The Promise of Patient-Led Research Integration into Clinical Registries and Research

CMSS | Council of Medical Specialty Societies

PATIENT-LED RESEARCH COLLABORATIVE

Patient-Led Research Scorecards

The *Promise of Patient-Led Research Integration into Clinical Registries and Research* project moves beyond patient engagement toward a solution where patient-generated data and patient-led outcomes research become an essential component of medical research, leading to more patient-centric comparative effectiveness research (CER). Patients and patient organizations, funders, research institutions and other traditional biomedical research teams can collaboratively build the infrastructure and dynamics needed for patient-led CER.

The Council of Medical Specialty Societies (CMSS) and Patient-Led Research Collaborative (PLRC) have developed a sustainable collaborative model of CER based on information from and the expertise of patient communities, researchers, funders, and clinical research organizations. This model takes the form of scorecards which serve to evaluate how effective a patient group and research partner collaboration will be at conducting truly patient-led research.

These scorecards focus on the following four areas to advance patient-led collaborative research efforts:

- **Patient/Partner Governance:** Evaluates the degree to which decision-making power and governance is shared between patient groups and partner groups
- **Integration into Research Process:** Evaluates the degree to which patients are involved in every phase of the research process and key committees, including study design, protocols, trial inclusion, analysis, and reporting.
- **Patient Burden:** Evaluates the degree to which patient burden and associated trauma is addressed, including accommodating patients who are dealing with illness and symptoms, compensation for patients' time and skills.
- **Research Organization Readiness:** Evaluates the ability of the research organization to engage in meaningful patient partnership. This readiness assessment allows patients to discern the research organization's level of collaboration and willingness to share control.

For more information on this project and the organizations involved, visit: CMSS and PLRC.

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Patient Burden

-2 Non-collaboration	-1 Minimal collaboration	0 Acceptable collaboration	1 Great collaboration	2 Ideal collaboration
Accessible Engagement				
Research organization dictates engagement avenues with no consideration of the patient population's access needs. Full participation may be impossible; carry a high time, effort, or monetary cost; or cause patients harm.	Research organization considers the patient population when designing engagement avenues, but rarely provides additional accommodations when requested.	Research organization designs engagement avenues to offer sufficient time and accessibility for the patient population's needs, and provides individuals with additional accommodations upon request.	Research organization designs engagement avenues to offer sufficient time and accessibility for the patient population's needs, ensures patients can easily request additional accommodations, and works with patients to co-design systemic updates in response to requests.	Patients co-create engagement avenues from the outset to ensure that full participation is accessible and minimally harmful across patient sub-populations.
Trauma-Informed Practices				
Research organization does not consider the trauma burden to patients. Patients may experience discrimination, hostility, new or recalled trauma, or other harms as a result of participation. No trauma-informed practices are in place, and patients receive no resources or support for the trauma caused by participation.	Research organization is aware of a possible trauma burden, but no systemic trauma-informed practices are in place, and patients receive no resources or support for their trauma.	Research organization recognizes the trauma burden, and some trauma-informed practices are in place. Resources and support are provided to patients upon request.	Research organization implements trauma-informed practices throughout the study, and collaborates with patients to co-design adjustments to those practices during the study. Requests for resources and support are honored at a systemic level for all patients.	A diverse array of patients, representative of the study's sub-populations, collaborates from the outset to co-create a safe, inclusive, mutually respectful environment; implement and adjust trauma-informed practices throughout the research process; and ensure all patients proactively receive sufficient, comprehensive resources and support.
Responsiveness to Patients				
No formal channels for patient input are established. Research organization does not address patient feedback, and may exclude or retaliate against patients who voice concerns.	Patients find channels for input to be unclear, difficult to access, or unsafe from retaliation. Patient feedback may be acknowledged, but rarely results in changes to the current study.	Research organization creates clear, accessible, safe channels for patient input only after the research process has begun. Patient feedback is acknowledged, resulting in changes to analysis, presentation, or communication; and ad-hoc changes to the current study.	Research organization creates clear, accessible, safe channels for patient input throughout the research process; acknowledges patient feedback; and establishes mechanisms for patients to co-design systemic changes to the current study.	Patients co-lead the study from end to end, including creating clear, accessible, safe channels for input, using that input to inform the research process, and acknowledging its impact. Members of the research organization are excited about and fully engaged in patient collaboration.
Compensation				
Patients are compensated below market rate for their domain expertise and experience level, with no or limited options for when and how they are paid. Expenses, harm, and risk assumed from participation are not compensated.	Patients are compensated at market rate for their expertise and experience, with no or limited payment options. Expenses, harm, and risk are not compensated.	Research organization sets patient compensation at market rate for their expertise and experience; and for anticipated expenses, harm, and risk. Multiple payment options are offered upfront. Requests for additional compensation and/or payment options are honored ad-hoc.	Research organization sets patient compensation at or above market rate for their expertise and experience; and for anticipated expenses, harm, and risk. Multiple payment options are offered upfront. Requests for additional compensation and/or payment options result in systemic changes that benefit all patients.	Patients have decision-making roles in setting and adjusting compensation. Patients are compensated at or above market rate for their expertise and experience; and for anticipated expenses, harm, and risk; in the method and timing of their choice. Requests benefit all patients. Patients receive non-monetary compensation in the form of visibility, professional development, authorship, and awareness of their impact.

Patient/Partner Governance

-2 Non-collaboration	-1 Minimal collaboration	0 Acceptable collaboration	1 Great collaboration	2 Ideal collaboration
Meaningful Decision-making between groups				
Decision-making for significant decisions (funding, study design, publication, etc.) is not communicated transparently and/or the research organization decides the decision making process without patient input.	Decision-making process for significant decisions (funding, study design, publication, etc.) is not communicated and/or agreed upon. Patients have limited or not meaningful decision-making power.	Decision-making process for significant decisions (funding, study design, publication, etc.) is well communicated and agreed upon between patients and research organization.	Decision-making for significant decisions (funding, study design, publication, etc.) is well communicated and agreed upon between patient and partner group, with deference given to patient group.	Decision-making for significant decisions (funding, study design, publication, etc.) is well communicated and agreed upon between patient and partner group, with deference given to patient group with sufficient support to make the decisions.
Accountability between groups				
There is a lack of understanding of the rules of engagement/culture between groups with no written agreement and no defined consequences for not following through.	There is an understanding of the rules of engagement/culture but no written agreement and/or defined consequences for not following through between groups.	There is a shared understanding and written agreement of the rules of engagement/culture with defined consequences for not following through between groups.	Shared understanding and written agreement of the rules of engagement/culture with defined consequences for not following through between groups. Deference is given to patient groups to define the engagement.	Shared understanding and written agreement of the rules of engagement/culture with defined consequences for not following through between groups. Deference is given to patient groups to define the engagement with sufficient support.

Research Organization Readiness

-2 Non-collaboration	-1 Minimal collaboration	0 Acceptable collaboration	1 Great collaboration	2 Ideal collaboration
Recognition of Biases				
Research organization does not recognize bias and ignores feedback from patients	Research organization has limited awareness of own biases and listens to some feedback from patients.	Research organization is aware of own biases, is open to feedback from patients, and implements some of the feedback.	Research organization is aware of own biases and is open to feedback from patient group and actively iterates on feedback given	Research organization is aware of own biases and is open to listening to feedback from patient group. Actively iterates on feedback given. Other patient groups can attest to a positive working relationship. Research organization has a systemic process for accepting input from patients and patient groups.
Collaboration Process				
Research organization has no dedicated infrastructure for collaborating with patients.	Research organization has minimal resources/infrastructure for collaborating with patients.	Research organization has dedicated some resources and infrastructure for collaborating with patients (ie. patient panels); has at least one coordinating personnel focused on meeting the patient group's needs; conducts limited training to build skills to engage with patients.	Research organization has an established infrastructure and process for collaborating and codesigning with patients including at least one dedicated person focused on meeting the patient group's needs and advocating to the rest of the research organization; conducts routine training to build skills to engage with patients.	Research organization has an established infrastructure and process for collaborating with patients that has been vetted by other patients/patient groups; has at least one dedicated person who is focused on meeting the patient group's needs. The partner is recognized as a patient ally vetted by other patients and patient groups with background in disability justice. Conducts extensive training on meaningful engagement with patients.
Knowledge in Disease Subject				
Research organization has no knowledge/experience with the disease being researched	Research organization has minimal knowledge/experience (less than one year) with the disease being researched.	Research organization has at least one year worth of knowledge/experience with the disease being researched.	Research organization has more than one year worth of knowledge/experience of the disease being researched.	Research organization has extensive knowledge and direct experience with the disease being researched and those with knowledge are in decision-making roles. Research organization has a systemic way to keep on top of information from the patient community as well as the latest research.

Integration Into Research Process

-2 Non-collaboration	-1 Minimal collaboration	0 Acceptable collaboration	1 Great collaboration	2 Ideal collaboration
Hypothesis Generation				
Research goals are siloed from patients' priorities. Patients' questions and experiences are not included and/or are dismissed when generating research hypotheses.	Research goals attempt to involve patients' priorities, but limited by communication or collaboration. Patients' inquiries and lived experiences are rarely included when generating research hypotheses. Patients may have suggested the research question with no further involvement.	Research goals take into account patients' priorities. Patients' inquiries and lived experiences are included when generating research hypotheses.	Research goals proactively address patients' priorities with sufficient ongoing collaboration. Patient organization's inquiries and lived experiences are included when generating research hypotheses. Patient organizations work with patients to co-design research hypothesis.	Research goals are based on patients' priorities and co-written by patient organization or patient-researchers. Patient's inquiries and lived experiences share an equal weight with research organization's interests when generating research hypotheses.
Study Design				
Research organization does not include patients in the study design process. Patients do not have the opportunity to provide input on study design. Patient groups are utilized for recruitment purposes only, if at all.	Research organization does not include patients in the study design process. Patients may be invited to review study design but feedback is rarely incorporated and no functioning accountability system is in place.	Select patient voices are approached to inform the study design. Patients are invited to review study design and have an impact on the study design.	Patient organization and their community's input are proactively invited to help inform the study design. Patient organizations are invited to co-design and review study design and patient feedback changes the study design.	Study design is co-written and reviewed by a diverse array of patient-researchers representative of the study's sub-populations. If applicable, protocol testing is done by the patient community.
Analysis				
Patients do not have input in what data to prioritize for analysis and methods of analysis.	Patients are asked to review manuscript drafts but have little say in what data to prioritize for analysis and methods of analysis.	Patients are involved in interpreting data and carrying out analysis in some capacity.	Patients or patient organizations are invited and involved in interpreting data and carrying out analysis anywhere in the study.	Patient-researchers co-lead on the interpretation and analysis and/or work concurrently with partner organization's research team to carry out analysis.
Publication				
Study results are inaccessible to patients and/or behind an academic paywall. Findings are not communicated in lay terms.	Research organization summarizes findings in lay terms, but study results are inaccessible to patients and/or are behind an academic paywall.	Study results are freely accessible to patients and the public. Findings are summarized in lay terms in ways that are informative to the patient population.	Study results are freely accessible to patients and the public. Findings are summarized in lay terms and are actively disseminated to patient population. Patient-researchers co-write the interpretation and analysis.	Study results are freely accessible to patients and the public. Findings are summarized in lay terms and are actively disseminated to patient population. Patient organizations invite patients to co-write findings and reports. A channel of communication is available for patients to ask questions of the research organization.
Attribution				
Patients' work is attributed to others and/or patients are not attributed at all.	Patients are listed as being involved without a description of how they were involved. Patients were not consulted on how they prefer to be attributed.	Patients are acknowledged/ credited in major public facing communication (press, announcements, papers), to the extent that patients wish to be named. Patients were consulted on how they prefer to be attributed.	Patient group is credited in all public-facing communication and included as authors on papers, to the extent that the patient group wishes to be named. Patient group was consulted on how they prefer to be attributed.	Patients are acknowledged specifically for what they did throughout the engagement process, are credited in all public-facing communication, and included as authors on papers, to the extent that the patient group wishes to be named. Patient group was consulted on how they prefer to be attributed.