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## 12 STUDY IMPLEMENTATION

Once a site has completed study-specific training of site study staff and received a study activation notice from the Coordinating and Operations Center (CORE), the site may initiate study procedures. Detailed study implementation guidelines are included in the study-specific procedures (SSP) manual for each study (see Section 10.13).

This section includes general guidelines, applicable to all HPTN studies, on participant accrual and follow-up (Section 12.1), data collection and documentation (Sections 12.2 and 12.3), and reporting (Section 12.4).

### 12.1 Participant Accrual and Follow-up in HPTN Studies

#### 12.1.1 Accrual

Study-wide and site-specific participant accrual targets are specified in HPTN protocols and/or SSP manuals, based on the scientific objectives and statistical considerations of each study. Unless otherwise specified, study-wide accrual periods are considered to begin on the first day of participant enrollment at any participating study site; site-specific accrual periods are considered to begin on the first day of participant enrollment at that site. For many studies, the time from the first day of participant screening through the end of participant accrual will also be tracked and reported.

In addition to the total number of study participants, multi-site studies typically have an estimated number of participants to be enrolled at each participating study site indicated in the protocol, often with provisions to shift enrollment targets across sites in response to actual site performance in meeting accrual targets. For multi-site studies, protocol teams should consider whether to specify a maximum number of enrolled participants for any site to ensure that one or more sites or populations of interest are not inappropriately over-represented in the study data. The Protocol Chair(s) and biostatistician will take the lead in making this determination with the protocol team and work with the CORE Clinical Research Manager/Protocol Specialist (CRM/PS) and Statistical and Data Management Center (SDMC) Project Manager (PM) to ensure that the determination is operationalized in the SSP manual as needed. In studies for which enrollment targets are shifted across sites, sites will inform their Institutional Review Boards/Ethics Committees (IRBs/ECs) of increases or decreases in their enrollment targets in accordance with IRB/EC requirements. At a minimum, updates are provided to IRBs/ECs at least annually in the context of obtaining continuing review of ongoing studies.

In some cases, HPTN protocols include guidelines for adding participants to achieve a certain number of fully evaluable participants. In this setting protocol teams should consider whether to specify a maximum total number of enrollees. The Protocol Chair(s) and biostatistician should take the lead in making this determination with the protocol team, and work with the CORE CRM/PS and SDMC PM to ensure that the determination is specified in the study protocol and operationalized in the SSP manual as needed.

The CORE CRM/PS and SDMC PM discuss accrual plans during study-specific training. They will emphasize the importance of closely monitoring the accrual process at each site and managing the last several weeks of the accrual period (when inadvertent over-enrollment is most likely to occur). For example, training materials may highlight the need to inform potential study participants screened toward the end of the accrual period that even if they meet the criteria for enrollment, there is no guarantee that they will be enrolled in the study if the study quota is reached before the participant is enrolled.

For each HPTN study, the SDMC generates routine study enrollment and retention reports from the primary study database (see also Section 12.4.3) as specified in the study

reporting plan in the SSP. In addition to this report based on data received from the sites, the Investigator of Record (IoR) or designee at each participating study site will report accrual information — at minimum the number of participants screened for and enrolled in the study — to the CORE CRM/PS on a weekly basis, for inclusion in cross-site accrual reports that the CORE CRM/PS distributes to the protocol team. Detailed instructions for reporting accrual information to the CORE CRM/PS will be provided in the SSP manual (see Section 12.4.2). Protocol teams are responsible for reviewing both the site accrual reports and SDMC enrollment and retention reports on an ongoing basis during the study accrual period and taking action as necessary to ensure that accrual and retention targets are met.

### 12.1.2 Enrollment

For each HPTN study, screening and enrollment procedures are described in detail in study protocols and SSP manuals. Information pertinent to participant screening and enrollment that is applicable to all HPTN studies is provided in the remainder of this section.

From both a statistical and operational perspective, it is important to define the effective point of enrollment in a research study in the study protocol and/or SSP manual. A few examples of the definition of enrollment are as follows:

- The point in time when a participant provides informed consent for study participation (adequately completed with signature and date)
- The point in time when a participant is assigned to a study treatment group

Written informed consent must be obtained from all HPTN study participants prior to the performance of any protocol-specified screening or enrollment procedures. See Section 8.5 for additional information on the informed consent process.

It is the responsibility of each IoR and designated staff to establish study-specific participant recruitment plans or Standard Operating Procedures (SOPs) for each HPTN study, and also plans to ensure that only persons who meet study eligibility criteria are enrolled in HPTN studies. See Section 10.4 for further guidance on the content of such SOPs.

The Division of AIDS (DAIDS) policy on essential documents (*Requirements for Essential Documents at Clinical Research Sites Conducting DAIDS Funded and/or Sponsored Clinical Trials*) requires study sites to document HPTN study screening and enrollment activities on screening and enrollment logs. Screening and enrollment logs may be maintained separately or combined into one log. Sample logs that may be adapted for local use at participating study sites typically are provided in SSP manuals.

For all HPTN studies, the SDMC will provide participating study sites with a list of participant identification numbers (commonly referred to as “PTIDs”) to be used for purposes of study data management. Detailed information on the structure and format of the PTIDs to be used in each study, and instructions for assigning PTIDs to individual study participants, are provided in SSP manuals.

The DAIDS policy on essential documents specifies that participant initials be recorded on screening and enrollment logs, in addition to PTIDs. Per HPTN policy, in agreement with DAIDS, participant initials need not be recorded on screening and enrollment logs if doing so presents a potential threat to participant confidentiality. However, in such cases, a separate document must be available to document the link between a participant’s name and PTID.

### 12.1.3 Over-Enrollment

In addition to ensuring that accrual targets are met, protocol teams also are responsible for ensuring that accrual targets are not substantially exceeded. In most cases, over-enrollment greater than 5% of the target study sample size or 50 participants — whichever

is smaller — should not occur. Protocol teams should consult the HPTN Study Monitoring Committee (SMC) if higher rates of over-enrollment are to be considered and should seek approval from the sponsor.

Over-enrollment is not permitted as a means to “make up for” participant loss-to-follow-up, unless specifically directed by the SMC or the DAIDS Data and Safety Monitoring Board (DSMB). Adjustments to the sample size initially estimated in the study protocol may be made at the recommendation of the SMC and/or the study DSMB, based on actual event rates observed among enrolled participants. If the sample size required to achieve the power specified in the study protocol is adjusted per recommendation of the SMC or DSMB, the over-enrollment specifications will then apply to the final adjusted sample size.

During the study accrual period, based on both the site-generated and SDMC-generated accrual reports, the Protocol Chair(s) and biostatistician, together with the CORE CRM/PS and SDMC PM, are responsible for proactively addressing potential over-enrollment and under-enrollment issues. Accrual and over-enrollment/under-enrollment issues are discussed during routine protocol team conference calls, meetings, etc. Toward the end of the accrual period the Protocol Chair(s) and biostatistician take the lead in determining with the protocol team whether to allow eligible participants who initiate, but do not complete, the study screening process before the accrual target was met to complete the screening process and enroll in the study after the accrual target was met. This determination should be based on the risk-benefit ratio of the study screening and enrollment (on-study) procedures. In the event that the protocol team decision would result in an over-enrollment rate greater than 5% or 50 participants (whichever is smaller), the protocol team will consult with the SMC, Prevention Management Group (PMG), and the sponsor prior to finalizing a decision. The CORE CRM/PS maintains documentation of this consultation in the CORE study implementation files.

#### **12.1.4 Follow-up Visits**

For each HPTN study, the expected duration of participant follow-up, as well as the number and type of follow-up study visits or contacts that are scheduled to take place during the course of the study, are specified in the study protocol. For each protocol-specified follow-up visit, a target date for when the visit should be conducted is also defined in the protocol or SSP manual.

In addition to specifying target visit dates, HPTN protocols and/or SSP manuals also specify allowable visit “windows” for certain follow-up visits. Visit windows are defined as the period of time around the target date during which the visit procedures must be performed. For example, suppose a follow-up visit is targeted to take place on study day 90 and a  $\pm 14$ -day window is specified for the visit. Every effort should be made to conduct the visit as targeted on day 90; however, the visit could take place any time between days 76 and 104. Depending on the protocol specifications, when scheduled follow-up visits do not take place during the allowable visit window, the visit may be considered missed or changes to visit procedures may be required. In addition to allowable visit windows, more narrow “target” visit windows within which the visit is expected to be performed may also be defined and used when reporting participant retention and the number of visits conducted early or late.

Interim visits are those that are not expected per protocol and are in addition to regular study visits. Interim visits or contacts may take place for a variety of reasons, e.g., a participant may be sick, need additional study product, additional laboratory tests, etc. The handling of interim visits is specified in each SSP manual.

### 12.1.5 Participant Transfer between HPTN Research Sites

Participant transfer between HPTN research sites participating in the same study is allowed in some, but not all, HPTN studies. Transfer procedures, including the handling of study product-related documentation for each study, will be detailed in the SSP manual. The study coordinators at both the originating research site and the receiving site must coordinate the participant transfer to ensure that all transfer procedures are followed and documented.

After details of the transfer have been agreed upon, staff of the originating HPTN research site are responsible for the following, ensuring that each item is performed and documented according to appropriate local regulations:

- If appropriate, obtaining approval for release of information from the participant as required by the institution and country involved
- Providing a written evaluation regarding the participant's condition along with a synopsis of the subject's involvement in the study. All supporting documentation should be forwarded to the receiving site.
- Identifying and resolving all outstanding quality control (QC) notes for all visits conducted at that site involving the transferring participant
- Sending copies of study files to the receiving HPTN site and documenting what is sent
- Completing and faxing Participant Transfer Form to SDMC

The receiving HPTN site is responsible for:

- Requesting the participant to sign a new informed consent form(s) if the consent form at the receiving site contains new or different information from the transferring site
- Reviewing the participant's records and other documentation received from the originating site and identifying any additional information required
- Completing and faxing the Participant Receipt Form to the SDMC

*NOTE: Transferred participants always retain the original assigned PTID and remain in the Enrollment and Retention reports for the original transferring site.*

Until the Participant Receipt Form has been received at the SDMC, the originating site has primary responsibility for tracking the participant and maintaining any appropriate documentation.

### 12.1.6 Investigator-initiated Termination of Participants

HPTN study participants may withdraw their consent to participate in HPTN studies at any time, for any reason. However, to avoid biasing study results, investigator-initiated termination of HPTN study participants should occur only under extraordinary circumstances. For instance, termination may be considered if there is potential for harm to study staff or severe disruption of study operations.

In studies involving investigational products or interventions, IoRs will not routinely terminate study participants solely because the participants, for any reason, are non-adherent to the protocol-specified regimen for use of the investigational product or intervention.

In all studies, protocols and SSP manuals will specify requirements for monitoring medical and/or social harms to participants and will delineate when participants should be terminated for medical or social harms. Study staff will follow these requirements to monitor and respond to participant safety issues.

In all cases, prior to terminating a participant from an HPTN study, the IoR will seek approval of members of the protocol team designated in the study protocol; at a minimum, the Protocol Chair, DAIDS Medical Officer, CORE CRM/PS and protocol statistician must be consulted. Designated members of the protocol team will assess the scientific, operational, and statistical implications of the requested termination and determine whether the termination may take place.

A designated member of the protocol team will document the team's determination in writing (email or meeting minutes are acceptable) for purposes of onsite documentation, and the determination of the designated protocol team members will rule. Site staff must always record reasons for termination in participant study records.

### **12.1.7 Participant Unblinding**

#### **12.1.7.1 Unblinding of Individual Participants During the Conduct of a Blinded Clinical Trial**

Whether unblinding of individual participants is allowed during the conduct of a clinical trial must be stated in the protocol. In general, unblinding of participants during conduct of a clinical trial is not allowed unless there are compelling medical or safety reasons to do so, e.g., knowledge of the blinded information is necessary for treatment of severe adverse events.

If participant unblinding is allowed during conduct of a clinical trial, the protocol must state procedures for obtaining permission to unblind.

If a participant is unblinded for medical reasons, if at all possible, the random assignment should be given by the SDMC directly to the participant's health care provider and should not be revealed to study site staff or other HPTN staff unless absolutely necessary.

If a participant has been unblinded to HPTN site staff, the participant should be encouraged to remain on study and if at all possible on study product unless medically contraindicated.

#### **12.1.7.2 Unblinding of Participants After Study Completion**

The protocol team, in conjunction with the SDMC, determines the timing of participant unblinding. Except in unusual circumstances, the unblinding of participants cannot occur until all participants have completed their final data collection visit.

For Phase IIb or III trials intended to contribute to a regulatory submission, unblinding of participants cannot occur until the study database at the SDMC is formally locked for the primary analysis.

For Phase I/II trials participants may be unblinded prior to complete database lock, as per the protocol team and SDMC.

Phase IIb or III trials that are not intended to contribute to a regulatory submission or that have been terminated before completion due to DSMB or sponsor decision may unblind participants after all participants have completed their final data collection visit and before database lock. This decision is the responsibility of the protocol team, in consultation with the DSMB when applicable.

The protocol team should determine the method of informing participants of their blinded random assignment. In some situations "Dear Participant" letters will be appropriate. In settings where mailing letters is not possible or appropriate (e.g., for reasons of confidentiality) it will be necessary to plan for disclosure of randomization to participants in person. If disclosure of the random assignment requires counseling of the participant or could cause distress, it should be done in person. The study site staff may consult with their

Community Advisory Board (CAB) in order to determine the most appropriate method of unblinding participants and in developing participant letters or counseling materials. The protocol team will make a good faith effort to inform all trial participants of their individual treatment assignment.

The protocol statisticians at the SDMC will generate unblinding lists, by participant and by study arm, for each site. The lists will be sent to the study site via secure courier or password protected electronic file.

## 12.2 Data Collection

Study site staff are responsible for the collection, storage, timely submission, and quality assurance of study data collected at their site, and documenting the plan for these tasks in a Data Management SOP. All study data should be collected in accordance with applicable specifications of the DAIDS policy: *Requirements for Source Documentation in DAIDS Funded and/or Sponsored Clinical Trials* and SSP specifications.

In addition, the site is responsible for maintaining all documentation critical to the conduct of the study, known as "essential documents", in accordance with the DAIDS policy: *Requirements for Essential Documents at Clinical Research Sites Conducting DAIDS Funded and/or Sponsored Clinical Trials* (see Section 12.6 for complete URLs to both DAIDS policies).

### 12.2.1 Participant Research Records

The US Code of Federal Regulations (CFR) and International Conference on Harmonization (ICH) Good Clinical Practice (GCP) guidance requires study site staff to maintain adequate and accurate participant "case history records" containing all information pertinent to the study for each HPTN study participant.

#### 12.2.1.1 Participant Research Record Contents

Participant research records should contain all of the following elements:

- Basic participant identifiers such as PTID or initials
- Documentation that the participant provided written informed consent to participate in the study prior to the conduct of any study procedures
- Documentation that the participant met the study's eligibility criteria
- A record of the participant's random assignment (if applicable)
- A record of the participant's exposure to investigational products (if applicable)
- A record of all contacts, and attempted contacts, with the participant including all clinic visits, off-site visits (e.g., at home or work), and all verbal and written contacts
- A record of all procedures performed by study staff during the study
- Complete source documents
- All CRFs and other study data collected from the onset of screening through end of participation
- Study-related information on the participant's condition before, during, and at the conclusion of study participation, including:
  - subjective data obtained directly from the participant (e.g., interview responses)
  - objective data ascertained by study staff (e.g., exam and laboratory findings)
  - objective data obtained from non-study sources (e.g., medical records)

In addition to the above, the DAIDS policy: *Requirements for Source Documentation in DAIDS Funded and/or Sponsored Clinical Trials* requires that all protocol deviations involving participants be documented in participants' study records, along with reasons for the

deviation and attempts to prevent or correct the deviations, if applicable. See Section 12.4.10 regarding requirements for reporting protocol deviations.

### 12.2.1.2 Concept of Source Data and Source Documentation

The ICH/GCP guidance defines source data and source documentation as follows:

- The term “source data” refers to all information in original records and certified copies of original records of clinical findings, observations, or other activities in a clinical trial necessary for the reconstruction and evaluation of the trial. Source data are contained in source documents (original records or certified copies).
- The term “source documents” refers to original documents, data and records (e.g., hospital records; clinical and office charts; laboratory notes; memoranda; subjects’ diaries or evaluation checklists; pharmacy dispensing records; recorded data from automated instruments; copies of transcriptions certified after verification as being accurate and complete; microfiche; photographic negatives; microfilm or magnetic media; x-rays; subject files; and records kept at the pharmacy, the laboratories, and medico-technical departments involved in the trial).

Source documents are commonly referred to as the documents — paper-based or electronic — upon which source data are first recorded.

HPTN study sites must adhere to the standards of source documentation specified in the DAIDS policy: *Requirements for Source Documentation in DAIDS Funded and/or Sponsored Clinical Trials*. This policy contains both requirements and recommendations. Study sites must comply with all requirements and are advised, but not required, to comply with all recommendations. Source documentation includes original documents and certified copies that include documentation pertaining to a participant while on study.

For each HPTN study, participant case history records typically will consist of some or all of the following:

- Narrative chart notes
- Visit checklists or flow sheets
- Laboratory reports
- Medical records or clinic charts
- DataFax CRFs
- Randomization log or other documentation (when applicable)
- Investigational product dispensing and accountability records (when applicable)
- Other source documents and non-DataFax data collection tools or questionnaires

As a condition for study activation, each site must establish an SOP for source documentation that specifies the use of these documents as source documents.

Supplemental information on use of chart notes, visit checklists, and DataFax and non-DataFax forms as source documents is provided below. Also provided below is information related to investigational product dispensing and accountability records, document organization, and record retention requirements.

### 12.2.1.3 Chart Notes

Chart notes must be used to document the following:

- Procedures performed that are not recorded on other source documents
- Pertinent data about the participant that are not recorded on other source documents
- Protocol deviations that are not otherwise captured on other source documents

All chart notes or other tools used as source documentation must document the PTID of the study participant to whom they pertain, the identity of the study staff member who entered information, and the date of the entry. Study sites are strongly encouraged to adopt a common format — such as the Subjective-Objective-Assessment-Plan (SOAP) format for all chart notes, to help ensure adequacy and consistency of note content and maximize adherence to GCP standards, see Appendix 2 – *Guidelines and Examples on the SOAP Format for Chart Notes*. Alternative standardized formats are acceptable and may be adopted by study sites.

#### **12.2.1.4 Visit Checklists**

The SSP manuals typically include a series of visit checklists to guide the staff performing procedures at each study visit (in accordance with the protocol). In some studies, visit checklists are also a convenient tool for study staff to fulfill the requirement of documenting all procedures performed with each study participant. The CORE CRM/PS is responsible for developing these checklists with input from the SDMC PM, Network Laboratory (NL), and the sites. Study sites are allowed to develop site-specific versions of these checklists in order to best reflect local staffing plans, logistics, and procedures. Any site-specific visit checklists should be provided to the CORE CRM/PS for review prior to use.

Note that checklists alone often are not sufficient for documenting all procedures. For example, chart notes may be required to document procedures performed at unscheduled study visits to explain why procedures, in addition to those specified on a checklist, may have been performed or why procedures specified on a checklist were not performed. Chart notes also may be required to document the content of counseling sessions and/or other in-depth discussions with participants (e.g., related to adherence to protocol requirements).

Study procedures for which visit checklists are used as source documentation must contain the PTID, the initials or signature of the authorized study staff member completing the procedures, and the date the procedure was completed. Individual study staff members must initial only those procedures that they complete. In addition, if procedures listed on a single checklist are completed across multiple dates, the date upon which each procedure is completed must be clearly noted. Additional detailed guidance related to proper use of visit checklists is provided in each SSP manual.

#### **12.2.1.5 CRFs and Other Study Materials Provided by the SDMC**

The CRFs developed for each HPTN study are designed for use with the DataFax data management system described in Section 12.3. Before the beginning of each protocol, the SDMC develops a CRF production plan with each site depending on their printing capabilities. For some studies, the SDMC also will provide non-DataFax forms to each participating site.

The SOP for source documentation requires that a site must document which CRFs, if any, will be used as source documents. Study staff must follow the specifications of this SOP consistently for all study participants throughout the study. In the event that study staff are not able to record source data directly onto forms designated as source documents, the following procedures should be undertaken:

- Recording the data onto an alternate source document
- Entering the alternate source document into the participant's study chart
- Transcribing the data from the alternate source document onto the appropriate CRF
- Recording a chart note stating the reason why an alternate source document was used

#### 12.2.1.6 Laboratory Specimen Labels Provided by the SDMC

Blank label-stock and a computer program for printing labels, or in some circumstances pre-printed labels, may be provided by the SDMC. These labels include PTID and a space to write the specimen collection date and visit code for the visit at which the specimen was collected. The labels are only intended to be used on original specimen “containers” (such as vacutainers, slides, etc). If a specimen is to be stored, then the Laboratory Data Management System (LDMS) labeling system will be used to generate other labels once the information has been entered into the LDMS and the sample has been processed.

#### 12.2.1.7 LDMS Specimen Tracking Sheets Provided by the SDMC

The LDMS Specimen Tracking Sheet is designed to accompany specimens from the clinic to the site’s laboratory and facilitate entry of specimens into LDMS. A study-specific LDMS Specimen Tracking Sheet can be provided by the SDMC with the CRFs for the study, but sites may elect to use their own laboratory requisition forms instead.

#### 12.2.1.8 Product Dispensing and Accountability Records

As indicated in Section 10.7, the receipt, dispensing, and final disposition of all investigational product supplies used in HPTN studies must be documented by designated study site staff in accordance with the *Pharmacy Guidelines and Instructions for DAIDS Clinical Trials Networks* as well as any supplemental instructions provided in the study protocol and/or SSP manual.

#### 12.2.1.9 Document Organization

All participant study records must be stored securely at the study site in accordance with the specifications of the study protocol and SSP manual. See also Section 8.6 for additional considerations related to participant confidentiality.

#### 12.2.1.10 Record Retention Requirements

For studies under an Investigation New Drug (IND) application, investigators must retain study records for a period of two years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such indication, until two years after the investigation is discontinued and the Food and Drug Administration (FDA) is notified (21 CFR 312.62). For studies not under an IND, investigators must retain study records for a minimum of three years. The three-year time period begins when the institution’s engagement in the human subjects research activity ends. For all studies, retention of study records must also be in accordance with local IRB/EC policies and procedures. **No study records are permitted to be destroyed without prior written authorization from DAIDS.**

### 12.3 The DataFax System and CRFs

For HPTN studies for which the SDMC manages study data, CRFs are transmitted to the SDMC, and data are entered and cleaned using the DataFax data management system.

DataFax is a data management system that integrates fax and computer technologies for processing CRFs. The study site retains the original CRF hard copy and transmits an electronic image to the SDMC. All data transmissions are stored as electronic images at the SDMC.

Electronic transmission is accomplished by a standard fax machine via phone lines or via the Internet either by an Internet-ready fax machine. The SDMC’s Information Technology (IT)

staff can work with each study site to determine the best method for their data transmission or assist with problem solving.

Study sites must transmit completed forms to the SDMC as soon as possible after completion (generally within 5 days after the participant's visit, with safety information such as adverse events (AEs) sent within 24-48 hours) and respond promptly to SDMC Quality control (QC) reports, clinical queries, and requests for clarifications and corrections. Site data management performance, including number of QC notes, the percentage of resolved QCs, and the time it takes the site to transmit the completed CRFs to the SDMC, is tracked by the SDMC on a regular basis and reported to the protocol team and other HPTN study oversight and leadership groups, as specified in the study reporting plan.

### **12.3.1 Processing of CRFs at the SDMC**

Each DataFax CRF is identified by a barcode denoting the protocol number and type of form. Pages do not need to be faxed in sequence. DataFax processes images by separating a fax into individual pages, adjusting each page to correct for proper alignment and rotation, and identifying each page based on the barcode information in addition to key items such as PTID and visit code. DataFax stores each image of a CRF that has been received and tracks all versions of each CRF received, along with all associated QC notes.

DataFax uses Intelligent Character Recognition (ICR) to read data from checkboxes and numbers from numerical fields and enter it into the study database. The SDMC staff review each CRF at least twice, comparing the data entered by the ICR process with the actual data image and correcting any discrepancies. Data in specified text and comment fields are entered manually as appropriate.

Data fields requiring clarification or correction (e.g., missing data or out-of-range values) or clinical data on CRFs needing verification or clarification (e.g., a severity grading on an adverse event log) are flagged with QC notes that are included in QC reports regularly emailed to the Clinical Research Sites (CRSs) for review. Corrections or clarifications in response to QC notes are made on the original CRF and re-faxed to the SDMC. The QC reporting schedule is determined by the size and progress of the study and is documented in the protocol reporting plan (see Section 12.4).

### **12.3.2 CRF Distribution and Duplication**

The SDMC may distribute CRFs to CRSs in several different formats. The format is determined by the SDMC PM with input from the study sites. The formats are:

- Bulk CRFs: preprinted CRFs bundled by form type
- Master CRF notebook: notebook containing one copy of each form to be photocopied by the site as needed
- Electronic CRFs: PDF versions of the CRFs are furnished to the site and the site is responsible for printing them

### **12.3.3 CRF Completion**

Site staff are trained to enter data on the CRF correctly, usually during protocol-specific training. Form-specific instructions are, in most cases, printed on the back of each CRF.

#### **12.3.3.1 Standard CRF Elements and Forms**

All HPTN DataFax CRFs have been designed using standards and conventions developed by DataFax and the SDMC. The standard elements include: participant ID format, page numbers, visit codes, and staff initial/date fields. Instructions for study staff on correct completion of each of these CRF elements on DataFax CRFs are included in SSP manuals.

Certain CRFs have been standardized within the HPTN to ensure that all required data is collected and to create as much consistency as possible between protocols. An individual protocol may warrant a modification to these standard CRFs. Requests for modification are made by the SDMC PM to the SDMC Standard Forms Committee which assesses and decides upon the proposed change. To date, the following CRFs are considered standard in the HPTN:

- Adverse Event
- Social Impact
- Select Components of Laboratory Results CRFs
- Concomitant Medications
- Pre-existing Conditions
- Pregnancy History and Report
- Pregnancy Outcome
- Missed Visit
- Participant Transfer
- Participant Receipt
- Termination

#### **12.3.3.2 CRF Revisions**

The need for revisions to study-specific CRFs during the conduct of a study is identified by the protocol team or SDMC. The SDMC is responsible for revising and reissuing CRFs. Revised CRFs are sent to the protocol team for approval, as appropriate, prior to printing and reissuing to study sites. Revised CRF pages are given a revision date and new version code. If IRB/EC approval is required for new or revised CRFs, the study site staff are responsible for seeking the approval and communicating it to the SDMC PM and CORE CRM/PS. Once approval has been obtained, the site is further responsible for removing and destroying all previous versions and implementing new versions according to instructions provided by the SDMC.

#### **12.3.3.3 Storing DataFax Forms**

DataFax forms are designed for storage in a standard two- or three-ring binder with the holes punched down the left side of the form. They may also be placed in ordinary file folders.

Storage of bulk CRF supplies should be done in an organized fashion, enabling a site to inventory current supply at any time during the course of a protocol.

#### **12.3.3.4 CRF Transmission Maintenance**

The SDMC Internet IT staff are responsible for maintaining the CRF data transmission processes between the CRSs and the SDMC. Maintenance responsibilities include:

- Assisting CRSs with troubleshooting data transmission problems if they occur and developing alternate data transfer methods, if necessary
- Providing support and supplies, as appropriate, for the maintenance and operation of data transmission systems
- Tracking the transmission of CRFs to the SDMC
- Performing technical validation of the SDMC's DataFax data management system

### **12.4 Study Team Communications**

After initial release of a study protocol and SSP manual, several types of study-related communications may be issued to report on study progress or provide further

clarification of protocol-specified procedures and study documentation requirements. Such communications may include, but are not limited to, the following:

- *Conference call and meeting summaries*: Protocol teams, and in some cases other designated study working groups, take part in routine meetings and conference calls throughout the period of study implementation. Summaries of these meetings and conference calls, which often document key protocol-related and study implementation decisions and action items, are prepared and distributed as described in Section 6.2.
- *Protocol clarification memos, letters of amendment, and full amendments with an attendant summary of revisions*: These documents are developed and issued as described in Section 9.3. Development of these documents is coordinated by the CORE CRM/PS, and final versions are distributed to all protocol team members and study sites. Final versions also are posted on the HPTN website.
- *SSP Manual updates*: These updates are developed and issued as described in Section 10.13. Like the initial version of an SSP manual, development of the updates is coordinated by the CORE CRM/PS, and final versions are distributed to all study sites. Final versions also are posted on the HPTN website.
- *Data communiqués*: These documents are developed and issued by the SDMC PM to clarify issues related to study data collection. Final versions are distributed to all study sites for filing in the SSP manual and are posted on the HPTN website. They are considered an official part of the SSP.
- *Reports*: Data reports on study progress, protocol adherence, data quality, etc., are developed and issued by the SDMC in accordance with the study reporting plan (see Section 12.4).
- *Study implementation questions*: Site questions about study implementation should be directed to the CORE CRM/PS and the SDMC PM. They will determine between them who is the most appropriate person to respond. They will also forward the query to another party for a response if deemed appropriate. In cases where the CORE CRM/PS and SDMC PM determine that the question and answer may be relevant or informative to staff from other study sites, they will forward the information to relevant site staff. They also may raise the issue for discussion during study-related conference calls and/or issue a more formal communication (e.g., SSP manual update, Clarification Memo, or Data Communiqué) if needed to properly address the issue.

All of the above-listed communications are issued with specific instructions for filing and further distribution as appropriate. Recipients are responsible for filing copies of documents as instructed and for communicating relevant information contained in the documents to all applicable study staff members, collaborators, etc.

## 12.5 Reporting

The HPTN has developed a standardized reporting and QC system for tracking study progress and site performance.

A study reporting plan is prepared by the SDMC PM in conjunction with the study statisticians and is reviewed by the protocol team prior to the start of the study. The reporting plan lists the types and frequencies of reports to be produced for a given protocol. The approved reporting plan is included in the study SSP manual. Reports that may be included are:

- Enrollment and retention reports
- Adherence reports
- Protocol Safety Review Team (PSRT) reports

- QC reports
- Clinical query reports
- Data management quality summary reports
- Laboratory performance reports
- SMC reports
- DSMB reports

### **12.5.1 Confidentiality of Study Data**

The discussion of study end points during an ongoing study should be limited to designated committees (e.g. SMC, DSMB) to avoid bias in study conduct and/or interpretation of data.

### **12.5.2 Accrual Reports**

To track accrual (i.e., recruitment, screening, and enrollment) in HPTN studies as closely as possible to “real time”, study site staff report relevant accrual information to the CORE CRM/PS throughout the study accrual period. The CORE CRM/PS will compile information received from each study site into a cross-site report and distribute the report to the protocol team.

Working with the Protocol Team Chair and SDMC, the CORE CRM/PS determines the relevant accrual information to be reported and the frequency for site reporting and report distribution. In addition to using the report to assess accrual performance at all sites, the CORE CRM/PS and SDMC PM will review the report to identify significant discrepancies between site- and SDMC-reported enrollment information, since such discrepancies may indicate data submission problems at the sites, data receipt or entry problems at the SDMC, or both. In general, SDMC-generated enrollment and retention reports will lag behind real-time accrual reports due to the time required to transmit and enter data into the study database.

### **12.5.3 Enrollment and Retention Reports**

During the protocol accrual period, the SDMC routinely generates protocol-specific enrollment reports showing projected and actual participant enrollments. The SDMC also generates protocol-specific retention reports on participant retention and loss to follow-up rates for each scheduled study visit. Details of these reports are included in the reporting plan included in the SSP manual.

### **12.5.4 Protocol Safety Review Team Reports**

For most biomedical clinical trials, a PSRT will be established (see Section 14.2.2). This team includes the responsible National Institutes of Health (NIH) Medical Officer(s), Protocol Chair(s), SDMC Clinical Affairs Safety Associate, the SDMC Protocol Statisticians, as needed, and others depending on protocol design and safety considerations. The CORE CRM/PS, SDMC PM, and additional SDMC clinical affairs staff may also facilitate and participate in PSRT reviews and other communications. The SDMC prepares reports for the team to review on a schedule determined by the protocol PSRT.

### **12.5.5 SDMC Clinical Query Reports**

In addition to the safety review provided by the PSRT, SDMC clinical safety staff review clinical data submitted on CRFs. Using the DataFax system, they attach a query to any data items that need verification or further clarification from the CRS site clinician. On a regular basis outlined in each protocol's SSP, the SDMC clinical staff generate a clinical query report that is sent to the site's clinical staff on a regular basis. Site clinical staff review these

reports and correct, verify, or clarify the items in question. These reports are considered to be of high priority.

#### 12.5.6 QC Reports

On a regular basis as determined by the internal SDMC protocol operations team, the SDMC Data Coordinator sends protocol-specific DataFax QC reports to CRSs. The reports identify data items submitted on CRFs that are inconsistent, missing, contain out-of-range values, and/or are illegible. CRS data management staff members review the reports, correct or clarify the CRF items in question, and re-transmit the CRF to the SDMC. If flagged items are correct as shown on the CRF, the staff member should verify with a brief note on the CRF next to the item in question and re-transmit the CRF. If the site has questions about any flagged items that show up repeatedly on QC reports, they should contact the Data Coordinator and SDMC PM for further explanation of the QC.

The CRS data management staff should respond to QC reports as soon as possible, generally within 7 to 10 working days of receipt. To ensure that the SDMC has adequate time to resolve QC notes, revised CRF pages should be re-transmitted by CRS data management staff no less than five days prior to the next scheduled QC report.

#### 12.5.7 Data Management Quality Summary Reports

The SDMC routinely generates reports on site-specific and protocol-specific data management performance. The reports include:

- Total number of CRF pages faxed during the report period
- Total number of items identified for QC
- QC rate (the number of QC items per 100 CRF pages)
- Percentage of QCs resolved
- Mean number of days from the visit date to the date the CRF page was received at the SDMC

If the SDMC PM or CORE CRM/PS is aware of any technical or site issues that have affected the information in this report (e.g., loss of Internet connectivity, electrical power loss to the site, or misunderstanding of documentation requirements), an explanation will be provided in the cover letter for the report. If there are concerns about a site's data management quality, the SDMC PM will work with the site to help develop strategies for improving performance.

#### 12.5.8 SMC Reports

The SMC reviews all protocols at a minimum of every six months (see Section 4.2.2 for reporting frequency). The CORE CRM/PS is responsible for identifying the date of each SMC review and for arranging SMC conference calls and documenting the SMC review. The SDMC prepares reports (blinded if necessary) for these reviews that include:

- Trial design
- Accrual
- Demographics and other baseline characteristics
- Summaries of expedited adverse event/ serious adverse event/ adverse event/ data or social impact reporting
- Protocol and intervention adherence
- Participant retention
- Laboratory performance, specimen storage and quality assurance (QA) testing
- Data quality and timeliness
- Endpoint summary

Additional information about study conduct, site-specific issues, and materials other than study data collected by the SDMC may be included as an addendum to the SDMC report. Such addenda are prepared only at the request of the SMC or SDMC, and are typically prepared by the CORE CRM/PS and/or other protocol team members.

After the SMC review, the CORE distributes a summary to the protocol team.

### **12.5.9 Data and Safety Monitoring Board Reports**

A DAIDS DSMB periodically reviews data reports from all Phase IIb/III HPTN trials and other selected studies. The primary responsibilities of the DSMB are to:

- Safeguard the interests of study participants
- Preserve the integrity and credibility of the trials in order that future participants will benefit from optimal prevention therapy
- Ensure that definitive and reliable results will be available in a timely way to the medical community

To do this, the multidisciplinary panel of DSMB members conduct comprehensive reviews to evaluate the:

- Study design and statistical analysis plan
- Accumulated efficacy data, typically according to formal interim analysis plan
- Integrity of the trial with regard to accrual, eligibility, compliance, and retention

Typically, a report is prepared by the SDMC for review by the DSMB. It is composed of an open report in which data are presented aggregated across treatment arms and a closed report containing data presented by treatment arm, blinded or unblinded. Topics covered in the report include:

Open report (data not reported by arm):

- Trial design and history
- Accrual
- Baseline characteristics
- Adherence
- Participant status and retention
- Serious and non-serious adverse events
- Data quality and timeliness
- SMC review summary

Closed report (data reported by arm — blinded or unblinded):

- Accrual
- Baseline characteristics
- Retention
- Adherence
- Participant status and termination
- Efficacy endpoints
- Safety endpoints
- Other secondary outcomes

After the DSMB review, a summary is distributed by the CORE to investigators for submission to the site IRBs/ECs, unless otherwise directed by DAIDS.

### **12.5.10 Modification of Study Recommended by DSMB**

When the DSMB recommends modification to a study, this information will be immediately communicated by the study Protocol Chair to HPTN leadership. This leadership team includes:

- Network PI/CO PI
- NL PI
- CORE Project Director
- SDMC PI
- Others as deemed necessary

Prior to NIAID's release of a press release or public statement, it is imperative that the DSMB findings remain confidential. In an effort to ensure study confidentiality, all study team members must sign a confidentiality agreement. (See Section 12.7 for link to Network Templates).

Recognizing that in some cases DSMB findings may require immediate action, communication of DSMB results with network constituents and study participants will be coordinated with the Protocol Chair, HPTN leadership and NIAID in a timely fashion. Advance communication planning and development of possible DSMB outcomes will expedite this process.

### 12.5.11 Reporting of Protocol Deviations

The HPTN has established a process for staff at HPTN study sites, the CORE, the NL and the SDMC to document the occurrence of protocol deviations and to report them to the sponsor (DAIDS), particularly those that might otherwise not be evident in the study data or reported otherwise. Reportable protocol deviations are defined by the HPTN as individual incidents, trends or omissions that result in:

- Significant added risk to the participant
- Non-adherence to significant protocol requirements
- Significant non-adherence to GCP

Examples of reportable protocol deviations are:

- Enrollment of an ineligible patient
- Informed consent not obtained prior to performing protocol-specified procedures
- Non-compliance with study randomization and blinding procedures
- Protocol-specified procedures not followed
- Breach of participant confidentiality
- A protocol-specified laboratory assay not being performed at all (a single missed assay would not be considered a reportable protocol deviation)
- A site-specific laboratory assay is deliberately added to protocol requirements by the investigator to be conducted for all participants

*Participant non-compliance with the study protocol, including treatment specifications, is not considered to be a reportable protocol deviation but should be discussed by the protocol team.*

All deviations that meet the above criteria will be reported using the HPTN Protocol Deviation Form (Appendix 3), which is available on the HPTN website or through the CORE. Study staff or other protocol team members will work jointly with the DAIDS staff to assess the deviation's severity. Protocol deviations that meet the above criteria that are identified by site staff or staff from CORE, SDMC and NL must be documented within 30 calendar days of awareness.

If more than one participant has the same deviation, the PTIDs for all of the affected participants should be listed on the form. If the deviation does not involve specific participant(s), the PTID item should be left blank. If the deviation occurred over a period of time, the date the deviation first started and when it ended or if it is ongoing at the time this report is completed should be indicated on the form.

A copy of all reports for each study, regardless of author, should be maintained at the site and the distribution list for the reports should include: the Protocol Chair, IoR, Site Study Coordinator, Site QA/QC Coordinator(s), CORE CRM/PS, SDMC PM, NL representative, Prevention Science Program (PSP)/ Office of Clinical Site Oversight (OCSO) representative for the site, the DAIDS Medical Officer for the study and, if the deviation involves an investigational product, the DAIDS Protocol Pharmacist.

The Clinical Site Monitor identifies protocol non-adherence events and violations in their monitoring reports, and some of these may also be reportable protocol deviations; however, there is not a one-to-one correlation between events reported by the Clinical Site Monitor and those to be reported through the HPTN protocol deviation reporting system. The Clinical Site Monitor may report protocol non-adherence events and violations that encompass every infraction of the protocol. For example, if a blood specimen is drawn for ALT, but is not processed by the laboratory, it is a non-adherence event according to the Clinical Site Monitor but this would not be a reportable protocol deviation. If, however, an ALT is to be drawn at each patient visit and is not being done at all, this would be a reportable protocol deviation.

## 12.6 Release of HPTN Study Data from the SDMC

Analysis of data related to the protocol objectives is the core responsibility of the SDMC. In order to ensure rapid, high quality analysis and dissemination of study results, the protocol statisticians at the SDMC conduct these analyses centrally. Premature distribution of the data has the potential to:

- Jeopardize the integrity of the trial
- Compromise the quality of study results that are disseminated
- Divert the resources of the SDMC from the preparation, dissemination and support of protocol analyses

This section describes how HPTN study data is released by the SDMC without compromising the interests of trial participants or the integrity and credibility of the trial.

### 12.6.1 Release of Data During the Conduct of a Study

Return of data to the sites by the SDMC is achieved by making files available to the site where the site's individual participant identified data are listed in a computer-readable format. In some cases, sites may directly access their own site CRF data using protected data return systems developed by the SDMC.

All data returned or accessed directly by a site will be limited to data submitted by that site to the SDMC. Site-specific data should only be shared with those responsible for monitoring the safety or conduct of the trial. Publication or presentation of site-specific data during the trial generally is not approved under the *HPTN Operating Policy 011: HPTN Publication Policy* and should not occur unless authorized by the PMG. It is the responsibility of the site Principal Investigator (PI) and the IoR to ensure that inappropriate dissemination or analysis of data does not occur.

#### 12.6.1.1 Early Safety Trials

In Phase I and Phase IIa trials in which the primary objective is to provide an early assessment of participant safety, most data submitted from a site can be made available to the site by the SDMC. The following data will not be made available to the site:

- Coding (e.g., by MedDRA) of AEs
- PTID identified data from Computer-Assisted Self-Interviews (ACASI or CASI)

- Laboratory data not submitted on a CRF (e.g., sent directly to the SDMC from the NL or other central laboratory)
- For blinded trials, the participant's random assignment

#### **12.6.1.2 Clinical Efficacy Trials**

In Phase IIb and III trials, the primary objective is typically to extend insights about safety and to assess effects on clinical efficacy endpoints or on surrogates relating to biologic or behavioral plausibility of an intervention. In such trials, most data collected from the participants prior to randomization can be made available to the site during the trial by the SDMC. In general, data collected post-randomization is not made available. The following data are almost never available:

- Data that constitute primary or secondary endpoints
- PTID identified data from Computer-Assisted Self-Interviews (ACASI or CASI)
- Coding (e.g., by MedDRA) of AEs
- Laboratory data sent directly to the SDMC from the NL or a central laboratory
- For blinded trials, the participant's random assignment

#### **12.6.1.3 Other Types of Studies**

In "non-comparative" cohort and natural history studies and studies with retrospective data collection (e.g., case-control), all data submitted to the SDMC can be made available to the sites during the conduct of the study with the exception of:

- Coding (e.g., by MedDRA) of AEs
- PTID identified data from Computer-Assisted Self-Interviews (ACASI or CASI)
- Laboratory data sent directly to the SDMC from the NL or a central laboratory

### **12.6.2 Release of Data after Completion of a Study**

#### **12.6.2.1 Final Release of Site-specific Data to Site Investigators After the Completion of the Study**

Site-specific study data can be released to the site investigators once the database is cleaned and locked and all intended manuscripts reporting primary results of the protocol objectives have been approved by the Manuscript Review Committee (MRC) for publication. The Protocol Chair will communicate to the SDMC and HPTN PI the protocol team's decision that the team has completed all intended publication of protocol objectives, and request that the site-specific data may be released to site investigators if requested. All manuscripts based on HPTN study data, with the exception of Public Use datasets (see Section 12.6.5), must be reviewed by the MRC (see *HPTN Operating Policy 011: HPTN Publication Policy*). The SDMC will not check or validate the accuracy of data summaries and analysis computations completed outside the SDMC.

#### **12.6.2.2 Final Release of Data to HPTN Investigators after the Completion of the Trial**

The complete study database can be released to all HPTN investigators once the manuscripts reporting the results of the protocol objectives have been approved by the MRC for publication. The Protocol Chair will communicate to the SDMC and HPTN PI the study team decision that the team has completed all intended publication of protocol objectives, and may request that the data be released to all Network investigators. Data may be released to HPTN investigators within one year of this decision, providing the SDMC has completed the procedures required to lock the dataset. The data must be locked prior to release. All manuscripts based on HPTN study data, with the exception of Public Use

datasets (see Section 12.6.5), must be reviewed by the MRC. The SDMC will not check or validate the accuracy of data summaries and analysis computations completed outside the SDMC.

### **12.6.3 Limited Release of Data to Non-HPTN Investigators**

For pre-specified purposes, e.g., ancillary studies involving data external to the HPTN, investigators may request approval for release of data to HPTN and non-HPTN entities (information on administrative approval of ancillary studies can be found in Section 17.2).

- Release of follow-up data prior to the final study visit and study unblinding (if applicable) requires approval of the Protocol Chair, the SDMC PI and the Scientific Committee Chair and would typically be approved only in extraordinary circumstances.
- Release of data after the final study visit but prior to database lock and completion of publications requires approval of the Protocol Chair(s) and the protocol statistician.
- Release of baseline data after completion of enrollment requires approval of the Protocol Chair(s) and the protocol statistician(s).
- The timeline for release of the data is negotiated with the SDMC and the protocol team, taking data cleaning, database lock and study analysis commitments into consideration.

### **12.6.4 Release of Data from a Study Conducted Under an IND**

The Clinical Trials Agreement (CTA) governs the release of data to the manufacturer. The guidelines in this policy will hold for IND studies unless otherwise specified by the CTA. Data cannot be released unless it is in agreement with the terms of the CTA.

### **12.6.5 Public Use Datasets**

Federal research sponsors often require that data be made available to the public in the form of "Public Use" datasets that have been prepared by the SDMC for wide scale dissemination. Data from HPTN studies may be released as a Public Use dataset after all analyses and publications of study results by the protocol team are considered complete by the protocol team and public release is approved by the Protocol Chair(s), the relevant Scientific Committee, the HPTN Executive Committee and NIH as the study sponsor. See *HPTN Operating Policy 011: HPTN Publication Policy* regarding publications based on an HPTN study Public Use data set.

### **12.6.6 Other Release of Data from HPTN Studies**

Requests for release of data not covered in *HPTN Operating Policy 011: HPTN Publication Policy* must be negotiated with the SDMC PI and the relevant Scientific Committee Chairs.

**12.7 Referenced Web Links**

DAIDS policy Requirements for Source Documentation in DAIDS Funded and/or Sponsored Clinical Trials	<a href="http://www.niaid.nih.gov/labsandresources/resources/daidsclinrsrch/documents/sourcedocpolicy.pdf">http://www.niaid.nih.gov/labsandresources/resources/daidsclinrsrch/documents/sourcedocpolicy.pdf</a>
DAIDS policy Requirements for Essential Documents at Clinical Research Sites Conducting DAIDS Funded and/or Sponsored Clinical Trials	<a href="http://www.niaid.nih.gov/labsandresources/resources/daidsclinrsrch/documents/essentialdocpolicy.pdf">http://www.niaid.nih.gov/labsandresources/resources/daidsclinrsrch/documents/essentialdocpolicy.pdf</a>
Confidentiality Agreement Link	<a href="http://www.hptn.org/network_information/network_templates.htm">http://www.hptn.org/network_information/network_templates.htm</a>