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Kelli Hammock: Hello, and welcome. I'm Kelli Hammock, senior Client Solutions Manager at L&E Research. And we are so happy you could join us today. Before we get started, I want to mention that we are recording today's webinar. And that will be made available via our on-demand page at leresearch.com. We will be taking questions and answering them at the end of our discussion. So please use the Q&A function on this platform, it's going to be down there in the menu, to post your questions. We will be collecting and posing these to our panel at the end of the discussion today. And if we can't get up to all the questions, we will enter those in email afterwards. If you would like to say hello, share where you're joining from, or share your LinkedIn, please use the chat function to do so. And remember, you can chat to only the presenters or to the presenters and attendees by making that selection in the chat window. Today we're going to be discussing healthcare research and the adaptations that were implemented when the world changed a few years ago. We've gathered a panel of experts that have extensive experience on this topic. So let's get started with meeting our guest speakers. Tell us a little bit about yourself. So Stephanie, you want to get started?

Stephanie Larsen: Sure. Hi, everyone. I'm Stephanie Larsen. I'm a managing human factors specialists at Emergo by UL. And at a high level, Emergo by UL helps medical device manufacturers, pharmaceutical companies, and the like to develop safer and easier-to-use medical technology. I've been in the business for about ten years now. And one of the main types of research that we conduct is what we call usability testing. So where we have people come in in-person and interact with the various products that were researching. So because of that, COVID was a big impact for us, and that's why I'm, what I'm here to talk about today.

Kelli Hammock: Thank you, Stephanie. And Amy, how about you? Tell us a little bit about yourself and what you do.

Amy Lin: Sure. Hi, everyone. My name is Imani. I'm a research associate at the Health Services Program at the American Institutes for Research. AIR is a not-for-profit organization that conducts behavioral and social science research and delivers technical assistance. AIR is based in DC and we have offices all throughout the country. But most of our workforce is largely remote still. And so today I'm Zooming in from my home office in Seattle. Within our health division, we have a number of research, evaluation, and technical assistance projects that work to advance care that is equitable, high quality, affordable, and patient-centered. Most of what I'll be sharing today is from our translation center project, where I'm the cognitive testing lead. What we do is essentially translate clinical research results into summarized abstracts easily understood by patients, caregivers, and stakeholders. Our ultimate goal is to publish these online so stakeholders can make informed healthcare decisions using up-to-date and accessible research. So I'll just pause there and hand it over to April.

April Leonard: My turn?

Kelli Hammock: Go ahead.

April Leonard: All right. So I am very excited to be here with you all today as well. My name is April Leonard, I am the director of medical operations for L&E Research. I oversee a team of 11 now medical market research professionals who are highly specialized and trained in supporting clients, such as Stephanie and Amy, in the recruitment, but not just their recruitment, also the consultative support of clients conducting qualitative market research within the healthcare scope. I've been working in the market research industry for nearly a decade. But I'm a registered nurse by trade. I spent 12 years as an acute care nurse prior to joining L&E. And it's just been a real blessing to be able to combine that clinical experience together with market research to help bridge barriers within clinical insights as they arise. So I look forward to talking a little bit more about that later.

Kelli Hammock: Awesome. Well, thank you, everyone. Let's go ahead and get started. So since some of our discussion today is around adaptation or research methodologies over the past few years, let's start by setting the stage. Hero at L&E, as was the case with many qualitative researchers, roughly 80% of our client's needs were in-person. We had experience hosting interviews virtually and we have built great relationships with a variety of technology partners, meaning we have solutions in place to give our clients choices on how they can effectively conduct their research. As very fortunate bonus, the majority of L&E staff are remotely based across the US and have been for over a decade.

So we already had a structure and metrics in place to keep our business moving forward. Our guests today have different experiences. So I'd like to start by hearing about that. Amy, let's start with you. Can you tell us a little bit about what you do at the American Institutes for Research, and what adaptations you had to make when stay-at-home orders halted in-person research?

Amy Lin: Sure. So we were very lucky, at least for this project that we had very minimal changes. So I'll dive a little bit deeper about what our cognitive testing looks like. So like I mentioned before, we work to translate clinical research results from studies funded by the patient-centered outcomes research institute, into plain language summaries written at about a six to eighth grade reading level. So we are actually in the seventh year of this project and have produced about 400 summaries to date. So contrasting in this context, is kind of an interview method, figuring out the thought processes and the reactions that people have as they read information. So we're looking to identify the readers' reactions and perceived usefulness of each summary, specific comprehension issues, and suggestions for improvement. Typically, Cog testing is done in one-on-one interviews, either in-person or virtually. But for our project, we conduct most of our Cog testing, asynchronously via email. So we have our own database of about, I'd say 160 clinicians, researchers, patient advocates, and patients. And we invite them to review our translated summaries. And then they provide feedback on clarity and comprehensiveness. We do also work with L&E to recruit a couple of patients with specific conditions for certain studies that compare two or more treatment options for specific health conditions. But all of these communication and review processes are, like I said, conducted over email. So we share the translation summary, and the reviewer form, which has a standard set of questions about the clarity, the content in each section, as well as some questions regarding specific issues that came up in the translation writing process. And then the panels complete peer-review forum in like two to three days, they email it back to us. And then we kind of synthesize their feedback. So this has been our process for, way before the pandemic, it continues to be our process. So our work, fortunately, transitioned with minimal difficulty.

Kelli Hammock: Awesome. Thank you, Amy. So it does sound like your experience was really similar to L&E's. And that you were already conducting your research remotely, and you just had to make minimal changes. Stephanie, you had a very different experience. Emergo by UL was conducting a lot of research in-person, as you said. So can you talk about that transition? What did those first few months look like?

Stephanie Larsen: Yeah. So the vast majority of our research is in-person, that's the best way for us to understand how someone's interaction with the product is, is to just see them in-person interacting with the product. So March 2020, when COVID really hit and people basically went into lockdown, we were kind of at a standstill. And I think everyone had the same experience of, OK, is this going to last a week, or a couple of weeks? Or is, that's kind of what we thought at the beginning. So it's like, OK, we'll just pause. And then when it seemed like, it was going to last for a long time, as it has been proven to, we had to think about how to make the show go on, basically. And we didn't want to just halt our research and halt our business. So we had to think about some different solutions. There were different types of remote research that we explored. And once travel bans were a little bit looser, some different ways where we could include some remote moderation, moderating from sort of the back observation room of L&E research and similar facilities. So I'll dive into the details a bit more later. But basically, it was incredibly disruptive. We had to think about, think creatively about different ways for us to proceed in conducting research.

Kelli Hammock: Thank you, Stephanie. So over the past year, so we, and I mean, those of us in the industry, not just specifically L&E, we've all questioned, when will in-person research return? The short answer is that it didn't really stop, it was just what I like to call fit for purpose. Simply put, some research must be conducted in-person. Device testing and sensory research are just a couple of examples. April, I briefly shared L&E's process, but can you talk a bit more about L&E's experience as it specifically relates to healthcare research?

April Leonard: Yeah, absolutely. So as Kelli mentioned, we saw the flip out of necessity that the industry as a whole experienced over the past three years. And I did pull some numbers, just out of curiosity, and also have some optimistic numbers to share already into 2023, specifically related to health care and medical market research subject matters. In 2019, we were about 25-26% remote research. And then that increased to 53%. As Stephanie mentioned, due to the, all the events in early 2020. So 2020, we sat around 53%, 2021 that increased even further to 62% online. And then in 2022, with the relaxing of local mandates and travel bans, we saw that dip back down to about 58%, which is still pretty high. But the good news so far, just one month into 2023, we're finally seeing, at least at L&E, that script flip. And we are trending about 52% in-person, 48% remote so far this year. So that said, I firmly believe, and we'll dive into this a bit more. But there's some research that we do not see fully reemerging, to answer your question Kelli on trends, just from lockdown. Clients were forced to adapt and to keep that forward momentum going. And in doing so, figure out oftentimes at a

pretty hefty cost to their bottom line. So definitely something we're continuing to monitor, in order to best be able to support the needs of our clients based on the trajectory of the research moving forward. But I am optimistic that more in-person is reemerging. And the numbers are proving that way so far this year.

Kelli Hammock: Thank you, April. I like those numbers. It's very optimistic. So I appreciate you sharing that. And thank you, Stephanie and Amy, for sharing as well. This is really great foundational information for this discussion. So moving on, Amy, AIR had to make minimal changes due to existing remote research process that was already in place. Did you find that the participants recruited for the research had to make any adaptations? And if so what did you do to increase their accessibility?

Amy Lin: Sure. So our email review process is fairly accessible, especially for our own panelists who have been reviewing for multiple years now with us. And so we made very minimal changes to the process for our internally recruited participants. However, like I mentioned, we do recruit with you guys. And so sometimes, those participants don't necessarily have access to computer, and we don't want that to be a barrier to participating in our studies. And so we have always offered a phone interview. And then with the pandemic and stay-at-home, we didn't bring our office phones with us. And so the only change that I think we kind of included was just using an online or desktop version of the phone just to make external calls. I think the platform we use is RingCentral. But I'm sure there's others.

Kelli Hammock: Thank you. And then, Stephanie, healthcare device testing is literally hands-on. So obviously, the shift away from in-person testing was a challenge. How much of a variable is the device being tested when it comes to designing the research?

Stephanie Larsen: Yes. So it was at a high level safer to conduct remote research. But in some cases, that just wasn't feasible or not possible. So in our industry, earlier stage research, when the product is more in development is more exploratory and there's less, there's fewer rules surrounding that, as opposed to when you're trying to do research when you feel the product is sort of complete, and we're conducting what's called a validation test, so validating the design. So if a company was earlier in development with their products that made it more feasible to do remote research, because the data collection methods could be slightly less rigorous, shall we say. The other consideration in terms of the device type is sort of the size and feasibility of being able to ship it to people, that's something that we did, especially with home-use products, like a prefilled

syringe or an inhaler. Those types of things are relatively easy to ship to participants that are recruited for a study and then conduct the study like this through a computer. Versus some of the larger products to work with, or products that are more expensive, where it's not possible for a company to just ship a product that costs $10,000, $20,000 through the mail.

Kelli Hammock: Thank you. And so April, we had to make some chips of our own to continue to provide that high level of support our clients were accustomed to receiving. So can you share a bit about some of the strategies and alternatives that were implemented to keep our clients researching?

April Leonard: Yes, absolutely. Lots of shifting lots of innovation. So we had numerous large scale and also some are simplified, but just simply not previously necessary innovations that were born quickly in 2020. So the first, Stephanie has touched on is remote moderation. I think that this is the big gun. We often found ourselves in the predicament of being able to fully recruit a study for in-person research. Respondents were willing to come into our office, they were willing to comply with the PPE requirements, and the testing or vaccine requirements. However, the clients were on travel bans. And the travel bans, they went on for a while, so they could not themselves get to us and especially impacting our international clients. So we came up with a plan to mobilize smaller groups of training team members in each of our markets, with facilities to essentially be our clients' hands. While they were then able to join remotely and be the voice, eyes, and ears of the research. That was usually successful and allowed us to continue to kind of push research there even kind of the most daunting of situations. From there, we developed a virtual facility, L&E's researchers' virtual facility. This facility was staffed by expert-level technical support, who are available to assist clients who have successfully converted their study to remote methodologies but did not themselves have the manpower or knowledge, or even let's frankly, the desire to run the technical aspects of the study. So from the pre-study tech checks to the technical hosting, any session-related technical troubleshooting, AB needs, so on and so forth, the known Achilles heels to remote research. We were able to take that on for our clients and really take that work off their plate in order to allow them to fully focus on data collection, and not the tech involved to get there. And that is something that will be ongoing into eternity is this facility offering. Because we've found that even clients who were previously remote have really benefited from having this taken off of them. Another avenue we deploy, that Stephanie also touched on and also the pain points of it, we've promoted and well-supported the Home-Use testing. Now HUT's been around since the dawn of market research. But we were kind of coming at this particular approach

specifically to the transfer of work that was once viewed solely as in-person. So shipping a syringe to a physician's desk, shipping a smaller device to a therapist's office, shipping a label or whatever to a patient's home. This was very successful. However, it did have its own challenges. Of course, we cannot ship certain levels of machinery. And also, if anybody recalls, on the Postal Service or all matters of mailing also went a little sideways, and was quite unpredictable, especially in the latter 2020 and early 21 months. However, with lengthened lead time and proper expectation sets, we were pretty successful with this approach out of necessity during those early years. So that was something else we were able to kind of use to our advantage. And then lastly, I wanted to touch on the paperwork. I will have to say this was probably the most unexpected and arduous impact to us, working mostly in the project management world. During the first few months, that kind of just like hit us in the face. In medical market research, as we all know, there is an ICF, an ETP, a Sunshine Act reporting agreement, and NDA for everything. And appropriately so, but then not to then touch on proof of prescriptions, proof of diagnosis, position verification forms, and contributing documentation on top of it. So when research suddenly jumped from 26% to 62% online, so it had all the accompanying signatures and paperwork needed from recruits. So with the volume of respondents we recruit and speak to, manual back and forth for scanning and what signature's not an option. One-by-one e-signature request, not an option, not realistic. So we had to come up with a way to mass execute the receipt of 1000s and 1000s of documents, and then routing those quickly and efficiently to the correct projects and sponsoring clients. So we did it, it was daunting, it was a process, and now it's full steam ahead. But establishing that process was critical to the success of efficiently executing the influx of remote work research. Anybody on here who works in project management, or in this type of role will agree that the paperwork is something that is not often talked about, but was a huge, huge daunting task for anybody doing this type of research during those years.

Kelli Hammock: Thank you April. I didn't even think about the paperwork process and how much of an add that was. I mean, just designing the research itself is an undertaking, and then all the little nuances, it's fabulous. So Stephanie -

April Leonard: I'll just say one more thing, Kelli, on that, sorry.

Kelli Hammock: Yeah, please.

April Leonard: Even in-person research because we were trying to be as contactless as possible, we were still tasked with trying to get everything signed

ahead of time. So don't forget that, yeah, 62% we were online, but that other percentage. I'm not doing quick math in my head right now. But the other percentage, we were still having to get the paperwork done ahead of time. So it was a lot.

Stephanie Larsen: April, did you say that in some cases you were not able to do digital signatures or did I misunderstand that?

April Leonard: There are some clients that do require wet signatures, so- and just trying to come around with a solution to that, with the mailing situations as they were, but just even coming up with a way to mass execute. Because doing the one-on-ones, recruiting a respondent for thousands and thousands, just wasn't going to be feasible or just a one-on-one e-signature request also is not realistic. So, figuring out how to mass get signatures and documentations, it was quite the process.

Stephanie Larsen: I bet. We have relatively minimal paperwork it sounds like, compared to some of the types of paperwork that you mentioned. But, from an L&E client perspective, it was very easy for us to share our informed consent forms, and then magically people would sign it ahead of time, so that was very convenient for us.

April Leonard: Well, that's the goal, so I'm glad that that was the interpretation.

Kelli Hammock: Thank you. And Stephanie, so I believe you have hands-on experience with the remote moderation that you and April had talked about, and not just in an L&E facility, but elsewhere. So, can you tell us about your experience?

Stephanie Larsen: So, I've touched on some of these styles of research already, as is April, but I see three main types of remote research. So, one was shipping to people's homes, which was in some cases, as I've already discussed, not possible for logistical reasons, for sometimes legal reasons of not wanting the product out in the environment. And it did pose its own challenge, when you have someone come to an L&E facility, there's a certain level of sort of control you have over the environment. And so, we were having to adapt to learning how to sort of set the stage, make sure that people were planning a quiet time and a dedicated space and didn't have distractions. And so, thinking through, sort of a new environment for people to be interacting with us. But of course, the benefit with shipping to people's homes is that the research can more easily happen, especially when the travel bans were in place. Another thing we did was, when

research in a particular location- for example, Raleigh's a hot-spot with you guys. If you guys said we could get enough people to Raleigh, but our moderator couldn't travel to Raleigh, there were times where the participants would come in and L&E would manage people coming in and getting set up, and kind of setting up the room, and the setup and then the moderator would be calling in to conduct the research. So again, big benefit in that you can conduct research even if travel restrictions were in place. But, still some challenges with not having, again, quite the same level of control you do if you're in the room with someone. And then, the last sort of style that we developed, which has continued on the most frequently I would say is- I don't know if you'd fully call it remote, but we adapted to running the sessions rather than sitting at a table with someone in the main research room. We were behind the one-way glass in the observation room, and this allowed us to be on-site to set up the room to configure things how they should be, and adapt if needed, but still have that separation of the one-way mirror. So, in the days of the social or physical distancing, it just took that out of the equation, we weren't even in the same room as people. So, that was- as far as visibility and adaptation, that was sort of the easiest. But, we definitely had to work to get our proper AV set up and our good angles, and all of that kind of thing, because we're just- we're so used to interacting with people face-to-face.

Kelli Hammock: On those remote, behind the glass, were you conducting- so you would be moderating from behind the glass, were you using like a video conferencing software to communicate with the person in the room?

Stephanie Larsen: Yeah. We'd use- we did it a bunch of different ways. We used video conferencing software, so they could see our faces even though we were just behind the glass, doing something like this, even if we're 10 feet apart, just so you could see that there's a real person. At times we would leave the lights on in the back room so they could sort of see through the glass, so that was an option. We would put- some other things we did were, put pictures of our unmasked faces on the desk in there with them, just because it felt so impersonal, bringing someone in and they might be nervous about what's going to happen, then it's like everyone's mask. In the beginning it was face shields and glove, it was just so intense as we all experienced, so we tried to do whatever we could to make it feel more personal and familiar.

Kelli Hammock: Thank you. And so, the amount of innovation we've seen within our industry over the last few years has been impressive to put it lightly. Stephanie just provided a few examples of how we can use and adapt technology solutions to solve a problem, which is actually a really great segue into my next question. So, are there any technologies that you use for virtual

research that were game changing? And Stephanie, I'll just go ahead, since we were just kind of talking about tech, go ahead and sling it back to you first.

Stephanie Larsen: One thing that was a big challenge for us, for the remote research, was how to be able to see what we needed to see, when talking through a webcam like this, for example. If we're wanting to see someone interact with a pre-filled syringe, which is an example I gave before, you're not holding it up in the air and injecting it like this. We use simulated skin and someone has it, for example on their abdomen or their thigh, so we had to think about ways to get the views that we wanted. In some cases, in earlier stage research, we could cut- have people kind of position the webcam, which is not incredibly innovative, but just was OK for that sort of research. But, for certain types of research where it was later stage, or there was just a desire to collect really meticulous data, we did something similar to the service it sounds like April was describing with the AV sort of setup crew. There were some services that we used where it was basically a full sort of AV setup in a box that they could mail to people, and it had a variety of cameras, and a laptop, and someone could sort of turn on the laptop and I believe the- a service would join and help someone to configure the setup. So, that was really useful if you were needing to get a variety of different angles. And also, the- in lieu of someone else doing that tech setup, we were signing on early to help people and make sure everything was working well, so that's definitely a challenge. The other thing we did in one case was, there was a product that a company was unable to distribute to people due to legal reasons, legal restrictions, and so in addition to research, our company has a design team as well, and the design team created a digital representation of the product that someone could interact with. So, I will say the interactions for this weren't incredibly intense, it was more looking at the packaging and unboxing, and getting those sorts of interpretations. But, because of that sort of innovation, we didn't have to ship anything, people could just sign in and we'd do a screen share and people could interact with the product that way. And, we were able to get really great feedback, because people were able to look at and do some basic interactions with the product without actually needing to send it to them.

Kelli Hammock: That's awesome. And, it sounds like there were some really good technologies out there that you- that sort of supported this. But, what I took from that is that in-person research would've been so much easier to manage, because just the AV set up and multiple cameras and making sure you're getting the angles, it's a huge undertaking. So, we've been talking about when will in-person research return, when is it coming back? And again, this just proves some research is suitable for that, and some would be better remote. And these examples you just shared, let's get it back to in-person

because that sounds like a pain in the rear end. So Amy, I'm going to go ahead and send the same question your way. Were there any technologies that proved to be game changing?

Amy Lin: I'll just start and say that luckily I didn't have to deal with any of the AV testing tuff for our products. I'll say that the only technology that comes to mind is that our project was designed knowing from the get-go that our staff were at different locations working across different time zones, and so what's really integral is our SharePoint site, which is our document management system. And, it just kind of spits out workflows and task lists and timelines, and so people can see their to-do lists and everything, and it just keeps all of our projects super organized and really makes people aware of everything. So, I think that was super critical as we transitioned to fully remote. That's- I would say it is probably the sole reason why we transitioned with no difficulty, but that's not necessarily game changing, so.

Kelli Hammock: It is. I think it is because April really talked about the paperwork aspect, and considering the work you do is almost- it is all paperwork. I am expecting an internal technology that can really help you organize and structure that, to me that would be game changing. And that would be something that can be applied to you and your organization, or any organization, because we all know there's going to be lots and lots of paperwork to handle, and it needs to be set up in a way that makes sense.

Amy Lin: Well, if you guys would like to know, I can speak a little bit more about it. It just- I think the key features is that we have folder systems, and everything's organized and nestled in. I think the- my favorite feature is that when I log on to our project site, I have a personalized homepage with all of my to-do lists outlined right there in front of me. And then, we also have automatic-automated task list, so when I mark off one of my tasks, my colleague is automatically notified via email that they can begin work, and so it's just makes everything work smoothly.

Kelli Hammock: Thank you for the elaboration, because our discussion isn't only about how do you adapt research, but it's how do you adapt those internal processes to make us all more successful on the research side. It doesn't have to be one direction or the other, it can definitely be shared. So then- so now, we've discussed how research methodology selection had to pivot and what strategies both remote and in person have proven successful. So now, let's talk about recruiting participants. At L&E, we know our panel, and we know what we're capable of accomplishing. Our gauge on providing

accurate and reliable feasibility, prior to project commencement, is expert level, but the world changed and everyone had to adapt. We could no longer rely on what we knew. So April, I'm going to give you a very loaded question here. How was recruitment during the pandemic? Did you encounter any unexpected challenges in healthcare recruitment? I can't even imagine, you must have had trouble securing healthcare professionals for research, either remote or in person, due to the demands of a health- of healthcare providers during a global pandemic. Scheduling must have been a doozy, please tell me about that.

April Leonard: So, I'm actually going to probably surprise you with what I'm about to say. I found, and I have to say my team would probably agree, that the most challenging aspect in determining feasibility and working with clients on the front end to get projects in the door, often boiled down to being a myth buster per se. And, clearing up a lot of misinformation regarding what the temperature truly was within the healthcare field versus the sensationalized perceived climate among specifically healthcare providers during the pandemic, that was a challenge. We're fortunate at L&E to have medical professionals on the team, to kind of have an insider look as to what is going on in boots on the ground in our local markets specifically. So, we spoke to countless clients who were feeling quite defeated and overwhelmed over those years, over the needs of potentially halt their research requiring any and all healthcare providers during the height of the pandemic, but this was simply unnecessary. It's important to remember that a very small percentage of physicians and advanced care providers actually work in acute care settings. So, speaking of physicians, DOs, MDs PAs, NPS therapists, unless you were testing emergency cardiology, pulmonology, anesthesiology or the hospitalist intensivist service lines, the pandemic actually couldn't have been a better time to conduct your research, as the majority of preventative and elective care medicine slowed, some to a full halt. I can tell you that if you wanted to talk to a plastic surgeon, there was no better time to talk to a plastic surgeon than 2020 to 2021. Many providers seeing patients in clinic, experience downtime between patients because their schedules were spanned due to keep social distancing and clean waiting areas. Tele-medicine was birthed, to the hilt and provided-providers with at-home work environments, many for the first time ever in front of computers in their home with gaps in their days typically. So, there was no greater time to easily catch and schedule these providers than in those couple years. I would also like to plug that if you are a team, supporting research, plagued by 'fear', and I put fear in quotes, and I'm sure the majority of those listening understand why fear market value. There's no greater time to conduct that research than in the throes of a global pandemic, as providers schedules were often clear, making them more

likely to accept a lower than standard honorarium because they were not blocking off clinic hours to participate. Oftentimes their clinic hours were already blocked off for other reasons, so just something to keep in mind in the future. Now, there is a flip side to this, in talking about the difficulties. And there were several provider types, who we did need to use more care in engaging with and ultimately advocated for them during this time, and those were primarily our nurses, who the opposite holds true for. The majority of nurses are employed in an acute care field, and during the pandemic it did not matter your specialty. It didn't matter if you were cardiology nurse, a Med Surg nurse, an OB nurse, you were in high demand. So others, such as first responders, respiratory therapists, or perfusionists, and the big one that's forgotten is the phlebotomist, and the lab tech, that's who's staffing all of these drive-in Covid screening sites. Those were recruitable, but we had to just handle them with a little bit more care, advocate for a more flexible schedule, increase the incentive because they're tired, just to make their time more worth their while. But, that is pertaining to the true frontline workers during those years, and I will say our share rates were great, they remained high, 97 to 98 percent. It was a great time for market research to engage healthcare workers, and sometimes we really tried to stay- and something we really tried to stay on top of, in educating our clients and the methodology solutions, to continue that forward progress of their studies, given the availability of the providers was there. And then, healthcare provider side, switching gears to our patient and caregivers. Of course, there were- we were in a position to really advocate for and protect those in an at-risk population. So, even if they were open and willing to participate, we would still kind of raise a flag, and talk to our clients to come up with manners in which they- we could make the research happen, but in a safe manner. So, our facility team members were absolutely fantastic in ensuring that every patient and caregiver was attended to, met where they were at, made you feel comfortable and confident in our aseptic practices to keep them and their loved ones safe. That said, there were particular populations that we would not chance it on, so our COPD-ers, our neutropenics, our CF patients, our immunocompromised patients, cancer patients, and our elderly folks. We would work around those and either find a way to perform that study remote, or don't forget your proxies. Don't forget your surrogates. There are a lot of conditions out there that are hot, but that there are really suitable patient populations who are not at risk, who have the same pathophysiologies, have the same symptomatologies, who are much more available, and less at risk for contracting a potentially contagious disease if fraught insights. So, that was something we, we always advocate for with these rare patients, to protect them in general. But in the height of Covid, that was really something we took forward and progressed onward, and we really found that that made a big difference, and able to top off quotas as needed to to move

market research forward. But all in all, we really just took each end study as it came and worked to make it make sense for the times, for the target audience, for the market mandates at the time. Because there were moments where all of our markets, they had something different going on. This has mask, this has social distancing, this one's completely locked down after this amount. So, we really had to kind of keep up with that and just work day in and day out, on a case-by-case basis. One other aspect I did want to touch on, our health assessments, contact precautions and screenings in present day. So, now that local mandates are lifted, we really allow our clients to drive, what we're going to do on site based on their comfort level, their company's policies or experiences or personal preferences, and we use those as a guide to how we would like to go about hosting and conducting the onsite. So that said, I did feel it might be helpful for anyone to ensure as to, "Hey, what is everybody else doing right now?", as we're emerging to make everybody aware of what we're seeing on probably 93, 95% percent of our in-person research proceedings as of today. So, regarding health assessments, and what I'm referring to are the verbal Covid screenings that accompany the initial qualifying screening, those are going by the wayside. For close to three years now, we've seen on every screener- we get a screener and there's Covid screening at the time of screening, but the reason this is going by the wayside is that the majority of recruitment for healthcare occurs with enough lead time to make the disclosure of exposure and symptoms essentially irrelevant on the day of research. If this is something that is a policy for your team, your sponsoring client teams, we really recommend there's no real reason to screen for that on the front end. Let's do a 24-to-48-hour call prior to their study date, that's when this matters, that's when exposure matters, that's where symptoms matter. Screening for that two to three weeks in advance, just lengthens the screening time, and ultimately is typically irrelevant. Regarding vaccine status and screening and COVID testing on sites or proof of vaccines, these are rarely screened for and are required by the majority of our clients at this point. We did see a spike in these practices within the first year with a vaccine being widely circulated and testing being widely available, but this is now very rarely requested. However, this is always dependent on the patient population, the client's team comfort level, and their internal policies. And all of that should be taken into consideration and respected, and we do execute on a project-by-project basis. Lastly, I wanted to discuss something a little bit of a different pace, and that is panel integrity and a final enhanced innovation per se incorporated throughout the pandemic by L&E, which was the process of digitally vetting your respondents. It is very important, and L&E takes a really- a great deal of pride in never losing sight of the work our research supports. Healthcare providers and the patients who contribute to these discussions and these conversations are shaping the future of medicine worldwide. That data is only as

valuable as the quality of the respondent providing it, so we have a no-compromise digital vetting system in place to validate all recruited HCPs. That they are who they say they are, and their licenses are active, in good standing, and not- we don't care that we talked to you six months ago, nine months ago, 12 months ago, we're still going to go and we're going to do our behind-the-scenes work to make sure that nothing has happened since then and you are who you say you are, and that nothing has happened with your license since we last spoke to you. And then for our patients, we have manners in which to quickly verify their diagnosis, what they say they are diagnosed with, and if applicable, are prescribed what they say they have been prescribed. And the reason I'm bringing this up is that there is a direct correlation between participant fraud attempts and directly with economic unrest. So in the pandemic times, and arguably the times we are in now, we have noted an uptick in these attempts. And to be clear, they're just that, they're attempts. But it's really important that if you're partnering with a client or you are a vendor and you yourself are doing your own recruitment, that you really do have these processes in place to catch them on the front end, just to make sure that your data remains pure and that you are talking to who you think you're talking to because ultimately, this is important work that we're all doing. And I just wanted to plug that as a little extra note on this, that it is something that we've seen over the past couple of years. It is an increase in fraudulent or attempting to be fraudulent participants. And that if you don't know your process, if you don't have a process or you're not sure what the process of your partnering vendor supplying recruitment for you is, to definitely dig into that, just to make sure that you're getting what you need.

Kelli Hammock: Thank you, April. That was really, really good information. And we've talked about panel frauds so much over the past couple of years, it's always been in the industry in the background. But to your point, I like the point you made about it increasing during economic hardships. Because when people are having trouble making ends meet, then they might be a little less honest. So I fully agree that these processes are so critical to not just the research that L&E assists with, but research in general. It's an industry-wide conversation. So, Amy, what was your experience? L&E does support some of your patient recruitment, as you mentioned earlier, but you have your own panel of experts on the clinician and researcher side. April elaborated on our experience with our panel, but did you find recruitment to be a challenge with any of the audiences you internally recruited?

Amy Lin: I'll just echo April's earlier comments. Really not too many challenges, unless we were focusing on topics like emergency department use or just trying to get some of those acute care clinicians. And I'll just also say that we've worked

with our panelists for multiple years now and we initially recruited them from our staff network and snowball recruitment, having them recommend colleagues. And so we do have a very engaged panel database, a database of panelists who are willing to participate. And we've worked on developing that relationship over the years, so they also know that if they have something going on in their lives, they can always ask for an extension and we will just be flexible on our end. And so we have about two weeks to synthesize reviewer feedback, so we just eat into our own time, just give them as much time as they need to complete the reviewer form and we'll just accommodate their needs.

Kelli Hammock: That flexibility is critical, and I think we've all learned. I think our fun words for today are flexibility and adaptation because they've been so important. If you're not able to keep on your toes, then research is going to continue without you. So it really is important that you've made those adjustments and allow that flexibility, even if it came at a cost of you having to rush some work at the very end of it. So then, now thinking of the recruits that are sourced from another party such as your friends of L&E, were there any audiences that you needed to speak with that were in high demand, but low supply from recruiting providers? And this could be professionals or patient populations. I know April touched on some of those. Amy or Stephanie, did either of you have this experience? And before I pass the mic, are there any potential challenging audiences that are still a challenge, or has that now passed? And I'm going to let one of you jump in, either- whoever feels comfortable.

Stephanie Larsen: April, I think what you said made a lot of sense of who was most busy early COVID versus not quite so busy. I had the experience of working on a ventilator project and also a monitor defibrillator project, the monitor defibrillator being used by EMTs and paramedics pre-hospital. And so we were able to recruit people, but especially for the first responders, we were seeing really high cancellation rates because people were getting pulled into overtime shifts. They were just really last minute being asked to come in for another shift, so we ended up recruiting slightly more than we usually would have or needing to last minute replace people. I wouldn't say that it really held up the research, but it was just- obviously, you want those types of people to be helping real people in the real world and coming to us when they're available. So on the clinician side, that was a little bit of a challenge. We did some studies that would involve patients with respiratory illnesses. And some of the more acute ones especially, people obviously didn't want to put themselves at risk by going to, especially early on, any sort of public place. So in some cases, we used some proxies as you had discussed, April. In other cases, the research just was not able

to proceed as planned. So I don't- I think April and the L&E team, you probably have a better sense for if those types of folks are still having hesitations and how productive that sort of research can be right now based on people's comfort. But I know as a researcher, we'd never want to put someone in an uncomfortable position. And also as you had touched on, even if they feel comfortable it's like, do we feel comfortable actually bringing these people in? So I see that as, potentially, a continued recruiting challenge.

Amy Lin: I'll just share I don't think anything really comes to mind for our method of testing. We've been able to recruit most of our clinicians and patients related to certain topics. I will say that I've seen an uptick in research studies funded by [INAUDIBLE] that focus on mental health services and telehealth services as a result of COVID. But I wouldn't say we've had difficulties recruiting for those topics.

Kelli Hammock: Before we start wrapping up, we're going to tie this all up in a bow with what have we learned? So, Amy, I'm going to start with you. Most of your work was conducted remotely prior to stay-at-home orders, so what have you learned? Is there anything that you or your organization have implemented?

Amy Lin: Like you mentioned earlier, just being flexible and adaptive. Internally, we review our processes to see how they can be improved. So, we ensure all of our internal training documents and resources are up to date. We also ensure our staff are cross trained across different activities. And so the team that I manage, they have their specific tasks, but then they've also received training for the other roles. For example, our memo writers who analyze the panelists' feedback are also able to step in and fill in for our recruitment manager who coordinates the product testing and communicates with the panelists. And all this allows for the project to continue to run smoothly and accommodate any staff absences. And then externally, we always ask our panelists for feedback to hear directly from them on what could be improved. So in every review or form, there's an opportunity for folks to give us feedback. And also at the end of the year, we send a thank you email, but we also ask them to complete a survey just to collect more feedback and just anything else they want to share. In summary, just trying to be proactive and improve before being forced to change.

Kelli Hammock: That's really good advice. And I think the bigger conversation we as an industry should be having is, what do we need to be doing to treat our panelists better and to make their experience more robust? Just giving them the opportunity to provide that feedback, I think, is really valuable. And

I like that you're adapting your processes and learning as you go. Stephanie, I'm going to flip the same question to you. We know a lot changed for you and your organization, so what have you learned?

Stephanie Larsen: I think the major thing is that, on a positive note, it was heartening to feel like we could all come together and adapt and conduct research in difficult times. I was reflecting on how things were really early, like the summer of 2020 when things were still in a really heightened state, and thinking about all of the different ways that we adapted with cleaning protocols and various PPE and distancing, just so much went into that. So I think collectively, just to reflect, it felt good to feel like we were able to adapt. As far as what we take with us in having to adapt and investigate some of these other remote research opportunities, I think because we've proven that they can be effective, in certain situations, we could perhaps be more open to those sorts of opportunities. For example, if there's like budgetary restrictions, if there's a difficult patient population to recruit. So instead of bouncing around to five cities, for example, could we conduct this remotely? And we've just had the opportunity, basically, to work through the different methodologies, to feel confident that that will be effective. So I think that's the big one. There are some more rare cases, but some cases where the devices that we're researching, someone is accustomed to using that device for an extended period on their own and we need to do really careful observations. So in some cases, observing from the back room has been helpful. The vast majority, not, but that was an interesting insight of if there's a trained professional used to- in our case, we work on some reprocessing or intensive cleaning of endoscopes, someone's just used to spending three hours working with the equipment on their own. If we can be not really in their face and be in the back room, that helps the realism of the situation.

Kelli Hammock: April, I'm going to sling it over to you. What are you hearing when it comes to new requests and conversations you're having with healthcare researchers?

April Leonard: I think we are seeing a divided group. We have, I would say, probably a 30/70. So we've got probably the 30%, we're seeing clients leaning more into their online platform capabilities, kind of like what Stephanie described as they figured it out. They figured it out, they developed out of necessity over the past few years. A lot of times, they did cost a lot of money that these clients were not expecting to pay. And so they're leaning into the advantages of this and not having to pay for travel and having to pay to put people up in hotels and do all of that. So they're further enhancing those

experiences because they work for them. But I would say that that is the smaller of the group. I would say probably 70%, we're seeing clients running as quickly as possible to get back into facilities and back to business as usual. I would say that is definitely the governing trend, which is really encouraging. Remote moderation was great, and home usage is great. All of those things are great, and I feel very blessed that we all have that in our back pocket now and are very well versed in it, so god forbid we ever find ourselves in these types of situations further on in our career, we have them. But nothing will ever replace clients in the facility doing the work, and I think that that's the message. And it's encouraging, in my opinion, that the art of market research remains alive and that the roots in talking to the recruits are well rooted in communication and just that interaction remains. And that yearning for that interaction, that one-on-one, hasn't been able to be replaced, so I think that that's great for all of us.

Kelli Hammock: Thank you. We're running close on time. There's not much in the Q&A, so if you do have a question, go ahead and drop that in here and we'll answer before we wrap up. But before we do that, I would like to thank you all for sharing your insights and experiences with us today. We're going to take some questions if they come in, but first, I'd like to take a brief moment to thank Focus Forward, our transcription partner who so graciously volunteered to transcribe this webinar for free. Focus Forward is just one of our tech partners that we've partnered with to bring complete qualitative and quantitative solutions to our clients. We will be emailing out a link to the recording of this webinar, or you can download a copy of the transcript. All of which can be found at our website at www.leresearch.com/resources. That'll be up in a few days to a week. And you can also learn more about our partners such as Focus Forward and a host of other solutions we offer at our website as well, all aimed to help you execute your research with one phone call or email. So let's see, any questions? Yes, we have a question in here. So I would love to know of the participants on this call, how many have gone back to in-person at all? So I guess we'll- yes, Stephanie definitely has. Amy, have you? I don't think you've done any in-person back yet, right?

Amy Lin: No.

Kelli Hammock: I'm sorry, I think the questioner might have meant the audience on the call. And to that, I can't speak, so if you guys want to chime in on the chat, please feel free. But go ahead, Stephanie. I'm sorry, I didn't mean to cut you off.

Stephanie Larsen: We've been in person for quite a long time, though in-person could mean in that back room. I'd say- COVID feels like a blur, doesn't it? But maybe at least a year that we've been in the same room with people. But that could mean masking, obviously, keeping a distance. At times, we had barriers. So I'd say in the past six months maybe, things have felt more truly normal of like being at a table with someone more closely and not having a lot of precautions in place besides, as April was describing, like the screening that we're doing in advance. I see another related question, which is, what types of safety measures or procedures have been put in the in-person testing room? We had a real lot, let me see if I can remember them. A lot of PPE in the beginning. We had masks and face shields. We had plastic barriers. We were keeping our distance. In the beginning, societally, we weren't sure if COVID transmitted via touch. So for a long time, the assumption was that it could, and so we were wearing gloves, we were very intensively wiping every surface down, wiping down the chairs, wiping down everything, documenting our cleaning protocols, assessing. We had air purifiers plentifully, which are hard, hard to ship and travel with, but we did. Also, an internal procedure to assess just the general safety level of conducting the research if it was appropriate. I think we all remember that times were changing very quickly also, as April discussed also in different places, like how do we make the right decision? So we had quite a lot and it does feel good. I was looking back to some pictures of how we had this set up early days and I was like, wow, we actually have come a long way here, so that felt good.

April Leonard: I don't think we'll ever- oh, sorry, Kelli.

Kelli Hammock: Oh, I was just going to chime in. On the L&E side, which may have been where April was about to go, we had Plexiglas dividers, we had electrostatic air sprayers. We even put hands-free door things on all the doors so you could use your foot to open them and you didn't have to touch anything. We converted our incentive processes to paperless. All of our processes actually got- most of them got to no touch.

Stephanie Larsen: Right.

Kelli Hammock: April, sorry, did you want to -?

April Leonard: I was just going to say none of us will ever look at Plexiglas the same again today, the outfitting of the facilities and such.

Kelli Hammock: Awesome. Well, I really hate to let this panel go, but we promised an hour so we're not going to keep anybody over that. We could probably keep talking for another hour, but thank you so much, Amy, Stephanie, and April. And thank you, everyone out there in our audience that joined today. Remember, we're going to email you links to the content and you can find it on our website. But thank you everyone for joining us today and we look forward to seeing you again soon, hopefully in person. Have a great day.

Stephanie Larsen: Thank you.