitment to and give serious forethought of the locations of their trials which are fundamental to ensuring an equitable opportunity for people to participate in clinical trials. We also recommend removing the word "may" in section A. that appears before the word "specifically" and replacing it with the word "will" to accurately reflect the priority of this issue. With these changes, section A. of Category #2 would read:

> A. Study design, study population (including study eligibility criteria), endpoints and, the geographic locations of the trials or studies and how these aspects of the trial or study will specifically address inclusion of underrepresented racial and ethnic populations.

Similarly, we recommend the word "justification" in the introduction to Category #3 of the draft guidance be replaced by the word "support." The word justification implies a defensive action whereas the word support reflects a proactive measure taken by a sponsor to achieve meaningful clinical trial diversity. We also believe that establishing goals for retention as well as enrollment are necessary to achieve diversity in clinical trials. Therefore, we recommend the title of Category 3, its introduction, and sections read as follows:

> 3. Goals for enrollment and retention of underrepresented racial and ethnic participants
>
> Define and provide support for the planned enrollment and retention of participants from underrepresented racial and ethnic populations.
>
> A. Specify underrepresented racial and ethnic populations based on assessment in Category #1.
> B. Specify goals for enrollment and retention of underrepresented racial and ethnic participants (e.g., based on the epidemiology of the disease and/or based on *a priori*

information that may impact outcomes across racial and ethnic groups; and where appropriate, leverage pooled data sources or use demographic data in general population). In some cases, increased (i.e., greater than proportional) enrollment and retention of certain populations may be needed to elucidate potential important differences.

We appreciate the detailed provisions included in Category #4 of the draft guidance and believe they will assist sponsors in improving the enrollment and retention of more racially and ethnically diverse populations. We applaud the specific examples in section B. (ii.) referencing community advisory boards and navigators, community health workers, patient advocacy organizations, and local healthcare providers which specifically align with two of our priorities:

- Conduct trials in the community setting where most cancer patients receive their care through community providers including rural areas and geographic areas with racially and ethnically diverse populations
- Recruit trial participants in the communities where people live, work, go to school, and play

CSC appreciates and values the involvement of navigators, patient advocacy organizations, community health workers and others in sharing information and opportunities about clinical trials. We will soon be launching a Peer Clinical Trials Support Program to increase trial diversity and we strongly believe programs such as these will help achieve greater participation of diverse populations in clinical trials.

One important strategy that improves clinical trial diversity and helps inform future trial design that is missing from section B. in Category #4 is the collection and incorporation of patient experience data. We strongly encourage adding a section B. (iv.) to Category #4 reading:

iv. collecting and incorporating patient experience data (PED) to understand patients' needs and concerns to help inform trial design, enhance recruitment, and ensure retention

Section C. in Category #4 should be amended to add the words "and retention" after the word enrollment to read:

C. Describe metrics to ensure that diverse participant enrollment and retention goals are achieved and specify actions to be implemented during the conduct of the trial(s) or studies if planned enrollment and retention goals are not met.

Our final recommendations are to add "retention" to Category #5 as well as to remove the words "and justification for" replacing them with the words "to support" so Category #5 and its section A. reads:

5. Status of meeting enrollment and retention goals (as applicable)

A. As the diversity plan is updated (when applicable), discuss the status of meeting enrollment and retention goals. If the sponsor is not able to achieve enrollment and retention goals despite best efforts, discuss a plan to support collecting data in the post-market setting.

**Conclusion**

The Cancer Support Community appreciates the opportunity to share these comments and we look forward to working with the FDA, sponsors, and other stakeholders to ensure people from

underrepresented racial and ethnic populations have equitable opportunity and access to participate in clinical trials.

Sincerely,

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