Cut >25 in 2025: Strategic Guidance for Industry Partners

Data-Driven Playbook for Reducing Clinical Site Training Burden

SCRS
Society for Clinical Research Sites

TABLE OF CONTENTS

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Data-Driven Playbook for Reducing Clinical Site Training Burden

The clinical research industry must fundamentally reframe how we approach site training. Training exists to ensure sites are competent with the protocol—able to execute study procedures safely, accurately, and in compliance with regulatory requirements. Training does not exist to index the mechanics of software navigation, demonstrate basic computer literacy, or create documentation trails disconnected from actual competency.

Current State: Training has devolved into a compliance exercise focused on hours completed, modules checked off, and certificates filed—regardless of whether learning occurred or capability improved.

Future State: Training becomes a competency verification system focused on one question: "Can this site team safely and accurately execute this protocol?" Everything else is waste.

The Shift Required:

- From **time-based** to **competency-based**: Measure capability, not hours
- From **content coverage** to **performance enablement**: Focus on what sites need to DO, not what we need to SAY
- From **universal remedial instruction** to **gap-targeted learning**: Assume professional baseline competency; address actual gaps
- From **compliance theater** to **genuine capability building**: Verify sites can perform, not that they sat through content

Core Principle: No one cares that someone scored 10/10 on an eLearning* quiz. What matters: Can they execute the protocol correctly when a patient is in front of them?

Training is a means, not an end. The goal is competent execution of protocol requirements. Training is merely one pathway to achieve that goal.

Ask yourself:

- If someone has executed 50 EDC trainings, do they need to watch "how to click Save" again?
- If someone demonstrates they can correctly perform a protocol procedure, does it matter if they watched the video?
- If someone fails a competency assessment, does completing another module fix the actual gap?
- Are you training to build capability or to create documentation?

The fundamental question for every training requirement: "What protocol execution risk does this training mitigate, and is there a more efficient way to verify competency?" If you cannot articulate the specific protocol execution risk, the training is likely unnecessary overhead.

How to Use This Playbook

This document is organized by strategic impact – from highest to lowest potential for achieving the 25% reduction target. Each recommendation includes:

- **Data foundation**: Survey findings
- **Strategic guidance**: What to address and why
- **Implementation considerations**: Questions to guide your approach
- **Success indicators**: Measurable outcomes utilized internally and measured to determine internal change to training requirements.

Mid-2026 Re-Survey: SCRS will re-survey using identical metrics. Organizations are expected to:

1. Demonstrate measurable training burden reductions
2. Share specific strategies that drove success
3. Document lessons learned for industry benefit

TIER 1: Highest Impact Opportunities

1. Implement EDC Training Reciprocity and Standardization

Data Foundation:

- 67% identified EDC as the #1 source of redundancy
- 64% of sites require separate EDC training for each study
- Only 11% always and 13% often accept previously completed EDC training

Strategic Guidance:

EDC training represents the single largest opportunity for burden reduction. Study-agnostic platform training (navigation, data entry mechanics, query resolution workflows) differs fundamentally from study-specific training (protocol-driven CRF completion, study-unique procedures, specific data collection requirements).

Implementation Considerations:

For Sponsors:

- Which EDC training elements are truly study-specific vs. platform-standard?
- Can you create tiered training: platform certification (study-agnostic, transferable) + study supplement (protocol-specific)?
- Within your organization, will you accept your own EDC platform training across studies?

- What documentation standards would enable you to accept external platform certifications?

For CROs:

- Can you develop cross-sponsor EDC training modules for platforms you commonly use?
- How might you create training databases that track platform certifications across studies?
- What advocacy role can you play with sponsors around standardization?

For Technology Vendors:

- Can you provide platform certification programs and/or certificates that transfer across implementations?
- How can you enable sponsors/CROs to easily customize study-specific layers atop standard training?
- What documentation/badging systems would facilitate reciprocity acceptance? Log-in history and usage?

Success Indicators:

- Reduction in platform-level EDC training hours per staff member per study
- Increase in acceptance rates of previously completed EDC platform training
- Decrease in sites reporting EDC as primary redundancy source
- Growth in cross-study platform certification programs

2. Ensure Content Appropriateness and Respect for Site Expertise

Data Foundation:

- Role-based training declined from 61% to 52%, meaning more staff receive generic content regardless of experience level
- Only 18% collect formal feedback on training effectiveness, limiting ability to identify inappropriate content
- 40% collect no feedback at all on whether training meets learner needs
- Competency-based assessment adoption remains minimal despite potential to eliminate unnecessary content
- 62% still use PDF/slide decks despite these ranking low in site value
- Training hour patterns remain stable at 2-10 hours per person per study with limited innovation in approaches

Strategic Guidance:

Training content must respect the expertise and intelligence of the clinical research workforce. Requiring experienced professionals to watch extended videos on basic computer skills (how to use dropdown menus, click buttons, enter text in forms) is insulting, contributes to burnout, and signals that organizations view sites as compliance checkboxes rather than skilled partners.

Training often assumes zero computer literacy and zero prior experience, even for staff who have completed dozens or hundreds of studies. This creates several negative outcomes: disrespect for professional expertise, disengagement when content is beneath skill level (causing learners to miss the small percentage that IS important), time waste on basic skills multiplied across multiple systems, and contribution to professional burnout.

Critical Distinction: Differentiate between system-specific functionality that genuinely requires training ("This study uses this unique EDC workflow for SAE reporting"), basic computer literacy that any professional possesses ("Here's how to use a dropdown menu"), and prior demonstrated competency that doesn't need re-proving ("You've used this EDC platform on 12 studies").

Implementation Considerations:

For All Partners:

Content Appropriateness:

- Review your training content: What percentage assumes zero computer literacy?
- What content treats experienced professionals like novices?
- Where are you training basic internet/computer skills that any professional already possesses?
- What training could be eliminated entirely for experienced users without quality/compliance risk?

Experience-Based Pathways:

- Can experienced staff test out of basic content via competency assessment?
- Can you create "new to clinical research" vs. "experienced" training pathways?
- How might you enable staff to skip content they can demonstrate they already know?
- Can you assume baseline professional competency and focus training on what's genuinely new?

Leverage Technology:

- Can adaptive learning platforms deliver content based on demonstrated knowledge?
- Can you use brief assessments to route experienced users past basic content?
- How might intelligent systems identify when someone clearly already knows the material?

Respect for Intelligence:

- Does your training language/tone treat learners as intelligent professionals?
- Are you explaining the "why" and "what matters" vs. basic mechanics?
- Have you removed condescending step-by-step instructions for universal skills?
- Does training focus on judgment, decision-making, and complex scenarios vs. basic navigation?

Feedback Mechanisms:

- Are you asking sites: "Was this training appropriate for your experience level?"
- Do you capture: "What content was unnecessary or insulting?"
- Can staff flag content as "too basic" to inform improvements?

- Are you measuring engagement/satisfaction, not just completion?

Success Indicators:

- Increase in experience-based training pathways
- Growth in competency-based assessment adoption
- Reduction in basic computer literacy content in professional training
- Improved site feedback on training respect/appropriateness
- Decreased training time for experienced staff without compromising competency
- Increased training engagement scores
- Reduction in "I already know this" feedback
- Higher completion rates due to relevant, appropriately-leveled content

3. Establish Training Reciprocity Frameworks

Data Foundation:

- Only 25% of partners regularly accept previously completed training
- 42% rarely/never accept reciprocal training
- When asked about accepting training from other organizations: 47% sometimes, 22% rarely, 10% never
- 60% of sites provide training evidence to multiple departments

Strategic Guidance:

Training reciprocity means establishing clear criteria for when completed training meets your requirements, regardless of which study it supported. This does not mean accepting inadequate training.

Implementation Considerations:

For Sponsors:

- What are your actual requirements for training adequacy? (completion, comprehension assessment, recency, documentation format, trial historic experience)
- Can you establish reciprocity standards within your organization first (across your own studies)?
- What systems/processes need to change to accept external training documentation?
- Who owns the decision about training acceptance, and how can you streamline this?

For CROs:

- How might you create training databases that track certifications across clients/studies?
- Can you standardize how you document training completion to facilitate sponsor acceptance?
- What governance structures enable reciprocity decisions without compromising quality?

For All Partners:

- What training categories have the lowest risk for reciprocity (platform training, standard procedures, common technologies)?
- How can you pilot reciprocity approaches before full-scale implementation?
- What feedback loops with sites will help refine your reciprocity criteria?

Success Indicators:

- Increase in percentage of partners accepting previously completed training
- Reduction in duplicate training requirements for common systems/platforms
- Decrease in sites providing training evidence to multiple departments
- Growth in cross-study, cross-sponsor training acceptance

4. Reduce IRT/RTSM Training Redundancy

Data Foundation:

- 31% identified IRT/RTSM as a top redundancy source
- 48% require separate IRT/RTSM training for each study
- Only 43% of those accepting reciprocal training do so for IRT/RTSM

Strategic Guidance:

IRT/RTSM systems follow similar operational patterns across studies: randomization workflows, kit assignment, temperature excursion reporting, return/destruction processes. While study parameters differ (randomization schema, kit types, specific study drugs), the system interaction mechanics remain largely consistent.

Implementation Considerations:

For Sponsors:

- Can you distinguish between platform functionality training and study-specific parameter training?
- If using the same IRT/RTSM vendor across studies, will you accept platform training transfer?
- What study-specific elements require supplemental training vs. complete retraining?

For CROs:

- How can you leverage relationships with IRT/RTSM vendors to create transferable training?
- Can you develop cross-sponsor training for commonly used IRT/RTSM platforms?

For Technology Vendors:

- Can you provide platform certification that sponsors/CROs will accept across implementations?
- How can your training design separate universal system functions from study-specific configurations?
- Can historical usage information be utilized to provide experience metrics?

Success Indicators:

- Reduction in full IRT/RTSM retraining requirements for experienced users
- Increase in platform + supplement training models
- Growth in vendor-provided certifications accepted across studies

5. Streamline Training Documentation and Evidence Requirements

Data Foundation:

- 60% of sites asked to provide training evidence to multiple departments/individuals
- This increased from 56% (July) to 59% (August), suggesting intensifying requirements
- 96% of sites are asked to provide evidence at least sometimes

Strategic Guidance:
Standardized, centralized documentation could deliver immediate burden relief without requiring changes to training content itself. When multiple departments request the same training evidence, or when documentation formats are incompatible across systems, sites spend valuable time on non-value-added administrative work.

Implementation Considerations:
For Sponsors:

- Do multiple departments within your organization request training documentation independently?
- Can you establish a single source of truth for training documentation that all departments access?
- What documentation format/content standards would meet all internal stakeholders' needs?
- How can you align documentation requests across studies/teams?

For CROs:

- Can you serve as the training documentation hub that provides to sponsors as needed?
- What documentation standards would satisfy multiple clients?
- How can you reduce duplicate requests to sites?

For All Partners:

- Can you accept standard documentation formats rather than requiring custom formats?
- What training evidence is truly necessary vs. historically requested?
- How can technology enable centralized, accessible documentation?

Success Indicators:

- Reduction in sites providing evidence to multiple departments
- Decrease in time sites spend on documentation administration
- Increase in standardized documentation formats across partners
- Growth in centralized documentation systems

6. Address eCOA/ePRO and Safety System Training Redundancy

Data Foundation:

- 31% identified eCOA/ePRO as top redundancy source
- 38% identified Safety/AE reporting systems as top redundancy source
- 53% require separate eCOA/ePRO training per study
- 54% require separate Safety/AE system training per study

Strategic Guidance:
Both areas have heightened quality/compliance focus that may create conservative training approaches. The key is differentiating between platform mechanics (how to navigate, enter data, resolve queries) and study requirements (what to collect, when to report, study-specific thresholds).

Implementation Considerations:
For Sponsors:

- When using the same eCOA/ePRO platform across studies, what training truly differs?
- For safety systems, which elements are universal workflows vs. study-specific requirements?
- Can you create platform certifications that transfer, with study-specific supplements?
- How can you leverage technology vendor training programs?
- How can an environment for testing and mock usage be implemented?

For CROs:

- Can you develop standardized training for commonly used platforms across sponsors?
- How might you create cross-study training for safety reporting workflows?

For Technology Vendors:

- Can you provide platform certifications that clearly separate from study-specific training?
- How can your training design support the platform + supplement model?

Success Indicators:

- Reduction in eCOA/ePRO and Safety/AE system redundancy rankings
- Increase in platform-level certifications accepted across studies
- Growth in vendor-provided, sponsor-accepted training programs
- Ability to practice and perform mock visits

TIER 2: Significant Impact Opportunities

1. Optimize Training Delivery Modalities

Data Foundation:

Most Used Formats (by training providers):

- eLearning modules: 81%
- In-person investigator meetings: 65%
- PDF/slide decks: 62%

Most Valuable Formats (per sites):

- eLearning: 64%
- In-person meetings: 60%
- Self-training: 32%

Most Valuable Formats (per providers' perception of site value):

- In-person meetings: 69%
- eLearning: 50%

Strategic Guidance:

PDF/slide review ranks low in value but remains heavily used (62%). Match content type to delivery method: procedural knowledge suits eLearning; complex problem-solving and relationship-building suit in-person formats.

Implementation Considerations:

For All Partners:

- What content are you delivering via PDF/slides that could be more effective as interactive eLearning, easier to retrieve, on demand resources or workflow embedded resources?
- What are you covering in investigator meetings that could be pre-learning via other modalities?
- How can you use in-person time for questions, practice, and relationship-building rather than information transmission?
- Can you adopt micro-learning approaches for small, focused content chunks?
- How might competency-based assessments replace time-based training requirements?
- Can elements of importance be indexed so it is easily referenced in the future?
- Can systems be re-accessed to find training completions in the future?
- Can commonly asked questions be periodically transformed into formal job aids or resources

Success Indicators:

- Shift in modality distribution toward high-value formats
- Reduction in passive delivery methods (PDF review, slide decks)
- Increased site satisfaction with training delivery
- Decreased total training hours while demonstrating high quality conduct and protocol compliance.

2. Implement Study-Agnostic Training Approaches

Data Foundation:

- 53% of providers report offering study-agnostic training (platform training that transfers) always or often
- Yet only 25% of partners regularly accept previously completed training (indicating a disconnect)
- 15% of providers always offer study-agnostic training, 38% often

Strategic Guidance:

The data reveals a critical gap: providers believe they offer study-agnostic training more frequently than acceptance rates suggest. This indicates potential issues with clarity (what constitutes "study-agnostic"), documentation (packaging/format that enables acceptance), trust (whether external training meets standards), and systems (mechanisms to verify and accept).

Implementation Considerations:

For Sponsors:

- Can you clearly define and communicate what training you consider study-agnostic? E.g. common procedures like PE, Vitals, Aes, ConMed, etc
- How can you document study-agnostic training separately from study-specific training?
- What governance would enable you to accept external study-agnostic training?
- Within your organization, will you accept your own study-agnostic training across protocols?

For CROs:

- How can you create truly transferable study-agnostic training modules?
- Can you maintain training records that clearly distinguish study-agnostic certifications?
- What standards/frameworks would enable sponsors to accept your study-agnostic training?

For Technology Vendors:

- Can you build training reciprocity into your platform onboarding?
- How can you provide platform certifications that clearly separate from study implementations?

Success Indicators:

- Increased alignment between study-agnostic training offering and acceptance rates
- Growth in cross-study platform certifications
- Reduction in redundant platform training for experienced users
- Clearer documentation distinguishing study-agnostic from study-specific training

3. Coordinate Cross-Departmental Training Requirements

Data Foundation:

- 31% report different business areas/departments request trainings from sites (yes)

- 27% report this happens sometimes
- Combined: 58% experience at least occasional cross-departmental training requests
- This contributes to the 60% of sites providing evidence to multiple departments

Strategic Guidance:
When different departments within sponsor or CRO organizations independently request training, several inefficiencies emerge: duplicate requests for similar/identical training, conflicting requirements across departments, administrative burden of managing multiple relationships, and poor visibility into total training burden being collectively created.

Implementation Considerations:
For Sponsors:
- What departments independently request training from sites? (Clinical Operations, Medical Affairs, Pharmacovigilance, Quality, etc.)
- Can you establish a centralized training coordination function?
- How can you create visibility into total training burden across departments?
- What governance structure would enable coordinated training requirements?
- Can you establish "one request, multiple uses" documentation approaches?

For CROs:
- Can you serve as the training coordinator between sponsors and sites?
- How can you reduce duplicate sponsor department requests flowing to sites?
- What role can you play in consolidating training requirements? Streamlining this process.

Success Indicators:
- Reduction in sites reporting multiple department training requests
- Decrease in duplicate training evidence requests
- Growth in centralized training coordination functions
- Improved internal visibility into total site training burden

4. Develop Role-Based Training Approaches

Data Foundation:
- 61% of providers tailor training by role (July data)
- This decreased to 52% in August—a 9 percentage point drop
- Yet role-based training aligns with adult learning principles and reduces irrelevant content

Strategic Guidance:
The decline in role-based training customization suggests organizations may be prioritizing administrative simplicity over training effectiveness. When coordinators receive PI-level content or vice versa, time is wasted on non-applicable material. The challenge is balancing customization

(which improves relevance and reduces time) against complexity (which increases administrative burden).

Implementation Considerations:
For All Partners:

- What training content is truly role-specific vs. universal? Based on delegation of authority
- Can you design modular training where roles select applicable components?
- How can technology enable easy role-based customization without administrative burden?
- What core content should all roles receive, with role-specific supplements?
- Can competency-based approaches help ensure each role achieves necessary proficiency without unnecessary content?

Success Indicators:

- Reversal of the declining trend in role-based training
- Increase in modular training designs
- Reduction in site feedback about irrelevant training content
- Maintenance or improvement of comprehension while reducing total time

TIER 3: Foundational Opportunities

1. Establish Feedback and Continuous Improvement Systems

Data Foundation:

- Only 18% collect formal feedback on training
- 42% collect informal feedback only
- 40% collect no feedback at all
- Sites report rarely being asked for feedback (31% rarely, 8% never = 39% rarely/never)

Strategic Guidance:
Without systematic feedback, training optimization becomes guesswork. Organizations cannot identify what's working, what's redundant, or what's missing. Establishing feedback mechanisms creates the foundation for data-driven training improvement.

Implementation Considerations:
For All Partners:

- What would make feedback collection valuable rather than burdensome?
- How can you close the feedback loop—showing sites how their input drove changes?
- What questions would generate actionable improvement insights?
- Can you implement lightweight, frequent feedback rather than heavy, infrequent surveys?
- How can you share feedback across teams to drive organizational learning?

- What metrics beyond completion rates should you track?

Success Indicators:

- Increase in formal feedback collection processes
- Growth in sites reporting being asked for feedback
- Evidence of training changes driven by site feedback
- Establishment of continuous improvement cycles

2. Leverage Technology for Training Innovation

Data Foundation:

- Training hour patterns remain remarkably stable: 72% report 2-10 hours per person per study
- 85% of training is delivered via on-demand modules, investigator meetings, or virtual/in-person sessions
- Current modalities represent established approaches with limited innovation

Strategic Guidance:

The stability in training patterns suggests limited adoption of innovative delivery methods. Alternative approaches include: micro-learning, competency-based assessments, just-in-time training, and integrated workflow training. These can fundamentally change the training paradigm from "complete before beginning" to "learn what you need, when you need it, with verification of competency." (or: "complete high-level essentials before beginning with verification, then offer a variety of guidance models and resources to execute within the workflow.")

Implementation Considerations:

For All Partners:

Micro-learning:

- Can you break training into small, focused modules/resources consumed on-demand or embedded into workflows?
- How can you enable "learn/remind today, apply today" approaches?

Competency-based assessments:

- Can you verify capability rather than time spent?
- How might you allow experienced staff to test out of content they already know?

Just-in-time training:

- Can training be available at the moment of need rather than weeks in advance?
- How can you embed training into workflows needed just for that visit/task happening at 11am on Wed?

Integrated workflow training:

- Can system prompts guide users through new processes as they work?
- How might you provide contextual help rather than separate training?

- Can training be implemented in a way that is consistent and valuable vs redundant or overkill?

Success Indicators:

- Reduction in pre-study training requirements
- Growth in alternative training modality adoption
- Increase in competency-based verification approaches
- Sites reporting training "when needed" rather than "just in case"
- Maintenance or improvement of performance with reduced formal training time

3. Address Training for New Technology Implementation

Data Foundation:

- 52% report technology implementation is neither easy nor difficult
- 26% report it's difficult or very difficult (combined)
- 60% report mid-study system changes require moderate effort (1-3 hours)
- 26% report significant effort (3-6 hours)
- 7% report major impact (>6 hours)

Strategic Guidance:

New technology adoption creates training burden spikes. When systems change mid-study or new technologies are introduced, sites must learn new workflows while maintaining ongoing study operations. Change management complexity adds to pure learning requirements, mid-study changes compete with operational priorities, and sites may be simultaneously learning multiple new systems.

Implementation Considerations:

For Sponsors:

- How can you minimize mid-study technology changes?
- When changes are necessary, how can you support smooth transitions?
- Can you provide parallel systems during transition periods?
- What advanced notice enables sites to prepare for changes?
- Can super-users be employed to provide direct lines of support?

For CROs:

- How can you advocate for technology stability during study conduct?
- What support can you provide during technology transitions?
- Can you create change management resources that reduce site burden?
- Can vendors be chosen that may be slightly higher cost, but overall provide efficiency in the training process?

For Technology Vendors:

- How can you design for easier adoption and intuitive use?

- Can you provide migration support when sites transition to your systems?
- How can you minimize retraining when updating platforms?
- Can you provide side-by-side comparison training for users transitioning from other systems?

Success Indicators:

- Reduction in mid-study technology changes
- Decrease in training hours required for new technology adoption
- Improved site feedback on implementation ease
- Growth in change management support resources

4. Standardize Lab, Biospecimen, and Shipment Portal Training

Data Foundation:

- 30% identify lab/biospecimen/shipment portals as top redundancy source
- 52% require separate training for these systems per study
- Only 23% of those accepting reciprocal training do so for these portals

Strategic Guidance:

Lab, biospecimen, and shipment portals often involve third-party vendors with their own training requirements. The opportunity lies in separating portal mechanics from study-specific requirements and potentially consolidating vendor relationships.

Implementation Considerations:

For Sponsors:

- When using the same lab/shipment vendor across studies, can portal training transfer?
- Can you work with vendors to create platform certifications?
- How can you separate portal navigation training from study-specific handling requirements?
- Can vendor consolidation reduce training proliferation?

For CROs:

- Can you leverage preferred vendor relationships to establish standard training?
- How can you coordinate across sponsors using the same vendors?

For Lab/Logistics Vendors:

- Can you provide platform certifications that sponsors accept across studies?
- How can you design training to separate portal mechanics from study requirements?

Success Indicators:

- Reduction in lab/biospecimen/shipment portal redundancy rankings
- Increase in reciprocity acceptance for portal training
- Growth in vendor-provided, sponsor-accepted certifications

5. Optimize Questionnaire/eSurvey Training

Data Foundation:

- 15% identify questionnaires/eSurveys as top redundancy source
- Lower than other categories, suggesting this is less problematic currently

Strategic Guidance:

While questionnaire/eSurvey training shows lower redundancy currently, the increasing use of patient-reported outcomes and electronic surveys suggests this may grow as a burden area. The opportunity is distinguishing between platform training (how to administer/support eSurveys), instrument training (specific questionnaire requirements, scoring, validation), and study-specific training (when/how to administer in protocol context).

Implementation Considerations:

For All Partners:

- Can platform training (eSurvey system mechanics) transfer across studies?
- For standardized instruments (common PRO measures), can instrument training transfer?
- What training is truly study-specific vs. reusable?
- How can you leverage vendor training for platform components?
- Is there opportunity to gain hands-on experience with the technology for patients prior to data entry?

Success Indicators:

- Maintenance of low redundancy levels as eSurvey use increases
- Growth in transferable platform training
- Separation of platform, instrument, and study-specific training

Implementation Framework

Baseline Assessment

Before developing your action plan, assess your current state:

1. **Measurement**
    - What is your current average training time per site staff member per study?
    - What percentage of your training content is redundant across studies/systems?
    - How often do you currently accept previously completed training?
    - How many departments independently request training from sites?
2. **Stakeholder Mapping**
    - Who within your organization needs to commit to change?
    - What departments/functions must coordinate around training?
    - How will you communicate changes to sites?
3. **Capability Assessment**

- What technology/systems enable training optimization?
- What process changes are required?
- What governance structures need establishment?

Developing Your Action Plan

1. **Select Priority Opportunities** (3-5 from across tiers)
   - Focus on highest impact aligned with your capabilities
   - Balance quick wins with foundational changes
   - Consider interdependencies between opportunities
2. **Define Specific Objectives**
   - What measurable outcome are you targeting?
   - How will you know you've achieved the 25% reduction?
   - What intermediate milestones indicate progress?
3. **Identify Required Changes**
   - What processes need redesign?
   - What systems/technology need implementation or modification?
   - What governance/coordination needs establishment?
4. **Establish Accountability**
   - Who owns each initiative?
   - What resources are allocated?
   - How will progress be tracked?
5. **Plan for Learning**
   - How will you pilot approaches before scaling?
   - What feedback mechanisms inform refinement?
   - How will you share lessons learned?

Measuring Success for Mid-2026 Survey

Prepare now to demonstrate:

1. **Quantitative Improvement**
   - Reduction in training hours per person per study
   - Increase in training reciprocity acceptance rates
   - Decrease in redundant training requirements
   - Reduction in sites providing evidence to multiple departments
2. **Qualitative Change**
   - Specific strategies you implemented
   - Barriers you overcame and how
   - Lessons learned through implementation
   - Recommendations for industry based on your experience

3. **Continued Commitment**
    - How you'll sustain and build on initial improvements
    - Additional opportunities you've identified

Documentation Best Practice: Track your starting baseline now across relevant metrics, document changes you implement, and measure ongoing impact.

APPENDIX
Complete Data Reference

Training Burden

- **2-5 hours:** 50% (startup), 54% (post-initiation)
- **6-10 hours:** 28% (startup), 13% (post-initiation)
- **Total 2-10 hour range:** 72% of training at startup
- **11-20 hours:** 7% (startup), 3% (post-initiation)
- **>20 hours:** 1% (startup), 1% (post-initiation)

Redundancy Levels

- **26-50% redundancy:** 43% of respondents
- **11-25% redundancy:** 26% of respondents
- **51-75% redundancy:** 18% of respondents
- **0-10% redundancy:** 9% of respondents
- **>75% redundancy:** 5% of respondents

Top Redundancy Sources

1. **EDC:** 67%
2. **Safety/AE reporting:** 38%
3. **IRT/RTSM:** 31%
4. **eCOA/ePRO:** 31%
5. **Lab/biospecimen/shipment portals:** 30%
6. **Protocol-specific procedures:** 30%
7. **Dermatology:** 24%
8. **Imaging platforms:** 21%
9. **Questionnaires/eSurveys:** 15%

Training Reciprocity Acceptance

- **Always accept:** 11%
- **Often accept:** 13%
- **Sometimes accept:** 33%
- **Rarely accept:** 31%
- **Never accept:** 10%

Study-Agnostic Training Provision

- **Always offer:** 15%
- **Often offer:** 38%
- **Sometimes offer:** 29%
- **Rarely offer:** 15%
- **Never offer:** 3%

Training Modalities - Provider Use

- **eLearning modules:** 81%
- **In-person investigator meetings:** 65%
- **PDF/slide decks:** 62%
- **Self-training:** 53%
- **Live webinars:** 31%
- **Train-the-trainer:** 31%
- **Video-on-demand:** 26%
- **Peer-facilitated internal training:** 13%

Training Modalities - Site Value Rankings

- **eLearning:** 64%
- **In-person meetings:** 60%
- **Self-training:** 32%
- **Live webinars:** 23%
- **On-demand video:** 20%
- **Train-the-trainer:** 17%
- **Peer-led sessions:** 12%

Training Modalities - Provider Perception of Site Value

- **In-person meetings:** 69%
- **eLearning:** 50%
- **Self-training:** 34%

- **Live webinars:** 24%
- **Peer-led sessions:** 19%
- **On-demand video:** 16%
- **Train-the-trainer:** 12%

Documentation Burden

- **Sites asked for evidence (at least sometimes):** 96%
- **Asked by multiple departments:** 60%
- **Increase from July to August:** 56% → 59%

Feedback Collection

- **Formal process:** 18%
- **Informal feedback only:** 42%
- **No feedback collection:** 40%

Sites Asked for Feedback

- **Always:** 9%
- **Often:** 22%
- **Sometimes:** 30%
- **Rarely:** 31%
- **Never:** 8%

Cross-Departmental Training Requests

- **Yes:** 31%
- **Sometimes:** 27%
- **No:** 42%

Role-Based Training

- **Yes:** 61% (July) → 52% (August)
- **Sometimes:** 31% (August)
- **No:** 7% (August)

Technology Implementation Difficulty

- **Very easy:** 4%
- **Easy:** 18%
- **Neither easy nor difficult:** 52%
- **Difficult:** 23%
- **Very difficult:** 4%

Mid-Study Technology Change Training Burden

- **No additional effort:** 1%
- **Minor effort (<1 hour):** 7%
- **Moderate effort (1-3 hours):** 60%
- **Significant effort (3-6 hours):** 25%
- **Major impact (>6 hours):** 7%

Geographic Distribution - Sites

- **North America:** 58%
- **Asia-Pacific:** 21%
- **Europe:** 15%
- **Latin America:** 3%
- **Middle East/Africa:** 3%

Geographic Distribution - Sponsors/CROs

- **Asia-Pacific:** 56%
- **Europe:** 42%
- **North America:** 16%
- **Latin America:** 8%
- **Middle East/Africa:** 4%

Respondent Types

- **Clinical research sites:** 63%
- **Sponsors:** 26%
- **CROs:** 8%
- **Technology/service providers:** 4%

Sample Size

- **Total responses:** 262 (July baseline)
- **Response growth:** 89% increase from initial to final collection