

eCast Raleigh, N.C.

## An interview with Peter Bechtel, president and chief executive officer

### Tell me about eCast's background.

I came up with the concept for eCast in July 1999, which basically involved joining large networks of physicians, such as IPAs [independent physician associations] and PHOs [physician-hospital organizations], together over a worldwide platform both for clinical integration and clinical research. In addition, I wanted the system to generate large numbers of clinical investigators and research subjects for pharmaceutical industry-sponsored clinical research. In 1999, I knew I had a long road. I couldn't present the final solution until all the building blocks were built.

The first block I built was the clinical data repository (CDR). The CDR had to be a central, searchable database with de-identified, HIPAA-compliant data. Then I extended it to build an EMR [electronic medical records] platform, called eCast EMR, which is an inexpensive web-based platform that is accessible by doctors, regardless of their specialty. I was aware at that time that the penetration of EMR systems was less than 5%, so it was a huge market that was really getting ready to grow.

I also wanted to include products that had not been thought of. One of those was a system that could take certain lab values and history values from health risk assessment and put them into a format that would enable doctors to predict their patients' risk for certain chronic diseases. Those data would also feed into the CDR and would be

used for research. The other building blocks were clinical protocols, which would give doctors the ability to have the computer system alert them for health preventive regimens, such as a mammogram or PSA test that are required for their patients. I also added a practice management system because many billing systems were becoming outdated and the doctors would want a completely integrated platform.

Finally, we created a powerful, web-based reporting tool that would allow doctors to query data from their own patients' EMRs and allow researchers and our internal staff and IPA directors to query all patients' de-identified data from the CDR. The EMR platform is the draw for both physicians and sponsor companies. We built the EMR platform, version 1, in less than a year. We started generating revenue for the rest of the products from the sales of the EMR. I had not raised any money at that point because I didn't want to raise any until the whole suite of building blocks was completed and I could go out to the private markets with a complete business plan. We finished everything in 2005 and then we got our first IPA contract with 870 doctors. At that point I finished the business plan and had our first IPA to go to the investors with. Last year we raised \$12 million, and we are growing. We now have more than 45 IPA/PHO contracts, which represent 14,100 doctors. I also have data from more than 2.5 million

**Year founded:** 1999

**Employees:** 65

**CRCs:** regional full-time eCast employees  
**EMRs in central data repository:**  
2.5 million

**IPA/PHO contracts:** 45

**Doctors in network:** 14,100

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patients and it's growing every day. We're also getting data imports from claim feeds such as Aetna and Blue Cross/Blue Shield and pharmacy benefit management feeds. Right now, we've completed all our products, and our EMR will be CCHIT-certified this month.

### What differentiates eCast from other technology companies?

Most IPAs are looking for a better solution for their patients specifically focused around EMR. We bring them that solution and also allow them to participate in clinical research. We create an EMR database specifically for a certain IPA's exclusive use. We start enrolling the doctors in the EMR process and begin training them on the EMR. The data that are gathered then get sifted off to the CDR, which is a central searchable de-identified database for all EMRs in our entire system. The doctors are restricted to seeing only the data from their practice. The IPA administrator can see the de-identified data from their IPA so that helps them understand

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trends in disease management. Once we identify an IPA in a geographic zone, we hire research coordinators for that zone under our payroll, so that takes the burden of the CRF [case report form] reporting, regulatory, and all the other administrative tasks away from the doctor and lets him or her focus just on the research component. We take care of all the administrative back-end work ourselves. We put them through investigator training. We offer physicians, who can demonstrate thorough understanding of Good Clinical Practice, safety reporting, standard operating procedures and general clinical trials management, the opportunity to participate as phase IV researchers or, if they've done research before, they can conduct phase II or III clinical trials. We share the revenue with the physician researcher. The cost of the EMR comes out of the revenue from the clinical trials, so a doctor can start using the EMR system for virtually no out-of-pocket costs, except training.

### Tell me about the CT Select™ model.

We pre-identify potential subjects through questionnaires we hand out in their waiting rooms, so we know which patients are interested in clinical trials. We get patients' permission to use their de-identified data, so what we can offer our clients, CROs and pharmaceutical companies is large numbers of pre-consented patients and large numbers of investigators with a foundation of very experienced clinical research coordinators already in place. We're the only ones who have access to the CDR data. We only use it for inclusion/exclusion criteria for our CRO customers. The data that comes into the CDR comes from the EMR, which is what makes eCast different. We supply the EMR as part

of this system, so that we get the highest quality data possible. For CT Select we first penetrate large networks of doctors, then pre-consent patients and then use their EMR to gather data points for the CDR.

So a CRO or pharmaceutical company will come to us and say, 'We've got an upcoming study and need 4,500 subjects. They have to have a history of diabetes type 2, they have to have an HbA1c of greater than 7 and must not be taking an ACE inhibitor.' CT Select runs a scan using our report system on the CDR and identifies 8,000 subjects that meet that criteria. We then go back to the doctors who are participating and say, 'The following list of control numbers—we do not know who the patients are, only they do—are eligible for the study and the doctor gets to do the final selection of his or her patients. You want the doctor to know who those patients are and that doctor-patient relationship is a building block of our entire system because it allows the doctor to then decide who would be a good subject. Once the doctor indicates which patients, of those who meet the inclusion/ exclusion criteria, would be good subjects, then the research coordinator contacts the patients and does the initial interview. All CT Select clinical research coordinators have a minimum of two years of clinical research experience working across multiple therapeutic areas. They all are either certified or working toward certification.

After that, a study budget is prepared by CT Select and provided to the client, and an investigator contract is quickly executed, and a regulatory documents package is prepared by CT Select and sent to the client. All CT Select investigators use a central IRB [institutional review board]. The advan-

tages of using CT Select is that it offers CROs and pharma access to a large pool of clinical trial subjects, many of whom are pre-consented, and also allows trial managers to select subjects. Ultimately, CT Select reduces the enrollment timelines, which can help reduce the study timeline. It also eliminates the cost of patient recruitment programs. We chose the name CT Select because we emphasize the fact that we can select very high quality subjects. Secondly we manage the trials with our own research coordinators. And we have a team of very experienced research people here who do that work with the highest level of quality. We want to give our customer, the CRO or pharmaceutical company, the confidence of knowing that we are concerned first and foremost with quality but we are going to give them the best selection criteria that they'll ever see.

### What are your plans for further growth?

We decided that we would expand worldwide at a slow, steady pace. We'll be opening the eCast European branch in The Netherlands soon, which will be wholly managed in the Eastern part of The Netherlands. A network of about 200 physician researchers that have been doing research for over 7 years is going to join our network and let us leverage their network and their research experience. We're also meeting one of the representatives for the Minister of Health there who is going to help us gather de-identified data from their different sources of data. We will make our first footprint in Europe that way and slowly and gradually worldwide from there. CROs don't want just one geographical zone. They need worldwide penetration. We've got everything in place.

