



Recruit to Retain

Building Better Enrollment
Outcomes from the Start

Enrollment Intelligence

Perspectives from CTM:
setting the standard in clinical
trial enrollment for more
than 30 years

Better randomization and retention are built upstream

For clinical trial sponsors, the ultimate measure of recruitment is not how many people respond to an advertisement, visit a study website or even pass an initial pre-screener. It is how many of the right patients ultimately move to randomization and remain engaged in the study once they get there.

That distinction matters.

Patient recruitment and retention remain persistent challenges for clinical research. In a 2025 survey of more than 600 clinical research sites worldwide, 28% identified recruitment and retention among the top issues affecting their sites, making it one of the industry's most frequently cited operational challenges. Trial complexity, study start-up and site staffing were the only issues ranking higher, at 35%, 31% and 30%, respectively.¹

The implications extend well beyond recruitment teams. Inadequate enrollment can delay study completion, increase costs and ultimately compromise a trial's ability to answer its scientific question. An analysis of 2,579 Phase II and Phase III interventional clinical trials registered on ClinicalTrials.gov found that 19% either terminated because of failed accrual or completed with less than 85% of their expected enrollment — putting their statistical power, and therefore their ability to meaningfully address the research question, at risk.²

The traditional response to an enrollment challenge has often been to increase the top of the funnel: generate more awareness, add media, find more potential participants, or send more referrals to sites.

But more volume does not automatically create better enrollment.

A stronger approach is to make every stage of recruitment work harder.

That means reaching patients with a greater likelihood of progressing. Screening them intelligently. Improving the quality and readiness of referrals. Keeping patients connected while sites act. And continually using what the study is learning to improve what happens next.

In other words, recruitment should be designed around the outcome it is meant to produce.

Randomization. And ultimately, retention. RECRUIT TO RETAIN

The problem is rarely a lack of recruitment activity.

It is a failure to connect that activity to the enrollment outcome.



Five Questions Sponsors Should Ask Before Recruitment Begins

A smarter recruitment strategy starts by asking different questions.

1

Are we optimizing for response - or for patients with the greatest likelihood of progressing?

2

Does our screening process help the right patients move forward?

3

What does a referral need to look like for a site to act on it confidently?

4

What happens between a qualified referral and site action?

5

How will new performance signals change the plan?

1

Are we optimizing for response - or for patients with the greatest likelihood of progressing?

Every recruitment program needs reach. But reach alone is a blunt measure of success.

Digital advertising has made it possible to identify and engage patient populations at enormous scale. The more valuable question is whether recruitment is reaching the people most likely to be appropriate for - and progress through - the specific trial.

That requires moving beyond traditional media measures.

Clicks, impressions, and cost per lead can provide useful information about campaign performance. But they are upstream indicators. A channel producing inexpensive responses may ultimately produce fewer qualified patients. A campaign generating a lower volume of responses may produce patients with a greater likelihood of qualification and randomization.

The distinction is important because patient recruitment is not simply a marketing funnel. It is an enrollment funnel. The goal is precision at the top of the funnel.

The patient you choose to pursue upstream influences every enrollment metric downstream.

2

Does our screening process help the right patients move forward?

Screening is one of the first substantive experiences a prospective participant has with a clinical trial. Poorly designed questions, excessive complexity, unclear terminology or an overly burdensome process can create friction before a patient ever speaks with a research site.

Research consistently shows that burden matters.

A systematic review examining patient perspectives across 63 studies and 1,681 adults identified confusion, lack of awareness, participation burden, fear and mistrust among the barriers influencing clinical trial participation. Conversely, transparency, support, trust and informed decision-making were associated with greater willingness to participate.³

Research involving Tufts Center for the Study of Drug Development and IQVIA has likewise found that protocol complexity and the burden placed on participants can negatively affect both recruitment and retention.⁴

Screening therefore has two jobs.

First, it must efficiently determine whether a prospective participant appears to meet relevant protocol requirements.

Second, it should help the right patient continue moving.

Successful screeners are designed around both protocol precision and patient progression.

3

What does a referral need to look like for a site to act on it confidently?

This may be the most consequential distinction in recruitment: a referral is not the same as a qualified referral.

Research sites operate with finite resources. Every referral requires some level of review, outreach, documentation and follow-up. When sites receive large volumes of patients who ultimately prove inappropriate for a study, recruitment activity can inadvertently create additional workload rather than relieve it.

The implication for sponsors is straightforward: recruitment should remove work from sites, not simply transfer work to them.

This changes the value equation.

Instead of measuring recruitment success by the volume delivered to the site, the more meaningful measure becomes what sites are able to do with what they receive.

A referral is valuable when it helps a site act, not merely when it arrives.

4

What happens between a qualified referral and site action?

Even a highly qualified patient can be lost in the space between recruitment and site action. A referral is a handoff - but from the patient's perspective, the trial journey is continuous.

The patient who has completed a screener, answered questions and expressed an interest in participating does not necessarily understand the operational boundaries between a recruitment provider, sponsor, and research site.

They know only whether someone contacts them, whether they understand what comes next, and whether the experience still feels worth pursuing.

Research suggests that time matters. In an analysis of early attrition from two randomized trials involving cancer patients, longer delays between consent and the first contact attempt were associated with greater patient dropout. The researchers concluded that time between consent and randomization should be kept to a minimum.⁵

A retrospective analysis of recruitment for a decentralized COVID-19 trial found that patients transferred immediately to a clinical research coordinator were more likely to enroll than those for whom a callback was arranged.⁶

Recruitment strategies therefore need to account for what happens after qualification.

This is where recruitment begins to become retention. Not after randomization. Before it.

5

How will new performance signals change the plan?

Recruitment optimization is often interpreted as media optimization. Which ad is performing best? Which audience is responding? Which channel has the lowest cost per lead? Those questions matter but only at one point in the enrollment journey.

The KPI that matters most changes as patients move through the funnel.

Early in recruitment, response volume and cost may provide useful signals. Then qualification becomes more important. Then referral quality. Then site contact. Then consent. Then randomization. Ultimately, retention and completion matter.

Optimizing the first metric while losing patients further downstream can create the appearance of recruitment success without producing enrollment success.

A more effective model is therefore to continually ask: what is preventing the next meaningful outcome?

If response is low, change identification or outreach. If response is high but qualification is low, investigate targeting, messaging, screening strategy or protocol criteria. If qualification is strong but randomization is weak, examine what happens between referral and site action. If specific sites or geographies are converting more efficiently, understand why. If patient questions repeatedly emerge at the same point in the journey, improve communication before the issue becomes a barrier.

This is the difference between reporting and optimization.

Reporting asks what happened. Enrollment intelligence asks what it means for what happens next.

**Building better
enrollment
outcomes.**

CTM Insights



When it comes to better recruitment, experience matters

CTM has focused on clinical trial enrollment since 1995. Over three decades, the company has seen recruitment evolve from media-led patient finding into a connected discipline spanning patient experience, sites, technology, data and operations.

That history matters because enrollment expertise is cumulative. Every study creates context about what patients respond to, where progression weakens, how site conditions affect conversion and which early signals deserve attention. The advantage is not simply access to more information. It is the judgment to know which information matters for the study in front of you.

30+	3,500+	6,300+	80+
years focused on enrollment	clinical trials supported	research sites supported	countries reached

CTM's scale provides breadth; its focus provides depth. The company's approach is designed around one central objective: helping more of the right patients progress toward randomization while reducing avoidable burden for patients and sites.

CTM delivers value throughout the enrollment journey

The strongest proof of recruitment is not the volume generated at the beginning. It is the enrollment value created later. CTM evaluates its contribution through downstream performance and the confidence clients place in the work.

25%	96%	3 months
average enrollment contribution	of sites highly satisfied or satisfied with CTM	faster completion of enrollment

What sponsors should remember

- **Volume can conceal weakness.** Top-of-funnel growth is valuable only when it creates meaningful downstream progression.
- **Patient experience is an enrollment variable.** Clarity, confidence, burden and continuity influence whether appropriate patients keep moving.
- **Site burden belongs in the recruitment conversation.** A strategy that creates unmanageable work for sites can undermine its own results.
- **Handoffs need ownership.** An integrated and seamless journey is critical to patient retention.
- **Learning must change action.** Connected performance signals matter when they help teams recognize risk and adapt earlier.

Recruit for the outcome that matters

Every study brings a different combination of population, criteria, competition, geography, site capacity and patient need. That is where experience, integration and execution become difficult to imitate. CTM brings them together to help sponsors identify where enrollment is losing momentum, determine what matters most and build a recruitment approach around the outcome the study needs.

Recruit to Retain

Talk with CTM about where your enrollment model may be losing the right patients and how to move more of them toward randomization.

References

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About CTM

CTM sets the standard in clinical trial enrollment. For more than 30 years, we have helped partners find the right patients, move more of them to randomization and keep them engaged for retention. Our integrated enrollment engine brings together purpose-built technology, experienced people and data intelligence to deliver more predictable enrollment performance while reducing burden on sites.

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