# Human Subjects

## Standard Operating Procedures

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1 Human Research Protection Program (HRPP)

1.1 Policy

The State University of New York at Stony Brook (University or Institution as used in this document) fosters a research environment that promotes the respect for the rights and welfare of individuals recruited for, and participating in, research conducted by or under the auspices of the University. In the review and conduct of research, actions by the University will be guided by the principles (i.e., respect for persons, beneficence, and justice) set forth in the *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (often referred to as the *Belmont Report*). The actions of University will also conform to all applicable federal, state, and local laws and regulations. In order to fulfill this policy, the University has established a human research protections program (HRPP).

1.2 Mission

The mission of the HRPP is to:
- Safeguard and promote the health and welfare of human research subjects by ensuring that their rights, safety and well-being are protected;
- Provide timely and high quality education, review and monitoring of human research projects; and
- Facilitate excellence in human subject research.

The HRPP includes mechanisms to:
- Establish a formal process to monitor, evaluate and continually improve the protection of human research subjects;
- Dedicate resources sufficient to do so;
- Exercise oversight of research protection;
- Educate investigators and research staff about their ethical responsibility to protect research subjects; and
- When appropriate, intervene in research and respond directly to concerns of research subjects.

1.3 Institutional Authority

The University HRPP operates under the authority of the University Policy #P202R, “Research Involving Human Subjects,” most recently revised and approved May 2009. As stated in that policy, the operating procedures in this document “serve as the governing procedures for the conduct and review of all human research conducted under the auspices of the University.” The HRPP Policy and these Standard Operating Procedures (SoPs) are available to all University investigators and research staff and posted on the *Office of Research Compliance’s website*.

1.4 Definitions

**Agent:** all individuals performing institutionally designated activities or exercising institutionally delegated authority or responsibility.
Committees on Research Involving Human Subjects (CORIHS): see Institutional Review Board

**Common Rule:** the “Federal Policy for the Protection of Human Subjects” adopted by a number of federal agencies. Although the Common Rule is codified by each agency separately, the text is identical to Department of Health and Human Services (DHHS) regulations in 45 CFR 46 Subpart A. For the purposes of this document, references to the Common Rule will cite the DHHS regulations.

**Engagement:** an institution is considered *engaged* in a research project when the involvement of their employees or agents in that project includes any of the following:
- Intervention for research purposes with any human subjects of the research by performing invasive or noninvasive procedures.
- Intervention for research purposes with any human subject of the research by manipulating the environment.
- Interaction for research purposes with any human subject of the research.
- Obtaining the informed consent of human subjects for the research.
- Obtaining for research purposes identifiable private information or identifiable biological specimens from any source for the research. In general, obtaining identifiable private information or identifiable specimens includes, but is not limited to:
  - Observing or recording private behavior;
  - Using, studying, or analyzing for research purposes identifiable private information or identifiable specimens provided by another institution; and
  - Using, studying, or analyzing for research purposes identifiable private information or identifiable specimens already in the possession of the investigators.

**Human Subject (for research covered by the Common Rule, e.g., 45 CFR 46, etc.):** a living individual about whom an investigator conducting research obtains data through intervention or interaction with the individual or through identifiable private information (45 CFR 46.102(f)).

- **“Intervention”** means both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject’s environment that are performed for research purposes.

- **“Interaction”** means communication or interpersonal contact between investigator and subject.

- **“Private information”** means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).

- **“Identifiable information”** is information obtained from or about a subject that is individually identifiable in such a way that the identity of the subject is, or may be, readily ascertained by the investigator or associated with the information.
**Note:** The terms “subject” and “participant” are used interchangeably in this document and have the same definition.

**Human Subject (for research covered by FDA regulations (21 CFR 50 and 56)):** an individual who is or becomes a participant in a clinical investigation either as a recipient of the test article or as a control. A subject may be in normal health or may have a medical condition or disease. In the case of a medical device, a human subject/participant also includes any individual on whose tissue specimen an investigational device is used or tested.

**Note:** The terms “subject” and “participant” are used interchangeably in this document and have the same definition.

**Human Subjects Research:** any activity that meets the definition of “research” and involves “human subjects” as defined by either the Common Rule or Food and Drug Administration (FDA) regulations.

**Institutional Official (IO):** the person designated by the University to be responsible for the University’s HRPP. The IO is legally authorized to represent the institution, is the signatory official for all Assurances, and assumes the obligations of the institution’s Assurance. The IO is the point of contact for correspondence addressing human subjects research with OHRP, FDA, and other federal regulatory agencies. Effective 12/22/17, the IO for SBU is the Vice President for Research.

**Institutional Review Board (IRB):** a board designated by the University to review, to approve the initiation of, and to conduct periodic review of research involving human subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the human subjects. The IRB may be assigned other review functions as deemed appropriate by the University.

**Research (Common Rule):** a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge.

For the purposes of this policy, a “systematic investigation” is an activity that involves a prospective study plan that incorporates data collection and analysis, either quantitative or qualitative, to answer a study question. Investigations designed to develop or contribute to “generalizable knowledge” are those designed to draw general conclusions (i.e., knowledge gained from a study may be applied to populations outside of the specific study population).

**Research (synonymous with Clinical Investigation, Study - for activities under FDA jurisdiction):** any experiment that involves a test article and one or more human subjects, and that either:
- Must meet the requirements for prior submission to the FDA under section 505(i) or 520(g) of the Federal Food, Drug, and Cosmetic Act. This means any use of a drug other than the use of an approved drug in the course of medical practice. [21 CFR 312.3(b)] or any activity that evaluates the safety or effectiveness of a device. [21 CFR 812.2(a)], respectively; or
- Does not need to meet the requirements for prior submission to the FDA under these sections of the Federal Food, Drug, and Cosmetic Act, but the results are intended to be later submitted to, or held for inspection by, the FDA as part of an application for a research or marketing permit. The
terms research, clinical research, clinical study, study, and clinical investigation are synonymous for purposes of FDA regulations. [21 CFR 50.3(c), 21 CFR 56.102(c)]

Note: Any activity in which results are being submitted to or held for inspection by FDA as part of an application for a research or marketing permit is considered to be FDA regulated research. [21 CFR 50.3(c), 21 CFR 56.102(c)]

Research under the Auspices of the University:
Includes research that:
- Engages this Institution in the activity, regardless of the location at which the activity is conducted;
- Is conducted by or under the direction of any employee or agent of this Institution (including students) in connection with his or her institutional responsibilities regardless of the location at which the research activity is conducted;
- Is conducted by, or under the direction of, any employee or agent of this Institution using any property or facility of this Institution, or involving the use of this Institution's non-public information to identify or contact human subjects.

Test Article: Under the FDA regulations, covered test articles include:

**Human Drugs:** the primary intended use of the product is achieved through chemical action or by being metabolized by the body.

**Drug:** (a) substance recognized by an official pharmacopoeia or formulary; (b) substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; (c) substance (other than food) intended to affect the structure or any function of the body; or (d) substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device.

http://www.fda.gov/Drugs/InformationOnDrugs/ucm079436.htm

**Medical Devices:** "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is (a) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (b) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or (c) intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes".

http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/C...

**Biological Products:** a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins.
Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Biologics are isolated from a variety of natural sources - human, animal, or microorganism - and may be produced by biotechnology methods and other cutting-edge technologies. Gene-based and cellular biologics, for example, often are at the forefront of biomedical research, and may be used to treat a variety of medical conditions for which no other treatments are available.

http://www.fda.gov/Drugs/InformationOnDrugs/ucm079436.htm

**Food Additives:** in its broadest sense, a food additive is any substance added to food. Legally, the term refers to "any substance the intended use of which results or may reasonably be expected to result -- directly or indirectly -- in its becoming a component or otherwise affecting the characteristics of any food." This definition includes any substance used in the production, processing, treatment, packaging, transportation or storage of food.

**Color Additives:** any dye, pigment or substance which when added or applied to a food, drug or cosmetic, or to the human body, is capable (alone or through reactions with other substances) of imparting color.

**Foods:** dietary supplements that bear a nutrient content claim or a health claim.

**Infant Formulas:** liquid foods intended for infants, which substitute for mother’s milk.

### 1.5 Ethical Principles

The University is committed to conducting research with the highest regard for the welfare of human subjects. It upholds and adheres to the principles of *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects in Research* by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research (1979). These principles are:

**Respect for Persons,** which is ensured by obtaining informed consent, consideration of privacy, confidentiality, and additional protections for vulnerable populations.

**Beneficence,** which is assured by ensuring that possible benefits are maximized and possible risks are minimized to all human subjects.

**Justice,** the equitable selection of subjects.

The University’s Human Research Protection Program (HRPP), in partnership with its research community, is responsible for ensuring the ethical and equitable treatment of all human subjects in research conducted under its auspices.
1.6 Regulatory Compliance

The HRPP is responsible for ensuring compliance with federal regulations, state law and institutional policies. All human subjects research at the University is conducted in accordance with the policy and regulations found in the Common Rule and 21 CFR 50 and 56.

Regulatory compliance for research funded by other federal agencies (e.g., Department of Defense, Department of Energy, Department of Education etc.) is addressed in the SOP Supplement: Additional Federal Criteria, as well as the Worksheet: Additional Federal Criteria to be used by IRB staff and members to ensure compliance with these specific regulations.

The University applies the International Conference on Harmonization (“ICH”) Good Clinical Practices ("GCP") Guidelines (sometimes referred to as “ICH-GCP” or “E6”) to research when required by a sponsor, and only to the extent that they are compatible with FDA and DHHS regulations.

The actions of the University will also conform to all other applicable federal, state, and local laws and regulations.

1.7 Federalwide Assurance (FWA)

The federal regulations require that federally funded human subjects research only be conducted at facilities covered by a FWA approved by the DHHS Office for Human Research Protections (OHRP). An FWA is an institution’s assurance to the federal government that human subject research conducted at that site is in compliance with federal regulations pertaining to the protection of human subjects. The FWA designates the Institutional Review Boards (IRBs) that will review and oversee the research, specifies the ethical principles under which the research will be conducted, and names the individuals who will be responsible for the proper conduct of the research.

The University has an OHRP-approved Federalwide Assurance (FWA# 00000125) and provides support to two on-site IRBs (Committees on Research Involving Human Subjects; CORIHSa [IRB Registration #00000054], CORIHSb [IRB Registration #00001653]). The HRPP also regularly utilizes the IRB services of Chesapeake Research Review, Inc. (for industry-initiated, industry-funded protocols), and of the Pediatric and Adult Central IRBs of the National Cancer Institute (for certain cooperative oncology group protocols). Details concerning the process for using these external IRBs are available on the Office of Research Compliance website. Together, these five IRBs review all human research protocols conducted under the auspices of the University (unless the University enters into a reliance agreement to cede IRB review to another outside reviewing entity, see section 1.14 for Multi-center research, and, e.g., via the SMART IRB Reliance Initiative (www.smartirb.org).

In its FWA, the University has opted to apply the Common Rule to all of its human subject research regardless of the source of support.
1.8 Research Covered by the Human Research Protection Program

The University’s HRPP covers all research involving human subjects that is under the auspices of the University. The research may be externally funded, funded from internal University sources, or conducted without direct funding.

1.9 Written Policies and Procedures

The University’s Standard Operating Policies and Procedures for Human Research Protection detail the policies and regulations governing research with human subjects and the requirements for submitting research proposals for review by the SBU IRBs. This is not a static document. The policies and procedures are regularly amended by the Assistant Vice President for Research Compliance, in consultation with applicable institutional entities (e.g., IO, Office of Research Compliance staff, Institutional Review Boards, University counsel, etc.). The IO will be kept apprised of all major revisions of the policies and procedures.

The Assistant Vice President for Research Compliance will keep the University research community apprised of new information that affect the human research protection program, including laws, regulations, policies, procedures, and emerging ethical and scientific issues on its website and through campus electronic mailing lists. The policies and procedures will be available on the University’s Human Research website and copies will be available upon request.

1.10 Human Research Protection Program Organization

The HRPP is a comprehensive system to ensure the protection of human subjects participating in research. It consists of various individuals, offices, and committees such as Institutional Official (IO), the Assistant Vice President for Research Compliance and Staff of the Office of Research Compliance (ORC), the Institutional Review Boards (IRB), other committees or subcommittees addressing human subject protection (e.g., Institutional Biosafety Committee, Research Radiation Consultants, Radioactive Drug Research Committee, Conflict of Interest), investigators, research staff, and research pharmacy staff. The objective of this system is to assist the University in meeting ethical principles and regulatory requirements for the protection of human subjects in research.

The following officials, administrative units and individuals have primary responsibilities for implementing the HRPP.

1.10.1 Institutional Official

The ultimate responsibility of the HRPP resides with the Vice President for Research (VPR) who serves as the Institutional Official (IO) of the program. The IO is the primary contact at the University for the Office for Human Research Protections, Department of Health and Human Services, and the Food and Drug Administration. The IO, in close partnership with the Assistant Vice President for Research Compliance (see Section 1.11.1), has ultimate responsibility for oversight of:
• The development, management and evaluation of policies and procedures that ensure compliance with all state, and federal regulations governing research. This includes monitoring changes in regulations and policies that relate to human research protection and overseeing all aspects of the HRPP program.
• The Institutional Review Boards and University Investigators, ensuring that all are appropriately knowledgeable to conduct research in accordance with ethical standards and applicable regulations.
• Keeping other appropriate Institutional officials apprised on key matters regarding research at the University.
• Implementation the University’s HRPP policy.
• Submission, implementation and maintenance of an approved FWA through the Department of Health and Human Services Office of Human Research Protection (OHRP).
• Assessment of the resources of the University’s HRPP.
• Ensuring assistance for investigators in their efforts to carry out University’s research mission.
• Development and implementation of needed improvements and ensuring follow-up of actions, as appropriate, for the purpose of managing risk in the research program.
• Development of training requirements as required and as appropriate for investigators, subcommittee members and research staff, and ensuring that training is completed on a timely basis.

1.10.2 IRBs

The University has two on-site IRBs, appointed by the IO. They are locally referred to as the Committees on Research Involving Human Subjects (CORIHSa, CORIHSb), referred to collectively in this document as IRB). The IRB prospectively review and make decisions concerning all non-exempt human research conducted at its facilities or by its employees or agents, under the auspices of the University. The IRB is responsible for the protection of rights and welfare of human research subjects. It discharges this duty by complying with the requirements of the Common Rule, FDA regulations, other relevant federal regulations, state regulations, the FWA; and University policies. (See Section 2 for a detailed discussion of the IRB).

The University also routinely utilizes the services of three off-site IRBs. They are:

• Chesapeake Research Review, Inc. (CRRI): the CRRI IRB is required to be used by University investigators who wish to conduct industry-initiated, industry-funded research activities.
• National Cancer Institute’s Adult CIRB: for applicable cooperative oncology group protocols involving adult subjects
• National Cancer Institute’s Pediatric CIRB: for applicable cooperative oncology group protocols involving minor subjects.

1.10.3 University Counsel’s Office

The University’s HRPP relies on the University Counsel for the interpretations and applications of New York State law and the laws of any other jurisdiction where research is conducted as they apply to human subject research.
1.10.4 The Investigator

The investigator is the ultimate protector of the human subjects who participate in research. The investigator is expected to abide by the highest ethical standards and to develop a protocol that incorporates the principles of the Belmont Report. He/she is expected to conduct research in accordance with the approved research protocol and to oversee all aspects of the research by providing supervision of support staff, including oversight of the informed consent process. All subjects must give informed consent (unless a waiver of informed consent is granted by the IRB) and the investigator must establish and maintain an open line of communication with all research subjects within his/her responsibility. In addition to complying with all the policies and standards of the governing regulatory bodies, the investigator must comply with institutional and administrative requirements for conducting research. The investigator is responsible for ensuring that all research staff completes appropriate training and must obtain all required approvals prior to initiating research. When investigational drugs or devices are used, the investigator is responsible for ceding oversight to the research pharmacy (for investigational drugs), or providing written procedures for their storage, security, dispensing and disposal.

1.10.5 Other Related Units

1.10.5.1 Office of Sponsored Programs (OSP)

The Office of Sponsored Programs (OSP) staff review all research grants and agreements with federal, foundation, for-profit or non-profit sponsors. This institutional review ensures that all terms of an award are in compliance with institutional and federal policies. Only designated individuals within OSP have the signature authority to approve and submit research proposals and to execute research grants and agreements on behalf of the University. As a further control, internal documents retained by OSP as part of the application process for extramural funding include information pertaining to IRB approval status, and investigator conflict of interest disclosure.

When the grant or contract agreement includes human research activities that will be conducted by investigators who are not employees or agents of the University, a subcontract is executed between the University and the collaborating institution. The subcontract includes the requirement for the collaborating institution to assure compliance with federal regulations for the protection of human subjects in research. For unfunded collaborations, a subcontract is not executed, but OSP nonetheless verifies compliance by the other institution (e.g., copy of their IRB approval, etc.).

1.10.5.2 SBU Pharmacy

Pharmacists from the Investigational Drug Service (IDS) within University’s Hospital Pharmacy Department serve as consultants to, and/or IRB members on the IRB. They receive minutes from all IRB meetings and applicable correspondence from the University’s off-site IRBs allowing the Pharmacy to have complete information about all IRB approved research that
takes place at the University and under its jurisdiction. The Pharmacists assure that information about all studies involving drugs used in research is shared with the Pharmacy staff as appropriate. The University’s Hospital Pharmacy and Therapeutics Committee is made aware of research involving drugs that is reviewed by the IRB.

The IDS controls the storage, dispensing, labeling and distribution of drugs used in human research conducted in the University Hospital, the Health Science Center, the Cancer Center, and the Ambulatory Surgery building. IDS reviews and approves plans for the storage, dispensing, labeling, and distribution of drugs used in human research conducted in other campus sites.

If a patient admitted to the hospital as an inpatient is a subject in a research protocol involving medication, whether or not the study is conducted by the University, the Pharmacy must receive copies of all relevant study materials from the PI in order for the patient to continue the study while an inpatient. The Pharmacy will review the protocol and accommodate the patient’s continued participation in the study if deemed appropriate, after consultation with the Assistant Vice President for Research Compliance (and IRBs as applicable).

The Pharmacy is available to provide guidance to investigators in relation to the management of the study drugs.

1.10.5.3 Office of Clinical Trials

The goals of this office are to streamline the process of industry sponsored clinical trials by utilizing the office as a single point of contact between industry sponsors and Stony Brook University Hospital. The functions of the Office of Clinical Trials are to:

- Match trials to appropriate investigators
- Help find resources for those investigators who lack support
- Review and/or create budgets for assessment and identification of study procedures, study visits, etc.
- Negotiate budgets with sponsors/Clinical Research Organizations
- Assist investigators with funding proposals, IRB, and regulatory submissions, if requested
- Collaborate with the Office of Sponsored Programs regarding CTA/Payment terms
- Collaborate with the Office of Grants Management regarding payments received.
- Advertise current studies enrolling subjects for recruitment purposes
- Track enrollment of subjects on Cerner/PowerTrials and OCT database
- Manage Clinical Trials Management System (CTMS)
- Provide Study Coordinator services, if requested.
- Mentor new investigators and study coordinators
1.10.6 Relationship among Components

The IRBs function independently of, but in coordination with, other University regulatory committees. IRB committees, however, make their independent determination whether to approve or disapprove a protocol based upon whether or not human subjects are adequately protected. The IRB has review jurisdiction over all research involving human subjects conducted, supported, or otherwise subject to regulation by any federal department or agency that has adopted the human subject regulations. Research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials of the University. However, those officials may NOT approve research if it has not been approved by the IRB.

The Clinical Trials Compliance Group meets quarterly to ensure that a dialogue is maintained between key HRPP entities relating to the conduct of clinical trials. Areas represented in the membership include Hospital Finance, Cancer Center, Office of Sponsored Programs, Office of Research Compliance, Office of Clinical Trials, Hospital Compliance, and others as deemed appropriate. This group reviews current clinical research practices in order to assess effectiveness and propose improvements for the proper conduct and continued compliance of clinical trials under the auspices of the University.

The Coordinator Training and Mentorship Group (CTMG) brings study coordinators of clinical trials together on a quarterly basis to receive updates and reminders from the ORC, to educate new coordinators on the basics of GCP, and to discuss topics of interest to the members of the group (e.g., how to prepare for an FDA audit, etc.).

Protocol-specific coordination: Submissions to the electronic management system for new and/or continuing studies must indicate University support, via appropriate, applicable electronic signature of delegated university officials for the following units and activities (as applicable), prior to commencement of the study:

- Pathology
- Pharmacy
- Radiology
- Privacy/Security
- Hospital Finance/Billing
- Chair of PI’s department
- Use of research-related radiation
- Use of surgical pathology or cytology specimens

*Note: electronic signature of PI and department chair must be present in order for the submission to be acted upon by ORC staff.*

OSP and OCT staff have full administrative access to the electronic management system to assist in the coordination of various required institutional reviews and approvals.
1.11 Human Research Protection Program Operations

In addition to the leadership structure described above, support staff members who dedicate 100% effort to the HRPP include, four (4) IRB Administrators and one (1) full-time IRB Assistant. See below for other individuals who contribute significant effort to the protection of human subjects at the University.

1.11.1 Assistant Vice President for Research Compliance (AVP-RC) and Staff of the Office of Research Compliance

The Office of Research Compliance (ORC), within the Office of Vice President for Research (OVPR), consists of an Assistant Vice President for Research Compliance (AVP-RC) and eight (8) staff. This office provides the primary administrative support for management of the University’s HRPP.

Staff of the ORC report to, and are supervised by, the AVP-RC. For matters concerning the HRPP, the AVP-RC serves as the designee for the IO in administering general oversight of the HRPP and assists him/her in the promulgation of the IO responsibilities detailed in 1.10.1.

The staff of ORC that is specific to SBU’s HRPP consists of:

- 2.5 FTE IRB Administrators: responsible for facilitating all aspects of the IRB experience throughout the life of a research proposal involving human subjects. This responsibility includes the pre-review of documents and screening of research proposals prior to review by the IRB, assignment of reviewers, as well as serving as the liaison between the investigators and the IRBs. The IRB Administrators attend IRB meetings and help ensure proper documentation of discussions, including controverted discussions and actions taken by the IRBs during convened meetings. Each FTE IRB Administrator serves as a voting IRB member on one of the two IRBs (and alternates for each other on the other IRB). These individuals either write, or oversee, the communication from the IRB to the investigator.

- 1 FTE IRB Assistant: The IRB Assistant is responsible for providing administrative support to the IRB Administrators, particularly in the areas of exemptions and review/assignment of reviewers to expedited studies.

- 1 FTE HRPP Administrator (Research Subject Advocate, Sponsor-Investigator IND/IDE Support, Reliance Administrator, Community Outreach)

- .5 FTE QA Administrator (for-cause, not for cause audits, HRPP researcher and institutional COI)

The AVP-RC is the Human Protections Administrator per the FWA. Along with an Assistant Director, these staff members also have responsibilities in other areas of ORC, i.e., administration and management of the Institutional Animal Care and Use, Institutional Biosafety- IBC (and DURC), Radioactive Drug Research (RDRC), and Stem Cell Research Oversight committees. The AVP-RC is also the Research Integrity Officer for the University (RIO; for handling research misconduct allegations and proceedings).
An additional ORC Assistant Director is responsible for Export Controls, Investigator COI, and Responsible Conduct in Research and Scholarship, as well as providing support in the AAHRPP re-accreditation processes. This individual works closely with the QA IRB Administrator in handling CO involving human research.

Finally, one FTE ORC member is clerical, providing support to the campus community for all CITI and other training initiatives (including those that are HRPP-related), and triages all communications between outside entities and the members of the ORC.

The IRB staff is always available to speak by phone or in person with investigators who need assistance in navigating any and all aspects of the IRB process. Individual consultations with the staff are particularly encouraged and strongly recommended for investigators of first-time submissions.

The structure of the Office of Research Compliance, with responsibility for the administrative support of multiple compliance committees, permits efficiencies and assurances that all relevant compliance approvals are obtained for a particular research activity.

1.11.2 Selection, Supervision and Evaluation of HRPP Supporting Staff

Selection Process: Policies and procedures of the Research Foundation of SUNY and SUNY, including AAEEO requirements, are followed for the recruitment and selection of HRPP professional and clerical staff. The University is an Affirmative Action/Equal Opportunity employer and educator. The University’s hiring departments and the search committee assigned to each recruitment work together with Human Resource’s Recruitment, the Office of Diversity/Affirmative Action and the local Affirmative Action/Equal Employment Opportunity Committee to demonstrate the University’s good faith efforts to locate and consider for employment a wide pool of applicants, including qualified persons of color, women, disabled persons and special disabled or Vietnam era veterans.

Depending on the position to be filled, variables to be considered in the selection of HRPP staff include prior experience in IRB administration or another position within an HRPP (e.g., study coordinator), or, at the assistant or clerical levels, a desire to learn and be an active participant in the regulatory, ethical, and procedural aspects that support an HRPP.

Supervision: The IRB Assistant is directly supervised by the IRB Administrators who, in turn, are directly supervised by the Assistant Director of ORC. The Assistant Director of ORC reports to the AVP-RC.

Evaluation: Research Foundation and SUNY policy requires that a written evaluation and performance program be completed for its employees on an annual basis.

The program is designed to:

- Increase communication between an employee and his/her supervisor by setting forth clearly what the employees is expected to accomplish, what factors are important to successful performance,
and at the end of the program period, how well the employee met his/her supervisor’s expectations of job performance.

- Identify areas where additional training or development will improve performance.
- Assist an employee's supervisor in recognizing and rewarding his/her accomplishments.

When an individual is hired or is transferred to a new position the employee and his/her supervisor will meet to discuss the supervisor's performance expectations for the following year. During the year, a supervisor will discuss performance with each employee and provide feedback on progress as well as guidance for improvements as necessary.

At the end of the performance evaluation period, (typically the 12-month period following the establishment of the performance program), the supervisor will complete a Performance Evaluation Form for each employee. Each employee is encouraged to participate in the performance program and performance evaluation process by completing a self-appraisal, which is encouraged, but not required.

1.12 Human Research Protection Program Resources

The ORC, is located within the Melville Library on Main Campus of the University and is equipped with all necessary office space, meeting space, storage space and equipment to perform the functions required for the HRPP.

The IO ensures procurement of adequate resources to the IRBs and ORC, including adequate meeting and office space, and staff for conducting IRB business. Office equipment and supplies, including technical support, file cabinets, computers, laptops, internet access, and copy machines, are made available to the IRBs and ORC staff.

The adequacy of personnel and non-personnel resources of the HRPP program, including the IRB committees and ORC is assessed on an annual basis by the AVP-RC, in consultation as required, with the Director of Grants Management, the Financial Administrator of ORC, and representatives from other administrative units, as applicable. The IO is advised of the outcome of this assessment for further action as required.

1.13 Conduct of Quality Assurance/ Quality Improvement Activities for the IRB Operation

The objective of the University’s HRPP Quality Assurance / Quality Improvement Plan is to measure and improve human research protection effectiveness, quality, and compliance with organizational policies and procedures and applicable local, state, and local laws. The Quality Assurance/Quality Improvement Plan will be managed and implemented by the AVP-RC, on behalf of the IO.

1.13.1 Directed Audits

Directed audits of research studies approved by any SBU-recognized IRB are initiated in response to issue(s) identified by the IRB, the ORC, or complaint/concern filed by a subject, investigator, or any
party. Such audits will be conducted by the QA Administrator, but may include other ORC staff, IRB members and/or others as appropriate.

Depending on the specific issue being investigated, activities of auditors during directed audits may include examining investigator-held research records, patient medical records, financial disclosure forms, and other activities as deemed appropriate by IRBs.

1.13.2 Not-for-Cause Reviews

For every active study undergoing continuing review, a not-for-cause review is undertaken by the ORC staff as follows: Required with continuing review submissions are copies of the consent/permission/assent documents signed by the last subject enrolled. These documents have subject signature and name redacted, leaving intact all dates and the name of the person who obtained consent. For studies that are more than minimal risk, redacted copies of the inclusion/exclusion (I/E) checklist that was completed for that last enrolled subject is also required. Random audits of source documents that support the information on the completed I/E checklist is also performed. These documents are reviewed for correct version status, accurate completion, and identity of the person obtaining consent (is the individual an approved investigator on the study? Is human research training completed and current?). Any non-compliance uncovered as a result of this not-for-cause routine review is brought to the next scheduled IRB meeting for committee deliberation.

SBU HRPP also has a formal consent monitoring program. See SOP section 3.9.4 ‘Consent Monitoring’

1.13.3 Non-University Institutional Audits

External directed (“for cause”) audits will be done on activities conducted at non-University sites, where the IRB serve as the “IRB of Record,” in response to concerns regarding compliance with federal, state, and local law, research subject safety, and IRB policies and procedures. These audits may include activities listed in section 1.13.1 above.

1.13.4 Reporting and Disposition

Noncompliance revealed from directed audits and not-for-cause reviews will be reported to the AVP-RC, as well as to the applicable IRB at the next scheduled meeting with jurisdiction over the study in question. For issues concerning studies under external IRB oversight, reporting will occur at the next scheduled on-site IRB meeting. if the issue concerns an investigator, and is not study specific, all affected IRBs will be notified of findings). Any noncompliance will be handled according the procedures in Section 10.4 of these SOPs.

If an audit or review finds potential serious noncompliance, and/or that subjects have been exposed to, or in danger of being exposed to conditions that compromise their safety, the IO, AVP-RC, and/or IRB Chair will be authorized to take immediate action as deemed necessary (prior to review or request for further investigation by the IRB), to ensure that the study subjects’ health and welfare are protected.
Findings from audits and reviews are reviewed by the AVP-RC, ORC staff and other applicable officials to determine if investigators might benefit from additional education (via e-mail 'Updates', postings on web etc.) impacting the compliant and ethical conduct of their research activities, and whether applications or guidance needs to be clarified or revised to facilitate compliance.

1.13.5 IRB Internal Compliance Reviews

- The AVP-RC conducts review of all on-site IRB minutes and other meeting documents to determine that adequate documentation of the meeting discussion has occurred and appropriate actions and determinations have been made. This review includes assessment that, e.g., federal approval criteria have been considered and met (in approved studies, or met pending prescriptive revisions by the investigator), quorum is met and maintained, appropriate handling of COI management plans for investigators, appropriate recusal of conflicted members, appropriate committee action for substantive modifications, documented protocol-specific determinations for protections of vulnerable populations, and quality of IRB member reviews.
- The IRB staff ensures that, for continuing reviews, no lapse in approval has occurred and if it has, they will obtain a report from the PI detailing activities that transpired during the period of study lapse. Any activity that has transpired will be brought to the following IRB meeting for assessment of noncompliance. The staff will also verify other IRB approvals from (and Federal Wide Assurances where federal monies are involved) for collaborating institutions or external performance sites.
- The AVP-RC and IRB staff routinely review HRPP standard operating procedures and other documents to ensure consistency with practice.
- Other monitoring or auditing activities will be conducted as deemed appropriate by the AVP-RC, and/or IO.

1.13.6 HRPP Quality Improvement

The AVP-RC, in consultation with the IRB Chairs and staff as deemed appropriate, defines (in an ongoing process) at least one targeted measure of operational efficiency and effectiveness and at least one targeted measure of compliance within the HRPP. In order to evaluate whether the defined goals are being achieved, data are reviewed and changes are instituted (e.g., education is conducted, processes modified etc.) by the AVP-RC regularly. The IO and IRBs are informed of outcomes as applicable. Outcomes will often drive targeted educational opportunities to the campus community.

1.14 Multi-site Research

When engaged in multi-site research, research involving external collaborators, or research that is otherwise under the jurisdiction of more than one IRB, the University acknowledges that each organization is responsible for safeguarding the rights and welfare of human subjects and for complying with applicable federal regulations. The University may choose to review the research in its entirety, only those components of the research the University is engaged in, rely on the review of another qualified IRB, or make other arrangements for avoiding duplication of effort. When the University is the prime awardee on a HHS grant, it will ensure that at least one IRB reviews the
research in its entirety (see section 17.16 regarding the single IRB requirement for multicenter grants awarded from NIH, where all sites are conducting all research procedures).

When relying upon another IRB or when serving as the reviewing IRB for an outside organization or external investigator, a formal relationship must be established between the University and the outside organization or investigator through an IRB Authorization Agreement, Investigator Agreement, a Memorandum of Understanding, or other such written agreement. The written agreement must be executed before the University will accept any human research proposals from the outside organization or investigator or rely on the review of an external IRB.

IRB reliance agreements establish the authorities, roles, and responsibilities of the reviewing IRB and the relying organization. The procedures for reliance, including for communication, information-sharing, and reports, may be outlined in the reliance agreement or in companion SOPs or other materials. The Reliance Administrator in the Office of Research Compliance utilizes a checklist to ensure that reliance agreements and any accompanying materials address all requirements and are consistent with the University’s standards. To support compliance, the University will make every effort to ensure as much consistency as possible across reliance agreements.

The University has signed the SMART IRB joinder agreement. When the organizations participating in the research are signatories to the joinder agreement, IRB reliance may be requested and documented utilizing the SMART IRB online reliance platform. The University will determine on a study-by-study basis whether the SMART IRB SOPs or alternative procedures will be utilized to implement the reliance via a reliance arrangement agreed upon between the relying and reviewing sites.

Requests for SBU to either rely upon an external IRB or to serve as the IRB of record for an external organization or investigator should be submitted as early as possible in the grant/contract process by submitting a reliance request following the instructions in Section 17.16 of these SOPs.

See Section 17.16 for procedures and considerations involved in IRB reliance arrangements.

Regardless of which IRB is reviewing the activity, if the SBU PI is the lead investigator, or the University is the coordinating center for multi-site or collaborative research, regardless of location of the research, the PI must document how the research plan and issues relevant to the protection of human subjects (e.g., IRB initial and continuing approvals, reports of unanticipated problems, study modifications, interim reports) will be communicated among participating sites and investigators.

To this end, SBU’s electronic management system permits web-based protocol sharing and collaboration with participating sites of all aspects of the IRB initial, continuing, and post-approval reporting submission requirements. As part of pre-review, the ORC staff ensures that the PI or other responsible party from each collaborating site has access to the study within the electronic management system in order to keep abreast of study status and to ensure reporting capabilities.
Institutional Review Boards (IRB)

2.1 Policy

The University has two on-site IRB’s (Committees on Research Involving Human Subjects (CORIHSa, CORIHSb) to ensure the protection of human subjects in human subjects research conducted under the auspices of the University. All non-exempt human subjects research conducted under the auspices of the University must be reviewed and approved by an authorized IRB prior to the initiation of the research.

Although the University has authorized a number of IRBs to fulfill this function, all on-site IRBs follow the same policies and procedures. The following describes the authority, role and procedures of the on-site IRBs.

2.2 IRB Authority

Under University policy P202R “Research Involving Human Subjects”, the IRB is authorized to:

- Approve, require modifications to secure approval, defer, or disapprove all research activities overseen and conducted under the auspices of the University, regardless of location of the research activities;
- Suspend or terminate approval of research involving human subjects not being conducted in accordance with University’s IRB requirements or that has been associated with unexpected serious harm to subjects;
- Observe, or have a third party observe, the consent process; and
- Observe, or have a third party observe, the conduct of the research.

Research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials of the institution. However, those officials may NOT approve research if it has not been approved by the IRB. University officials may strengthen requirements and/or conditions, or add other modifications to secure University approval or approval by another University committee. Such University-driven (as opposed to IRB driven) conditions/modifications to a study previously approved by the IRB will require approval by the IRB. The IRB staff, in consultation with the applicable IRB chair as needed, will determine whether the changes require full or expedited review.

2.3 Number of IRBs

There are currently two (2) on-site and three off-site IRBs that may review research under the auspices of the University.

The AVP-RC, with consultation from the IRB staff and the Chairs of the IRBs as needed, will review the activity of the IRBs on at least an annual basis and make a determination as to the appropriate number of IRBs that are needed for the University. This determination will be based on the evaluation of the
amount and type of research activities handled between the IRBs. The IO will be notified of this assessment, for further action as needed.

2.4 Roles and Responsibilities

2.4.1 IRB Chair

The University Institutional Official appoints the IRB Chairs. Any change in appointment, including reappointment or removal, requires written notification.

An IRB Chair should be a highly respected individual, from within the University, fully capable of managing the IRB, and the matters brought before it with fairness and impartiality. The task of making the IRB a respected part of the institutional community will be shared between the AVP-RC, IRB Chairs and IO. The IRB Chairs will be primarily responsible for ensuring that the IRB is perceived as fair, impartial and immune to pressure by the University’s administration, the investigators whose protocols/studies are brought before it, and other professional and nonprofessional sources.

The IRB Chairs are responsible for conducting the meetings and delegates to the IRB Administrators and Assistant (all IRB members) the responsibility of being signatory for correspondence generated by the IRBs.

The performance of the IRB Chairs will be reviewed and provided with feedback on an annual basis by the AVP-RC, with copy to the IO. If an IRB Chair is not acting in accordance with the IRB’s mission, following these policies and procedures, has an undue number of absences, or not fulfilling the responsibilities of the IRB Chair, he/she will be removed.

2.4.2 Subcommittees of the IRB

The IRB Chair, or as delegated to the IRB Administrators, may designate one or more other subcommittees of the IRB to perform duties, as appropriate, to review and undertake other IRB functions, and to make recommendations to the IRB as appropriate. The IRB Chair, or as delegated to the IRB Administrators, will appoint IRB members to serve on each IRB Subcommittee created under this Section. The number and composition of the IRB Subcommittee members shall depend on the authority delegated by the IRB Chair to such IRB Subcommittee (e.g., merely making recommendations versus decision-making authority). If the IRB Subcommittee has decision-making authority, then its members and composition must comply with the requirements specified in Section 2.6 of this document. Members of the IRB Subcommittee must be experienced in terms of seniority on the IRB, and must be matched as closely as possible with their field of expertise to the study assigned to the IRB Subcommittee.

2.5 Membership of the IRB

IRB members are selected based on appropriate diversity, including consideration of race, gender, cultural backgrounds, specific community concerns in addition to representation by multiple, diverse
professions, knowledge and experience with vulnerable subjects, and inclusion of both scientific and non-scientific members. The structure and composition of the IRB must be appropriate to the amount and nature of the research that is reviewed. Every effort is made to have member representation that has an understanding of the areas of specialty that encompasses most of the research performed at the University. In addition, the IRB will include members who are knowledgeable about and experienced working with vulnerable populations that typically participate in University research.

The IRB must promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects; and possess the professional competence necessary to review specific research activities. A member of the IRB may fill multiple membership position requirements for the IRB.

Individuals from the Offices of Sponsored Programs, Grants Management, Proposal Development, or Technology Transfer may not serve as members of the IRB or carry out day-to-day operations of the review process. Individuals from these offices may provide information to the IRB and attend IRB meetings as guests.

2.6 Composition of the IRB

1. The IRB will have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the University.
2. The IRB will be sufficiently qualified through the experience and expertise of its members, and the diversity of the members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.
3. In addition to possessing the professional competence necessary to review specific research activities, the IRB will be able to ascertain the acceptability of proposed research in terms of the University policies and regulations, applicable law, and standards of professional conduct and practice. The IRB will therefore include persons knowledgeable in these areas.
4. If the IRB regularly reviews research that involves a vulnerable category of subjects (e.g., children, prisoners, pregnant women, or handicapped or mentally disabled persons), consideration will be given to the inclusion of one or more individuals on the IRB, who are knowledgeable about and experienced in working with these subjects. When protocols involve vulnerable populations, the review process will include one or more individuals who are knowledgeable about or experienced in working with these subjects, as either members of the IRB or as consultants (see Section 6.0).
5. Every nondiscriminatory effort will be made to ensure that the IRB does not consist entirely of men or entirely of women, including the institution's consideration of qualified persons of both sexes, so long as no selection is made to the IRB on the basis of gender. The IRB shall not consist entirely of members of one profession.
6. The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.
7. The IRB includes at least one member who is not otherwise affiliated with the University and who is not part of the immediate family of a person who is affiliated with the University.
8. The IRB includes at least one member who represents the general perspective of subjects.
9. One member may satisfy more than one membership category.
10. IRB Staff of the ORC may be voting members of the IRB.

2.7 Appointment of Members to the IRB

The IRB Chairs, AVP-RC or staff of ORC, IRB membership, or IO can identify the need for a new or replacement member, or alternate member. A candidate may be nominated by any of these individuals, department chairs, or by other applicable officials within the University. The AVP-RC receives the nomination and consults with the IRB Chairs and ORC Staff to determine the appropriateness of the candidate, based on qualifications, reputation, and needs of the particular committee.

Where there are no nominees, appropriate department chairs, program directors, or other University officials will be contacted in writing for candidate nominees by the AVP-RC, on behalf of the IO.

The final decision in selecting a new member, and appointment thereof, is made by the IO. Appointments are made for a renewable two-year period of service. Members may resign by written notification to the AVP-RC or IO. Members may be removed on a for-cause basis by those individuals as well.

On an annual basis, the IRB Chair, IRB Staff, and the AVP-RC (on behalf of the IO) review the membership and composition of the IRB to determine if they continue to meet regulatory and institutional requirements.

2.8 Alternate Members

The appointment and function of alternate members is the same as that for primary the IRB members, and the alternate's expertise and perspective are comparable to those of the primary member. The role of the alternate member is to serve as a voting member of IRB when the regular member is unavailable to attend a convened meeting. When an alternate member substitutes for a primary member, the alternate member will receive and review the same materials prior to the IRB meeting that the primary member received or would have received.

The IRB roster identifies the primary member(s) for whom each alternate member may substitute. The alternate member will not be counted as a voting member unless the primary member is absent. The IRB minutes will document when an alternate member replaces a primary member.

2.9 IRB Member Conflict of Interest

No regular, alternate, or ex officio member or consultant may participate in the review (initial, continuing, or modification) of any research project in which the member or consultant has a conflict of interest (COI), except to provide information as requested. It is the responsibility of each IRB voting member to disclose any COI in a study submitted for review and to then recuse him/herself. At convened meetings, the IRB member recuses himself from the deliberations and vote by leaving the
Any primary, secondary, or expedited reviewer with a COI must notify the IRB staff who will re-assign the protocol.

All voting, alternate, and ex officio members of the IRB complete a “CORIHS Member Human Research Conflict of Interest Assessment Form” when first appointed and annually thereafter. [See Section 14 “Conflicts of Interest in Research” for a detailed description of managing conflicts of interest.”]. IRB Staff is informed by the AVP-RC or designee if a member has a significant financial interest so that review assignments can be managed accordingly.

Committee members and consultants may find themselves in any of the following COIs when reviewing research:

- Where the member or consultant is involved in the design, conduct, and reporting of the research.
- Where an immediate family member of the member or consultant is involved in the design, conduct, and reporting of the research.
- Where the member holds significant financial interests (See Section 14 for a definition of significant financial interests) related to the research being reviewed.
- Any other situation where an IRB member believes that another interest conflicts with his or her ability to deliberate objectively on a protocol.

The IRB Chair will poll IRB members at each convened meeting to determine if a COI exists regarding any protocols to be considered during the meeting and reminds them that they should recuse themselves by leaving the room during the discussion and vote of the specific protocol. IRB members with a COI are excluded from being counted towards quorum. All recusals by IRB members with COI are recorded in the minutes.

If the COI status of a IRB member changes during the course of a study, the IRB member is required to complete an amended “CORIHS Member Human Research Conflict of Interest Assessment Form” and submit the completed document to the AVP-RC, who will, in turn advise the IRB Staff of the change.

2.10 Use of Consultants

When necessary, the IRB staff or the IRB members may solicit individuals from within or outside the University competence in special areas to assist in the review of issues or protocols, which require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB. The need for a consultant may be determined in advance of, or during the review of the study at, the meeting. The ORC staff ensures that all relevant materials are provided to the consultant in a timely manner following determination that an outside review is required. When the convened IRB requires consultation by individuals with appropriate expertise, the study will be tabled and reviewed at the next convened IRB meeting.

Written statements of consultants will be kept in IRB records. Key information provided by consultants at meetings will be documented in the minutes. Written reviews provided by the outside reviewer will be filed with the study.
The AVP-RC reviews the COI policy for IRB members (Section 2.9) with consultants who must document for the record that they do not have a COI prior to review. Individuals who have a COI or whose spouse or dependent child have a COI with the sponsor of the research will not be invited to provide consultation.

The consultant’s findings will be presented to the full board for consideration either in person or in writing. If in attendance, these individuals will provide consultation but may not participate in or observe the vote.

Ad hoc or informal consultations requested by individual members (rather than the full board) will be requested in a manner that protects the investigator’s confidentiality and is in compliance with the IRB conflict of interest policy (unless the question raised is generic enough to protect the identity of the particular PI and research protocol).

2.11 Duties of IRB Members

The agenda, submission materials, protocols, proposed informed consent forms and other appropriate documents are made available electronically to members approximately one week prior to the convened meeting at which the research is scheduled to be discussed. IRB members will treat the research proposals, protocols, and supporting data confidentially.

2.12 Attendance Requirements of the IRB Members

IRB members should attend all meetings for which they are scheduled. If an IRB member is unable to attend a scheduled meeting, they should inform an ORC staff member as soon as possible. If the inability to attend will be prolonged, a request for an alternate to be assigned may be submitted to the AVP-RC.

If an IRB member is to be absent for an extended period of time, such as for a sabbatical, he or she must notify the IRB at least 30 days in advance so that an appropriate replacement can be obtained. The replacement can be temporary, for the period of absence, or permanent, following consideration by the AVP-RC. If the IRB member has a designated alternate (Section 2.8), the alternate can serve during the primary IRB member’s absence.

2.13 Training/ Ongoing Education for the IRB Chair and Members in Regulations, Procedures

A vital component of a comprehensive human research protection program is an education program for IRB Chairs and IRB members. The University is committed to providing training and an on-going educational process for IRB members and ORC staff related to ethical concerns and regulatory and University requirements for the protection of human subjects.
### Training

New IRB members, including alternate members, will meet with the AVP-RC or designee for a formal orientation/training session. At the session, the new IRB member will be given:

- Web links to the SBU Human Research Protection Program and SOPs
- Belmont Report;
- Stony Brook University HRPP Standard Operating Procedures;
- Federal regulations relevant to IRB.
- Reviewer worksheets and checklists
- Copy of the IRB Member Module (“What Every New IRB Member Needs to Know”)

In addition to the training session, the IRB members will complete the Biomedical Basic CITI Training

### Continuing Education

To ensure that oversight of human research is ethically grounded and the decisions made by the IRB is consistent with current regulatory and policy requirements, training is continuous for IRB members throughout their service on the IRB. Educational activities include, but are not limited to:

- In-service training at IRB meetings;
- Webinars;
- Copies of appropriate publications and articles;
- Identification and dissemination by the AVP-RC of new information that might have an effect on the human research protection program, including laws, regulations, policies, procedures, and emerging ethical and scientific issues to IRB members via email, mail, or during IRB meetings.

The IO will provide support to send as many members of the IRB as are interested in attending the annual PRIM&R conference.

The IRB staff is required to complete applicable modules of the CITI Course in the Protection of Human Research Subjects. IRB staff will be expected to attend at least one conference/webinar (e.g., PRIMR, etc.) annually.

### 2.14 Liability Coverage for IRB Members

The two on-site IRBs are constituted committees of the State University of New York (SUNY). NYS Public Officers Law, section 17 provides that where the requirements of Public Officers Law section 17 are met, and contingent on a determination by the Attorney General of the State of New York, the state shall provide for the defense of state employees and officers in civil action or proceeding in any state or Federal court arising out of the any alleged act or omission which occurred or is said to have occurred while the state employee, or officer was acting within the scope of his/her public employment or duties carried out on behalf of the state.
2.15 Review of IRB Member Performance

Annually, the following will be conducted:

- The IRB members are surveyed for feedback on the Chair of their committee.
- The Chairs provide feedback on the members of their committee.
- The IRB Staff provides feedback on the IRB members and Chairs.

The IO or designee takes the information above, along with attendance data, and writes an evaluation for each member and chair which is shared with them. The correspondence will either thank them for their continued service, or serve as notice that their services will not be necessary moving forward.

IRB members who are not acting in accordance with the University mission or its policies and procedures may be removed outside of the formal annual evaluation process.

The IRB members who are also IRB staff are annually evaluated by the AVP-RC in accordance with Section 1.11.2.

2.16 Reporting and Investigation of Allegations of Undue Influence

If an IRB Chair, member, or staff person feels unduly influenced by any party, they are to make a confidential report to the IO or AVP-RC, depending on the circumstances. The official receiving the report will conduct a thorough investigation and corrective action will be taken to prevent additional occurrences.

3 IRB Review Process

3.1 Policy

All human subjects research conducted under the auspices of the University must meet the criteria for one of the following methods for review:

- Exempt
- Expedited Review
- Full Committee Review

The IRB will ensure that the research meets all required ethical and regulatory criteria for initial and continuing review and any modifications of approved research.

The following describe the procedures required for the review of research by the IRB.
3.2 Definitions

**Minimal Risk:** the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

**Minor Change:** a change, in the judgment of the IRB reviewer, which makes no substantial alteration in:

- Level of risks to subjects
- Research design or methodology (adding procedures that are not eligible for expedited review [See Section 3.6] would not be considered a minor change)
- Number of subjects enrolled in the research
- Qualifications of the research team
- Facilities available to support safe conduct of the research
- Any other factor which would warrant review of the proposed changes by the convened IRB.

**Quorum:** consists of a simple majority of the voting membership, including at least one member whose primary concern is in a non-scientific area. If research involving an FDA-regulated article is involved, a licensed physician must be included in the quorum.

**Suspension of IRB approval:** a directive of the convened IRB or other authorized individual (See Section 3.11) to temporarily stop some or all previously approved research activities short. Suspended protocols remain open and require continuing review.

**Termination of IRB approval:** a directive of the convened IRB to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review.

3.3 Electronic Management System

The University uses an electronic management system for administration and management of its IRBs. This system provides electronic management of protocols and documents; on-line submissions; web-based protocol sharing and collaboration; automatic notifications; the furnishing of electronic signatures; event tracking; and other important electronic features. The University began requiring electronic protocol submissions effective December 2007. All protocols, including revisions and renewals, must be submitted electronically via the electronic management system, and all review decision notifications are issued electronically via the electronic management system. Instructions for the use of this system are located on the ORC website.
3.4 Human Subjects Research Determination

Some University activities involve people (e.g., academic classroom activities, hospital quality assurance/quality improvement [QA/QI] etc.) but that does not mean that it falls under the category of human subjects research.

The responsibility for initial determination as to whether an activity constitutes human subjects research rests with the investigator. The investigator should make this determination based on the definitions of “human subject” and “research” in Section 1.4. Since the University will hold them responsible if the determination is not correct, investigators are urged to request a confirmation that an activity does not constitute human subjects research from the ORC. The request should be made with the electronic management system. All requests must include sufficient documentation of the activity to support the determination.

In response to investigator requests, determinations that an activity does not constitute human subjects research will documented according to the definitions in Section 1.4 using the Human Subjects Research Determination Checklist. For activities determined to constitute human subjects research, the investigator will be instructed to commence with the exemption or IRB application process, as applicable.

Note: The University has a policy regarding the distinction between QA/QI initiatives and research activities. Section 17.1 “Quality Assurance/Quality Improvement (QA/QI) Activities vs. Research Activities” should be reviewed for details.

3.5 Exempt Studies

All research using human subjects must be approved by the University. Certain categories of research (i.e., “exempt research”) do not require convened IRB review and approval. Exempt research is subject to University review, conducted by ORC staff.

Reviewers will use the Reviewer Exemption Determination Checklist to determine and document whether the protocol meets the exemption criteria.

The exemption is valid for three years or when the project changes in any way (therefore requiring amendment) whichever comes first. Exemption renewal notices are generated by the electronic management system and if the research is expected to extend beyond that expiration date, the investigator must request another exemption. Investigators must communicate to ORC any changes proposed during the conduct of the activity so that it may be reviewed to determine if the exemption still applies. Decisions regarding exemption determination will be provided in writing to the investigator. Documentation will include the specific category/categories justifying the exemption.
3.5.1 Limitations on Research Subjects:

Vulnerable Populations:

**Children:** Exemption for research involving survey or interview procedures or observations of public behavior does NOT apply, except for research involving observations of public behavior when the investigator does not participate in the activities being observed.

**Prisoners:** exemptions do NOT apply. IRB review is required.

3.5.2 Categories of Exempt Research

With the above exceptions, research activities:

1. That involve no foreseeable risk, and
2. Are not regulated by the FDA (see Section 3.5.3 for FDA Exemptions), and
3. Where the only involvement of human subjects will be in one or more of the following categories are exempt from IRB review, but none-the-less require University review (via Staff in the Office of Research Compliance):

   **Note:** See also Special Topics Section 17.2 *(Data/Tissue Registries/Banks)* and 17.5 *(Guidance on Research (only) Involving Coded Private Information or Biological Specimens)* for information that may be relevant to the activity in question.

- Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as
  a) Research on regular and special education instructional strategies, or
  b) Research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
- Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
  a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
  b) Any disclosure of the human subjects’ responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subject’s financial standing, employability, or reputation.
- Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (2), if:
  a) The human subjects are elected or appointed public officials or candidates for public office; or
  b) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
• Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. \textit{Note: In order to be eligible for this exemption, all of the materials have to exist at the time the research is proposed.}

• Research and demonstration projects which are conducted by or subject to the approval of federal department or agency heads, and which are designed to study, evaluate, or otherwise examine:
  a) Public benefit or service programs;
  b) Procedures for obtaining benefits or services under those programs;
  c) Possible changes in or alternatives to those programs or procedures; or
  d) Possible changes in methods or levels of payment for benefits or services under those programs.
  e) The program under study must deliver a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older Americans Act).
  f) The research or demonstration project must be conducted pursuant to specific federal statutory authority, there must be no statutory requirements for IRB review, the research must not involve significant physical invasions or intrusions upon the privacy of subjects and the exemption must be invoked only with authorization or concurrence by the (external) funding agency.

• Taste and food quality evaluation and consumer acceptance studies:
  If wholesome foods without additives are consumed; or If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the FDA or approved by the EPA or the FSIS of the USDA. \[21 \text{CFR 56.104(d)}\]

\subsection*{3.5.3 Food and Drug Administration (FDA) Exemptions}

The following categories of clinical investigations are exempt from the requirements of prior IRB review:

• Emergency use of a test article, provided that such emergency use is reported to the IRB within 5 working days. Any subsequent use of the test article at the University is subject to the IRB review. \[21 \text{CFR 56.104(c)}\]

\textit{Note: See Section 7.3 (FDA Exemptions) for a detailed discussion of this exemption.}

• Taste and food quality evaluations and consumer acceptance studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or below the level found to be safe, by the FDA or approved by the EPA or the FSIS of the USDA. \[21 \text{CFR 56.104(d)}\]
3.5.4 Additional Protections

Although exempt research is not covered by the federal regulations, this research is not exempt from the ethical guidelines of the Belmont Report. The individual making the determination of exemption will determine whether to require additional protections, including requiring informed consent, for subjects in keeping with the guidelines of the Belmont Report.

3.5.5 Materials to be Submitted for IRB Review of Exemption Request

The following materials will be completed/submitted via the electronic management system:

- Application
- Study Protocol
- Informed consent documents, as applicable
- HIPAA relevant forms (see Section 16)
- Recruitment materials/subject information
- Data collection instruments (including all surveys and questionnaires)
- Supplemental forms as applicable (e.g., international research, minors etc.)
- Grant (if funded, or seeking funding)
- University Hospital Approval form (if applicable)

The application package must be electronically signed and dated by the responsible principal investigator and the departmental/departmental review committee chair in order for the package to be reviewed. If the activity will impact another department (e.g., use of their resources, i.e., facilities, patient populations, faculty, and/or staff, etc.), electronic signature of that department’s chair is required as well.

The primary reviewer for the submission will be one or more IRB Administrators/Assistants within the ORC. Investigators will receive feedback via the electronic management system regarding the results of review. Possible determinations include Approved (for exemption status), Modifications required (in order to secure exemption status), or Not Approved (letter from ORC would either clarify that the study is not acceptable to conduct at the University, or the study does not qualify for exemption status, i.e., activity requires either expedited or full committee review).

3.6 Expedited Review

The IRB may use the expedited review procedure to review either or both of the following:

1. Some or all of the research appearing on the list of categories of research eligible for expedited review and found by the reviewer(s) to involve no more than minimal risk.
2. Minor changes (as defined in Section 3.2) in previously approved research during the period (of one year or less) for which approval is authorized.
3.6.1 Categories of Research Eligible for Expedited Review

[63 FR 60364-60367, November 9, 1998]

The activities listed below should not be deemed to be of minimal risk simply because they are included on this list. Inclusion on this list merely means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimal risk to human subjects.

The categories in this list apply regardless of the age of subjects, except as noted.

1. The expedited review procedure may not be used:
   - Where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
   - For classified research involving human subjects.

2. The standard requirements for informed consent (or its waiver, alteration, or exception) apply regardless of the type of review-expedited or convened-utilized by the IRB.

Research Categories one (1) through seven (7) pertain to both initial and continuing IRB review:

**Note:** See also Special Topics Section 17.2 *(Data/Tissue Registries/Banks)* and 17.5 *(Guidance on Research (only) Involving Coded Private Information or Biological Specimens)* for information that may be relevant to the activity in question.

1. Clinical studies of drugs and medical devices only when condition (a) or (b) is met:
   a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)
   b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
   a) From healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an eight (8) week period and collection may not occur more frequently than two (2) times per week; or
   b) From other adults and children*, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml.
per kg in an eight (8) week period and collection may not occur more frequently than two (2) times per week.

[*Children are defined in the DHHS regulations as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted."][45 CFR 46.402(a)]

3. Prospective collection of biological specimens for research purposes by noninvasive means.

Examples: (a) hair and nail clippings in a non-disfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) un-cannulated saliva collected either in an unstimulated fashion or stimulated by chewing gum base or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

4. Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).

Examples: (a) physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject’s privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

5. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).

**Note:** Some research in this category may be exempt from the DHHS regulations for the protection of human subjects. See Exempt Categories and 45 CFR 46 101(b)(4). This listing refers only to research that is not exempt.

6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

**Note:** Some research in this category may be exempt from the DHHS regulations for the protection of human subjects. See Exempt Categories and 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.

8. Continuing review of research previously approved by the convened IRB as follows:
   a) Where:
      i) the research is permanently closed to the enrollment of new subjects;
      ii) all subjects have completed all research-related interventions; and
      iii) the research remains active only for long-term follow-up of subjects; or
   b) Where no subjects have been enrolled and no additional risks have been identified; or
   c) Where the remaining research activities are limited to data analysis.

   **Note:** Category (8) identifies three situations in which research that is greater than minimal risk and has been initially reviewed by a convened IRB may undergo subsequent continuing review by the expedited review procedure.

   [For a multi-site protocol, an expedited review procedure may be used by the IRB at a particular site whenever the conditions of category (8)(a), (b), or (c) are satisfied for that site. However, with respect to category 8(b), while the criterion that "no subjects have been enrolled" is interpreted to mean that no subjects have ever been enrolled at a particular site, the criterion that "no additional risks have been identified" is interpreted to mean that neither the investigator nor an IRB at a particular site has identified any additional risks from any site or other relevant source.]

9. Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

   Under Category (9), an expedited review procedure may be used for continuing review of research not conducted under an investigational new drug application or investigational device exemption where categories (2) through (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified. The determination that "no additional risks have been identified" does not need to be made by the convened the IRB.

### 3.6.2 Materials to be Submitted for IRB Expedited Review

The following summarizes the document requirements for submission to the IRB:
For initial submissions:
Registration Form and /or* Application
Study protocol
Consent/permission/assent documents
Recruitment materials
Data collection sheets (e.g., spreadsheets, case report forms)
Surveys, questionnaires
Grant (if funded, or seeking funding)
As applicable:
  Supplemental Forms:
    ▪ A: Pregnant Women, Fetuses, Non and Questionably Viable Neonates
    ▪ B: Prisoners
    ▪ C: International Research
    ▪ D: ICH-GCP
    ▪ E: Minors
    ▪ G: Consent Waivers

HIPAA forms
University Hospital Approval form
Protocol Review Committee (PRC) Approval (oncology studies only)
Fee authorization form (for industry studies going to CRRI)
Scientific merit review (for industry studies going to CRRI or NCI CIRB)
Inclusion/exclusion checklist (if requested by IRB reviewer)

For continuing review submissions:
Registration Form and /or* Application
Study protocol
Recruitment materials
Redacted consent/permission/assent documents of last subject enrolled
As applicable:
  ▪ Data safety monitoring board reports
  ▪ Gov’t or sponsor audit/monitoring reports
  ▪ Clean, current Inclusion/exclusion checklist (if requested by IRB reviewer)
  ▪ Redacted I/E checklist of last subject enrolled (If study was approved with one)

*depending on active electronic submission system

Prior to access of materials by the IRB members, IRB staff will verify that the application package is electronically signed by the responsible principal investigator and the departmental/departamental review committee chair; If the activity will impact another department (through use of their resources, e.g., facilities, patient populations, faculty, and/or staff, etc.) e-signature of that department’s chair will be required as well.

The determination of which committee receives an initial study for expedited review is made by the IRB staff on an alternating basis.
3.6.3 Expedited Review Procedures

Under an expedited review procedure, the review may be carried out by one or more reviewers designated by the IRB Administrators/Assistants, on behalf of the chairs, from among members of the IRB. Selected reviewers will be knowledgeable of the requirements to approve research under expedited review. IRB members with a conflict of interest in the research (see Section 2.9) will not be selected. Only members who have been voting members for at least 3 months are eligible to conduct expedited review, under the initial tutelage of IRB staff.

When reviewing initial or continuing research under an expedited review procedure, the designated IRB member(s), will have access to all submitted documentation, as well as pre-review comments from the IRB staff, and, in the case of a continuing review, all study history, which resides in the electronic management system.

In reviewing initial, or continuing research, the reviewers will follow the Review Procedures described in Sections 3.8 and 3.9 and may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may only be disapproved by the IRB following review at a convened meeting.

Reviewers will use the CORIHS Reviewer Checklist as an aid to complete the IRB Member Worksheet(s) for EXPEDITED REVIEWS, including assessment that the regulatory criteria necessary for expedited review and IRB approval have all been met, and indicate approval, required modifications or ‘deferred to full committee’. The Worksheet will be retained within the electronic management system to ensure documentation of regulatory determinations. The IRB Administrators/Assistant will draft an applicable letter and post it, along with associated documents (e.g., track-changed consent forms, etc.), within the electronic management system.

Investigators are notified by the electronic management system when an action is taken on a study. If the modifications are prescriptive, the IRB Staff, as IRB members, may serve as final reviewers to determine if the investigator has satisfied the conditions for approval. If the modifications are substantive, if the reviewer(s) request it, or if the IRB Staff deem it necessary, the modified submission will be sent back to the IRB member(s) for further review. If the reviewer determines that the research does not meet the criteria for expedited review (or for any other reason), then the reviewer will indicate that the research requires full review by the IRB and the study will be placed by the IRB Staff on the next available agenda for an IRB meeting.

3.6.4 Informing the IRB

All members of the IRB will be apprised of all expedited review approvals by means of a list in the agenda for the next scheduled meeting. Any IRB member can request to review the full protocol by contacting the ORC.
3.7 Convened IRB Meetings

Except when an expedited review procedure is used, the IRB will conduct initial and continuing reviews of all research at convened meetings at which a quorum (see below) of the members is present.

3.7.1 IRB Meeting Schedule

Each of the two IRBs meets monthly throughout the year. The meeting schedule for the IRBs may vary due to holidays or lack of quorum. The schedule of meeting deadlines and meeting dates is available on the ORC website.

Special meeting can be called at any time by the IRB Chair, the AVP-RC, or the IO.

3.7.2 Preliminary Review

ORC staff will perform a preliminary review of all study materials submitted for IRB review for determination of completeness, accuracy, special regulatory considerations, and required electronic signatures (department chair, principal investigator). Only complete submissions will be placed on an IRB agenda for review. The investigator will be notified of missing information through the electronic management system.

3.7.3 Primary and Secondary Reviewers

After it has been determined that the research study submission is complete, the IRB Staff will assign the research study to reviewers paying close attention to the scientific content of the protocol, the potential reviewer’s area of expertise, and ensuring, where applicable, that a scientific and non-scientific perspective is represented. Two reviewers will be assigned to each initial or continuing protocol and a reviewer may be assigned several protocols or other research items for review (generally, one reviewer is assigned to a protocol brought to committee for a modification/amendment review). When the IRB is presented with a protocol that may be outside of the knowledge base of any of the IRB members, an outside consultant will be sought. (See item 2.4.3 above)

Protocols for which appropriate expertise cannot be obtained for a given meeting will be tabled and moved to a subsequent meeting agenda.

The primary and secondary reviewers are responsible for:

1. Having a thorough knowledge of all of the details of the proposed research.
2. Performing an in-depth review of the proposed research.
3. Leading the discussion of the proposed research at the convened meeting, presenting both positive and negative aspects of the research, and leading the IRB through the regulatory criteria for approval (See Section 3.8).
4. Making suggestions for changes to the proposed research, where applicable.
5. Completing all applicable IRB reviewer forms.
If both the primary and secondary reviewer are absent from the meeting, consensus shall be taken to determine if the study in question must be tabled for a review at a future meeting, or if the present members have sufficient information and expertise, then review will proceed. Additionally, an absent reviewer can submit their written comments for presentation at the convened meeting, as long as there is another reviewer present at the convened meeting, who can serve as the primary reviewer. It should be noted that all of the IRB members receive and are expected to review all studies, not just the ones they for which they are assigned as primary or secondary reviewer.

3.7.4 Pre-Meeting Distribution of Documents

The study, including all required materials, needs to be submitted by the deadline for a particular meeting for inclusion on the applicable IRB agenda. The meeting agenda will be prepared by the IRB Staff and made available to the IRB members via the electronic management system prior to the meeting. All IRB members receive access to meeting protocol review materials, no later than five (5) business days before the scheduled meeting to allow sufficient time for the review process. Prior month’s meeting minutes, applicable business items and audits, and appropriate continuing education materials will be made available to the members as far ahead of the meeting as possible.

3.7.4.1 Investigator Contact Before the Meeting

To improve efficiencies and communication between the IRB and investigators, the IRB members are strongly encouraged to contact PIs with questions and clarifications ahead of the meeting in order to facilitate the review process, and decrease the probability of a deferral or disapproval determination.

3.7.5 Materials to be Submitted for IRB Full Committee Review

Each IRB member will be given access to all submission materials for all studies on the agenda:

The following checklists summarize the document requirements for submission to the IRB:

For initial submissions:

Registration Form and /or* Application
Study protocol
Consent/permission/assent documents
Recruitment materials
Data collection sheets (e.g., spreadsheets, case report forms)
Surveys, questionnaires
Grant (if funded, or seeking funding)
As applicable:

Supplemental Forms:
- A: Pregnant Women, Fetuses, Non and Questionably Viable Neonates
- B: Prisoners
- C: International Research
- D: ICH-GCP
- E: Minors
- G: Consent Waivers

HIPAA forms
University Hospital Approval form
Protocol Review Committee (PRC) Approval (oncology studies only)
Fee authorization form (for industry studies going to CRRI)
Scientific merit review (for industry studies going to CRRI or NCI CIRB)
Inclusion/exclusion checklist
Package inserts for approved drugs/devices
Investigator brochures for investigational drugs/devices

For continuing review submissions:

Registration Form and /or* Application
Study protocol
Recruitment materials
Redacted consent/permission/assent documents of last subject enrolled
  - Inclusion/exclusion checklist (clean, current)
  - Redacted I/E checklist of last subject enrolled
As applicable:
  - Data safety monitoring board reports
  - Gov’t or sponsor audit/monitoring reports

*depending on active electronic submission system

Prior to sharing submission materials with the IRB members, IRB staff will verify that the application package is electronically signed by the responsible principal investigator, and the departmental/departmental review committee chair. If the activity will impact another department’s resources (e.g., use of their facilities, patient populations, faculty, and/or staff, etc.), electronic signature of that department’s chair will be required as well.

Although the electronic management system permits all IRB members to review all materials submitted for review, the primary and secondary reviewers must review: any relevant grant applications; the sponsor’s protocol (when one exists); the investigator’s brochure (when one exists); the DHHS-approved sample informed consent document (when one exists); the complete DHHS-approved protocol (when one exists).

Reviewers will use the CORIHS Reviewer Checklist as an aid in completing the IRB Member Worksheet(s) for FULL COMMITTEE REVIEW.
3.7.6 Quorum

A quorum consists of a simple majority (more than half) of the voting membership, including at least one member whose primary concern is in a non-scientific area. If research involving an FDA-regulated article is involved, a licensed physician must be included in the quorum. The IRB Chair, with the assistance of the IRB staff, will confirm that an appropriate quorum is present before calling the meeting to order. The IRB staff will be responsible for ensuring that the meetings remain appropriately convened.

A quorum must be maintained for each vote to occur. The IRB staff takes note of arrivals and departures of all members and notifies the chair if a quorum is not present. If a quorum is not maintained for reasons relating to an IRB member’s recusal due to COI, the individual proposal must be tabled. If quorum is lost for the remaining duration of the meeting, the meeting must therefore be terminated.

IRB members are considered present if participating through teleconferencing or videoconferencing. In this case, the IRB member must have received all pertinent material prior to the meeting and must be able to participate actively and equally in all discussions.

Opinions of absent IRB members that are transmitted by mail, telephone, facsimile, or e-mail may be considered by the attending IRB members but may not be counted as votes or to satisfy the quorum for convened meetings.

It is generally expected that at least one unaffiliated member and at least one member who represents the general perspective of subjects (the same individual can serve in both capacities) will be present at all IRB meetings. Although the IRB may (on occasion) meet without this representation, a best effort will be made to make sure that individuals serving in this capacity will be present for at least 80% of the IRB meetings.

3.7.7 Meeting Procedures

The IRB Chair, or designee in the event that the IRB Chair is absent, will call the meeting to order, once it has been determined that a quorum is in place. The IRB will review and discuss the IRB minutes from the prior meeting and determine if there are any revisions/corrections to be made. Vote will be taken to consider the minutes either approved as written, approved pending minor revisions as addressed, or deferred pending significant revisions (the latter being brought to the subsequent convened meeting for vote).

The IRB reviews all submissions for initial and continuing review, as well as requests for modifications. The primary and secondary reviewers present an overview of the research and lead the IRB through the completion of the regulatory criteria for approval in the CORIHS Approval Criteria Worksheet, and other determinations that must be found and documented. When a study is funded by the Department of Defense, the ORC staff will review with the members the required information
contained within the ‘Meeting FINAL Determination: SUPPLEMENT: DOD’, and complete the document to confirm compliance with Department of Defense Instruction 3216.02.

All members present at a convened meeting have full voting rights, except in the case of a conflict of interest (see Section 2.9). Where an IRB member and his/her alternate are both present, only the IRB member has voting rights. In order for the research to be approved, it must receive the approval of a majority of those voting members present at the meeting.

It is the responsibility of the ORC staff to record final meeting determinations for each reviewed study at the meeting. This is accomplished via the minutes and Final Meeting Determination forms that are uploaded in support of the minutes.

3.7.8 Guests

At the discretion of the IRB, the principal investigator may be invited to the IRB meeting to answer questions about their proposed or ongoing research. The principal investigator and/or members of the study team may not be present for the discussion or vote on their research.

Ex-officio guests are individuals who, by virtue of their position and their role in the HRPP, regularly attend IRB meetings. Examples of ex-officio guests include IRB staff who are not IRB members, the AVP-RC, and the IO. Ex-officio guests may fully participate in the IRB discussion and deliberations, but may not vote.

Other guests may be permitted to observe IRB meetings at the discretion of the IRB Chair, AVP-RC, or the IO.

3.8 Criteria for IRB Approval of Research

In order for the IRB to approve human subject research, it must determine that the following requirements are satisfied:

1. Risks to subjects are minimized: (i) by using procedures, which are consistent with sound research design and which, do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.
2. Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.
3. Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted and should be particularly cognizant of the special problems of research involving vulnerable populations, such as
children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.

4. Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by 45 CFR 46.117.

5. Informed consent will be appropriately documented, in accordance with, and to the extent required by 45 CFR 46.117.

6. When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

7. When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

8. When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

3.8.1 Risk/Benefit Assessment

The goal of the assessment is to ensure that the risks to research subjects posed by participation in the research are justified by the anticipated benefits to the subjects or society. Toward that end, the IRB must:

1. Where the risk is deemed more than minimal, judge whether the anticipated benefit, either of new knowledge or of improved health for the research subjects, justifies asking any person to undertake the risks,

2. Not approve research in which the risks are judged unreasonable in relation to the anticipated benefits.

The assessment of the risks and benefits of proposed research - one of the major responsibilities of the IRB - involves a series of steps:

1. Identify the procedures being conducted specifically for research;

2. Identify the risks associated with the research procedures, as distinguished from the risks of therapies the subjects would receive even if not participating in research;

3. Determine whether the risks will be minimized to the extent possible;

4. Identify the probable benefits to be derived from the research;

5. Determine whether the risks are reasonable in relation to the benefits to subjects, if any, and assess the importance of the knowledge to be gained;

6. Ensure that potential subjects will be provided with an accurate and fair description of the risks or discomforts and the anticipated benefits.

Risks to subjects are minimized:

1. By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk; and
2. Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

Risks to subjects are reasonable in relation to anticipated benefits, if any, and to the importance of the knowledge that may reasonably be expected to result.

In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research.

The IRB should not consider possible long-range effects of applying knowledge gained in the research (e.g., the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.

3.8.1.1 Scientific Merit

In order to assess the risks and benefits of the proposed research, the IRB must determine that:

- The research uses procedures consistent with sound research design;
- The research design is sound enough to reasonably expect the research to answer its proposed question; and
- The knowledge expected to result from this research is sufficiently important to justify the risk.

In making this determination, the IRB draws upon (a) its own knowledge and disciplinary expertise, and (b) the knowledge and disciplinary expertise of others, such as departmental level review by chair or review committee (via e-signature on the submission to the IRB), and/or the peer review process of funding agencies.

Prior to the IRB review of new and continuing protocol applications, as well as major amendments, institutional scientific review is documented by the e-signature of the administrative official responsible for the investigator’s research unit.

3.8.2 Selection of Subjects is Equitable.

The IRB determines by reviewing the application, protocol and other submission materials that the selection of subjects is equitable with respect to gender, age, class, etc. The IRB will not approve a study that does not provide adequately for the equitable selection of subjects or has not provided an appropriate scientific and ethical justification for excluding classes of persons who might benefit from the research.

In making this determination, the IRB evaluates: the purposes of the research; the setting in which the research occurs; scientific and ethical justification for including vulnerable populations such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally
disadvantaged persons; the scientific and ethical justification for excluding classes of persons who might benefit from the research; and the inclusion/exclusion criteria.

At the time of the continuing review, the IRB will determine that the PI has followed the subject selection criteria that he/she originally set forth at the time of the initial the IRB review and approval.

3.8.2.1 Recruitment of Subjects

A study’s recruitment plan and all study recruitment materials must be reviewed and approved by the IRB prior to use. The recruitment plan submitted to the IRB should be detailed with respect to media to be used (e.g. flyer, newspaper, video, radio etc.), location (e.g., specific sites named, on or off campus) and process (i.e., under what conditions will subjects be approached? etc.). When drafting the plan, the investigator must be aware of special approvals that may be required at sites she/he wishes to include in the recruitment plan. These approvals should be submitted for the IRB file.

It is the policy of the HRPP that when recruiting patients as potential subjects, first contact must be made by someone who has a relationship (e.g., treatment etc.) with the patient: When patients come to our hospital, they come for clinical reasons. It is therefore respectful to them to ensure to when they are initially approached for about research, it is by someone who 'makes sense' to be approaching them, i.e., someone who has some type of relationship with them from their 'clinical world'. This policy protects the patient’s right to privacy. See SOPs section 16.4.2. for a recruitment method that is HIPAA compliant with respect to this right to privacy.

Stony Brook participates in “ResearchMatch”, a national research volunteer registry. Details for use of this recruitment tool are available in Section 17.13.

NOTE: See Section 3.9.7 for a discussion of the IRB review of advertisements, and Section 3.9.8 for a discussion of the IRB review of payments.

3.8.3 Informed Consent

The IRB will ensure that informed consent will be sought from each prospective subject or the subject’s legally authorized representative, in accordance with, and to the extent required by 45 CFR 46.116 and 21 CFR 50.20 (when applicable). In addition, the IRB will ensure that informed consent will be appropriately documented in accordance with, and to the extent required by 45 CFR 46.117 and 21 CFR 50.27 (when applicable). See Section 5 below for detailed policies on informed consent.

3.8.4 Data Safety Monitoring

For all research that is more than minimal risk, the investigator must submit a data safety-monitoring plan. The initial plan submitted to the IRB should describe the procedures for safety monitoring, reporting of adverse events and/or unanticipated problems involving risks to subjects or others, descriptions of interim safety reviews and the procedures planned for transmitting the results to the IRB. This description should include information regarding an independent Data and Safety Monitoring
Board (DSMB), if one exists, or an explanation why an independent data safety monitor is not necessary.

The IRB determines whether the data safety-monitoring plan makes adequate provision for monitoring the data to ensure the safety of subjects. The overall elements of the monitoring plan may vary depending on the potential risks, complexity, and nature of the research study. The method and degree of monitoring needed is related to the degree of risk involved. Monitoring may be conducted in various ways or by various individuals or groups, depending on the size and scope of the research effort. These exist on a continuum from monitoring by the principal investigator in a small phase I study to the establishment of an independent data and safety monitoring board for a large phase III clinical trial.

The factors the IRB will consider in determining whether the safety-monitoring plan is adequate for the research are as follows:

1. Monitoring is commensurate with the nature, complexity, size and risk involved.
2. Monitoring is timely. Frequency should commensurate with risk. Conclusions are reported to the IRB.
3. For low risk studies, continuous, close monitoring by the study investigator or an independent individual may be an adequate and appropriate format for monitoring, with prompt reporting of toxicity to the IRB, sponsor and regulatory bodies as appropriate. For an individual Safety Monitor the plan must include:
   - Parameters to be assessed;
   - Mechanism to assess the critical efficacy endpoints at intervals in order to determine when to continue, modify, or stop a study;
   - Frequency of monitoring; and
   - Procedures for reporting to the IRB.
4. For a Data Safety Monitoring Board, the plan must include:
   - The name of the Data Safety Monitoring Board;
   - Where appropriate, independent status from the sponsor;
   - Availability of written reports;
   - Composition of the monitoring group (if a group is to be used): experts in all scientific disciplines needed to interpret the data and ensure patient safety. Clinical trial experts, biostatisticians, bioethicists, and clinicians knowledgeable about the disease and treatment under study should be part of the monitoring group or be available if warranted;
   - Frequency and content of meeting reports;
   - The frequency and character of monitoring meetings (e.g., open or closed, public or private);

In general, it is desirable for a Data and Safety Monitoring Board (DSMB) to be established by the study sponsor for research that is blinded, involves multiple sites, involves vulnerable subjects, or employs high-risk interventions. For some studies, the National Institutes of Health (NIH) require a DSMB. The
IRB has the authority to require a DSMB as a condition for approval of research where it determines that such monitoring is needed. When DSMBs are utilized, the IRB conducting continuing review of research may rely on a current statement from the DSMB indicating that it has and will continue to review study-wide AEs, interim findings, and any recent literature that may be relevant to the research, in lieu of requiring that this information be submitted directly to the IRB.

3.8.5 Privacy and Confidentiality

The IRB will determine whether adequate procedures are in place to protect the privacy of subjects and to maintain the confidentiality of the data.

Definitions

Privacy: having control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others.

Confidentiality: methods used to ensure that information obtained by investigators about their subjects is not improperly divulged.

Private information: provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).

Identifiable information: where the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

3.8.5.1 Privacy

The IRB must determine whether the activities in the research constitute an invasion of privacy. In order to make that determination, the IRB must obtain information regarding how the investigators are getting access to subjects or subjects’ private, identifiable information and the subjects’ expectations of privacy in the situation. Investigators must have appropriate authorization to access the subjects or the subjects’ information.

In developing strategies for the protection of subjects’ privacy, consideration should be given to:

1. Methods used to identify and contact potential subjects.
2. Settings in which an individual will be interacting with an investigator.
3. Appropriateness of all personnel present for research activities.
4. Methods used to obtain information about subjects and the nature of the requested information.
5. Information that is obtained about individuals other than the “target subjects,” and whether such individuals meet the regulatory definition of “human subject” (e.g., a subject provides information about a family member for a survey).
6. How to access the minimum amount of information necessary to complete the study.
3.8.5.2 Confidentiality

Confidentiality and anonymity are not the same. If anyone, including the investigator, can readily ascertain the identity of the subjects from the data, then the research is not anonymous and the IRB must determine if appropriate protections are in place to minimize the likelihood that the information will be inappropriately divulged. The level of confidentiality protections should be commensurate with the potential of harm from inappropriate disclosure.

At the time of initial review, the IRB ensures that the confidentiality of research subject data is protected. The IRB assesses whether there are adequate provisions to maintain confidentiality. The IRB does this through the evaluation of the methods used to obtain information:

1. About subjects;
2. About individuals who may be recruited to participate in studies;
3. The use of personally identifiable records; and
4. The methods to protect the confidentiality of research data.

The PI will provide the information regarding confidentiality of research subjects at the time of initial review through the completion of the application, any necessary HIPAA Forms, research protocol, and/or other submitted, applicable materials. The IRB will review all information received from the PI and determine whether or not confidentiality of research subject data is sufficiently protected. In some cases, the IRB may also require that a Certificate of Confidentiality be obtained to additionally protect research data.

In reviewing confidentiality protections, the IRB shall consider the nature, probability, and magnitude of harms that would be likely to result from a disclosure of collected information outside the research. It shall evaluate the effectiveness of proposed de-identification techniques, coding systems, encryption methods, storage facilities, access limitations, and other relevant factors in determining the adequacy of confidentiality protections.

3.8.6 Vulnerable Populations

At the time of initial review, the IRB will consider the scientific and ethical reasons for including vulnerable subjects in research. The IRB may determine and require that, when appropriate, additional safeguards are put into place for vulnerable subjects, such as those without decision-making capacity. The adequacy of those safeguards will be confirmed at the time of continuing review.

For an extensive discussion about the IRB’s review and approval process for individual populations of vulnerable subjects, please refer to Section 6.

3.9 Additional Considerations during IRB Review and Approval of Research

3.9.1 Determination of Risk
At the time of initial and continuing review, the IRB will make a determination regarding the risks associated with the research protocols. Risks associated with the research will be classified as either “minimal” or “greater than minimal” based on the “absolute” interpretation of minimal risk. The meeting minutes will reflect the IRB’s determination regarding risk levels. If risk is deemed minimal, The IRB will additionally vote to determine if subsequent review of the study may be conducted via the expedited review process.

3.9.2 Period of Approval

At the time of initial review and at continuing review, the IRB will make a determination regarding the frequency of review of the research protocols. All protocols will be reviewed by the IRB at intervals appropriate to the degree of risk but no less than once per year. In some circumstances, a shorter review interval (e.g. biannually, quarterly, or after accrual of a specific number of subjects) may be required (see below). The meeting minutes will reflect the IRB’s determination regarding review frequency.

3.9.2.1 Review More Often Than Annually

Certain variables may be considered by the IRB in determining those studies that require review more often than annually. For example:

- Significant risk to research subjects (e.g. death, permanent or long lasting disability or morbidity, severe toxicity) without the possibility of direct benefit to the subjects;
- The inclusion of significantly vulnerable populations where, even in the presence of possible direct benefit, there is also a possibility of significant risk associated with the research procedures.
- A history of serious or continuing non-compliance on the part of the PI.
- The likely medical condition of the proposed subjects.
- The novelty of the research making unanticipated adverse events more likely.
- Any other factors that the IRB deems relevant.

In specifying an approval period of less than one year, IRB may define the period with either a time interval or a maximum number of subjects to be either studied or enrolled. If a maximum number of subjects studied or enrolled is used to define the approval period, it is understood that the approval period in no case can exceed one (1) year and that the number of subjects studied or enrolled determines the approval period only when that number of subjects is studied or enrolled in less than one (1) year.

3.9.3 Independent Verification That No Material Changes Have Occurred

The IRB recognizes that protecting the rights and welfare of subjects sometimes requires that the IRB verify independently, utilizing sources other than the investigator, that no material changes occurred during the IRB designated approval period. Independent verification from sources other than the investigator may be necessary at times, for example, in cooperative studies or other multi-center research.
The IRB will determine the need for verification from outside sources on a case-by-case basis using such variables as, for example:

1. Protocols where concern about possible material changes occurring without the IRB approval have been raised based on information provided in continuing review reports or from other sources.
2. Protocols conducted by Principal Investigators who have previously failed to comply with federal regulations and/or the requirements or determinations of the IRB.
3. Protocols randomly selected for internal audit.
4. Whenever else the IRB deems verification from outside sources is relevant.

If any material changes have occurred without IRB review and approval, the IRB will assess the issue in accordance with procedures for noncompliance detailed in Section 10.

3.9.4 Consent Monitoring

In reviewing the adequacy of informed consent procedures, the IRB routinely monitors consent processes of approved studies (see Section 5.9 for details). It may also, on occasion, determine that special monitoring of the consent process by an impartial observer (consent monitor) is required in order to reduce the possibility of coercion and undue influence.

Such monitoring may be particularly warranted where the research presents significant risks to subjects, or if subjects are likely to have difficulty understanding the information to be provided. Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular investigator or a research project.

See Section 5.9 for a detailed discussion of consent monitoring.

3.9.5 Investigator Conflicts of Interest

All investigators are informed of University Policy P209 and disclosures that must be completed for all investigators on the study. Where disclosure is made that an investigator has significant financial interests, the IRB and the University COI Committee will each independently assess the existence of a financial conflict of interest, and if yes, whether or not the conflict can be managed, in accordance with PHS policy. The IRB’s contribution to a resulting conflict management plan will specifically focus on the protection of human subjects. Where there is a conflict between the IRB and COI committees regarding the adequacy of a particular management plan, the IRB decision will be final. (See Section 14 for a detailed discussion of Conflict of Interest).

3.9.6 Significant New Findings

During the course of research, significant new knowledge or findings about the medication or test article and/or the condition under study may develop. The PI must report any significant new findings to the IRB and the IRB will review them with regard to the impact on the subjects’ rights and welfare. Since the new knowledge or findings may affect the risks or benefits to subjects or subjects'
willingness to continue in the research, the IRB may require, during the ongoing review process, that
the PI contact the currently enrolled subjects to inform them of the new information via a consent
addendum. The IRB will communicate this to the PI. The informed consent should be updated and the
IRB may require that the currently enrolled subjects be re-consented, acknowledging receipt of this
new information and for affirming their continued participation.

3.9.7 Advertisements

The IRB must approve any and all advertisements prior to posting and/or distribution for studies that
are conducted under the purview of the IRB. The following will be reviewed:

1. The information contained in the advertisement;
2. The mode of its communication;
3. The final copy of printed advertisement; and/or
4. The final audio/video taped advertisements.

This information should be submitted to the IRB with the initial application or as an addendum to the
protocol.

The IRB reviews the material to assure that the material is accurate and is not coercive or unduly
optimistic, creating undue influence to the subject to participate, which includes, but is not limited to:

1. Statements implying a certainty of favorable outcome or other benefits beyond what was outlined
   in the consent document and the protocol.
2. Claims, either explicitly or implicitly, that the drug, biologic or device was safe or effective for the
   purposes under investigation
3. Claims, either explicitly or implicitly, that the test article was known to be equivalent or superior to
   any other drug, biologic or device
4. Using terms like “new treatment,” “new medication,” or “new drug” without explaining that the
   test article was experimental.
5. Promising “free medical treatment” when the intent was only to say subjects will not be charged
   for taking part in the investigation.
6. Emphasis on payment or the amount to be paid, such as bold type or larger font on printed media.
7. The inclusion of exculpatory language.

Any advertisement to recruit subjects should be limited to the information the prospective subjects
need to determine their eligibility and interest. When appropriately worded, the following items may
be included:

1. The name and address of the clinical investigator and/or research facility.
2. The condition being studied and/or the purpose of the research.
3. In summary form, the criteria that will be used to determine eligibility for the study.
4. The time or other commitment required of the subjects.
5. The location of the research and the person or office to contact for further information.
6. A clear statement that this is research and not treatment.
7. A brief list of potential benefits (e.g. no cost of health exam).
8. Advertisements will not include compensation for participation in a trial offered by a sponsor to involve a coupon good for a discount on the purchase price of the product once it has been approved for marketing.

Once approved by the IRB, an advertisement cannot be altered or manipulated in any way without prior the IRB approval.

3.9.8 Payment to Research Subjects

Payment to research subjects may be an incentive for participation or a way to reimburse a subject for travel and other experiences incurred due to participation. However, payment for participation is not considered a research benefit. Regardless of the form of remuneration, investigators must take care to avoid coercion of subjects. Payments should reflect the degree of risk, inconvenience, or discomfort associated with participation. The amount of compensation must be proportional to the risks and inconveniences posed by participation in the study.

Investigators who wish to pay research subjects must indicate in their research project application the justification for such payment. Such justification should:

1. Substantiate that proposed payments are reasonable and commensurate with the expected contributions of the subject;
2. State the terms of the subject participation agreement and the amount of payment in the informed consent form; and
3. Substantiate that subject payments are fair and appropriate, and that they do not constitute (or appear to constitute) undue pressure on the individual to volunteer for the research study.

The IRB must review both the amount of payment and the proposed method of disbursement to assure that neither entails problems of coercion or undue influence.

Credit for payment should accrue and not be contingent upon the subject completing the entire study. The IRB does not allow the entire payment to be contingent upon completion of the entire study. Any amount paid as bonus for completion of the entire study should not be so great that it becomes coercive.

The consent form must describe the terms of payment and the conditions under which subjects would receive partial payment or no payment (e.g. if they withdraw from the study before their participation is completed).

Acting as an agent for the Research Foundation (RF) of SUNY, the Office of Grants Management (OGM) requires certain identifying information (name, address, SSN#) to issue checks, cash, or gift certificates to subjects. Payments to subjects are entered into the RF’s Oracle system, for tracking purposes; If/when payments to an individual subject reach or exceed $600 during the calendar year, the RF issues
a 1099 to the individual. The consent form must inform subjects who will be paid that if they earn more than $600 in a year as a research subject, their social security number will be reported to the IRS, and they will have to pay taxes on that money.

For certain sensitive research, e.g. HIV+ patients, the investigator may opt to use a payment form that only identifies the subject by a patient ID # (no name, address or SS# is identified). The PI is issued a cash advance from which the payments are made and the PI accepts the responsibility of tracking the amount of the payments during the calendar year to ensure compliance with IRS regulations. The consent form discloses the annual $600 criterion for payment of taxes.

3.9.9 Recruitment Incentives

Payment from sponsors for subject recruitment should be primarily based on expenses incurred by the site to run subjects through the course of the study. They must not place subjects at risk of coercion or undue influence or cause inequitable selection. Payment in exchange for referrals of prospective subjects from investigators (physicians) (“finder’s fees”) is not permitted. Payments that are designed to accelerate recruitment by being tied to the rate or timing of enrollment (“bonus payments”) are reviewed on a case-by-case basis by the IRB.

3.9.10 Compliance with all Applicable State and Local Laws

The IRB follows and must adhere to all applicable state and local laws in the jurisdictions where the research is taking place. The HRPP and the IRB rely on the SUNY Counsel for the interpretation and application of New York State law and the laws of any other jurisdiction where research is conducted as they apply to human subject research.

All consent forms must be consistent with applicable state and local laws.

3.10 Possible IRB Actions

Approval: The study is approved as submitted.

Modifications Required in Order to Secure Approval: The requested revisions are prescriptive, requiring concurrence by the PI. e.g., the submission requires minor revisions, such as wording changes, with replacement language provided or confirmation by the PI of the IRB’s understanding of a particular issue.

For studies undergoing full review, the needed revisions are agreed upon at the meeting; for those undergoing expedited review, they are designated by the reviewer(s).

In order to receive approval for a protocol requiring modifications:

- For full review studies, the investigator’s response, the revised protocol and the previously submitted protocol is triaged by IRB staff to assess if a final reviewer was specifically assigned at
the meeting in which the study was reviewed. If not, IRB staff who are IRB members will either conduct final review or share with either the IRB Chair, or a subcommittee (e.g. primary and/or secondary reviewers) for review. The reviewer(s) may approve the study upon receipt and approval of the revisions without further action by the IRB.

- For expedited studies, the investigator’s response, and all other materials will either be returned to the original reviewer, or handled by IRB staff.

Approval of the protocol application will not be granted and certification will not be issued until all deficiencies, if any, are corrected to the satisfaction of the final reviewer(s).

The outcome of the IRB’s or expedited reviewer’s deliberations is once again communicated to the investigator in writing. These deliberations are also documented in the minutes and in the electronic study file for full and expedited studies, respectively.

*Note: For full review, the expiration date for the protocol is calculated based on the date that convened the IRB reviewed the protocol and NOT on the final approval date.*

**Deferral (Expedited Review):** If an expedited reviewer defers a study, the IRB Staff will place it on the agenda for the next IRB meeting.

**Deferral (Full Review):** A deferral means that substantive changes regarding the submission must be addressed. This action is taken if substantive modification or clarification is required, or insufficient information is provided to judge the protocol application adequately (e.g., the risks and benefits cannot be assessed with the information provided). The IRB approval of the proposed research must not occur until subsequent review of the material the PI submitted by the convened IRB.

In order to receive approval for a protocol deferred for substantive issues:

- For full review, the investigator’s response must be submitted for review at a subsequent, convened meeting of the same IRB. The ORC provides the IRB with the investigator’s response. All prior and new materials are available to all members via the electronic management system. The item is placed on the agenda for re-review at the next meeting.

Approval of the protocol application will not be granted and certification will not be issued until all deficiencies, if any, are corrected to the satisfaction of the IRB.

The outcome of the IRB’s deliberations is once again communicated to the investigator in writing.

The IRB’s determination concerning the subsequent amended submission will be documented in the minutes of the IRB meeting.

**Disapproval:** The IRB has determined that the research cannot be conducted at the University or by employees or agents of the University or otherwise under the auspices of the University. Disapprovals
must be determined at meetings of the full committee; they cannot be determined at the level of expedited review.

**Tabled:** The IRB is unable to review the research at the convened meeting (e.g., due to incomplete submission, loss of quorum, etc.).

### 3.11 Study Suspension, Termination

#### 3.11.1 Suspension/Termination

The IRB may vote to suspend or terminate approval of research not being conducted in accordance with the IRB or regulatory requirements or that has been associated with unexpected problems or serious harm to subjects. (See Section 8 for a discussion of unexpected problems and Section 10 for a discussion of non-compliance).

Suspension of the IRB approval is a directive of the convened IRB, IRB Chair, AVP-RC, or the IO to temporarily stop some or all previously approved research activities. Suspended protocols remain open and require continuing review. Termination of IRB approval is a directive of the convened IRB to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review.

The IRB shall notify the PI and the PI’s department chair in writing of such suspensions or terminations and shall include a statement of the reasons for the IRB’s actions. The terms and conditions of the suspension must be explicit. The investigator shall be provided with an opportunity to respond in person or in writing.

The IRB Chair, AVP-RC, or IO may suspend research to ensure protection of the rights and welfare of subjects. Suspension directives made by these individuals must be reported to a meeting of the convened IRB for further deliberation and actions.

Research may only terminated by the convened IRB. Terminations of protocols approved under expedited review must be made by the convened IRB.

When study approval is suspended or terminated by the convened IRB or an authorized individual, consideration will also be made of actions needed to protect the rights and welfare of currently and/or formerly enrolled subjects, e.g., informing them of the suspension/termination, procedures that are needed to withdraw them safely such as transferring currently enrolled subjects to another investigator; making arrangements for care or follow-up outside the research; allowing continuation of some research activities under the supervision of an independent monitor; or requiring or permitting follow-up of subjects for safety reasons.

If follow-up of subjects for safety reasons is permitted/required by the convened IRB or individual ordering the suspension or termination, the convened IRB or individual ordering the suspension or
termination will require that the subjects should be so informed, and that any adverse events/outcomes be reported to the IRB and the sponsor.

Investigator MUST continue to provide reports on adverse events and unanticipated problems to both the IRB and sponsor just as if there had never been a suspension (i.e. all events that need to be reported during a study need to continue to be reported during the suspension period).

Refer to Section 11 for the University’s requirements for reporting suspensions or terminations to external agencies.

3.12 Continuing Review of Non-exempt Research

The IRB will conduct a continuing review of ongoing non-exempt research at intervals that are appropriate to the level of risk for each research protocol, but not less than once per year. Continuing review must occur as long as the research remains active for long-term follow-up of subjects, even when the research is permanently closed to the enrollment of new subjects and all subjects have completed all research-related interventions. Continuing review of research must occur even when the remaining research activities are limited to the analysis of private identifiable information.

3.12.1 Approval Period

Determination of the approval period is made by the IRB on a protocol-by-protocol basis.

For each initial or continuing approval, the IRB will indicate an approval period with an expiration date specified. The IRB approval is considered to have lapsed at midnight on the expiration date of the approval. For a study reviewed by the convened the IRB, the approval commences on the date that the IRB conducts its final review of the study; that is, the date that the convened IRB approves the research or the date that a final reviewer approves the study following a ‘modifications required’ determination, for non-substantive issues by the full committee. The expiration date is no later than one year from the date that the full committee last reviewed the study. For a study approved under expedited review, the approval period begins on the date the IRB Chair or the IRB member(s) designated by the IRB Chair gives final approval to the protocol, and the expiration date is no later than one year from date of final approval.

The approval date and approval expiration date are clearly noted on all the IRB letters sent to the PI and must be strictly adhered to. Investigators should allow sufficient time for development and review of renewal submissions. Electronic courtesy reminder notices are sent 90, 60, and 30 days prior to expiration, but it remains the PI’s responsibility to maintain continued approval for their studies.

Review of an amendment/modification to a protocol does not alter the date by which continuing review must occur.
The regulations make no provision for any grace period extending the conduct of research beyond the expiration date of the IRB approval. Therefore, continuing review and re-approval of research must occur by midnight of the date when the IRB approval expires.

### 3.12.2 Continuing Review Process

In conducting continuing review of research not eligible for expedited review, IRB members will be directed to conduct a substantive review of the materials submitted for continuing review along with all study history residing in the electronic management system. Primary and secondary reviewers will lead the discussion at the convened meeting regarding study, including its aims, progress, history, and assessment of whether or not the approval criteria continue to be met.

### 3.12.3 Expedited Review of Continuing Studies

In conducting continuing review under the expedited review process, the reviewers have access to all materials submitted for continuing review as well as all study history residing in the electronic management system. Reviewers will use the CORIHS Reviewer Checklist to complete the CORIHS Approval Criteria Worksheet for Expedited Reviews, including assessment that the regulatory criteria for expedited review and IRB approval continue to be met, with indication of approval, required modifications or ‘deferred to full committee’.

Generally, if research did not qualify for expedited review at the time of initial review, it does not qualify for expedited review at the time of continuing review, except in limited circumstances described by expedited review categories (8) and (9) at 63 FR 60364-60367 (see Expedited Review Categories). It is also possible that research activities that previously qualified for expedited review in accordance with 45 CFR 46.110, have changed or will change, such that expedited review would no longer be permitted for continuing review.

### 3.12.4 Continuing Review of Exempt Studies

IRB staff, on behalf of the institution, will review exempt studies that are proposed for continuation past the exemption approval period (no longer than three (3) years). IRB staff will ensure the activity continues to qualify for exemption, and that applicable protections are in place for human subject involvement.

### 3.12.5 What Occurs if there is a Lapse in Continuing Review?

The regulations permit no grace period or approval extension after approval expiration. Research that continues after the approval period has expired is research conducted without IRB approval and will be handled in accordance with the Noncompliance SOP. If the continuing review does not occur within the timeframe set by the IRB, all research activities must stop, including recruitment (media advertisements must be pulled), enrollment, consent, interventions, interactions, and data collection, unless the IRB finds that it is in the best interests of individual subjects to continue participating in the research interventions or interactions. **This will occur even if the investigator has provided the**
continuing information before the expiration date. Therefore, investigators must allow sufficient time for IRB review and approval before the expiration date.

The electronic management system notifies the investigator of the expiration of approval with notice that research activities must stop. With this notice, the PI is advised to immediately submit to the ORC a list of any currently enrolled research subjects for whom suspension of the research would cause harm. Enrollment of new subjects cannot occur, and continuation of research interventions or interactions for already enrolled subjects should only continue, when the IRB or the IRB Chair finds that it is in the best interest of the individual subjects to do so.

Once approval has expired, the IRB review and re-approval must occur prior to re-initiation of the research. If the study approval has lapsed more than 90 days and the PI has not provided the required continuing review information, the PI may be required to submit a new application to the IRB for review and approval. If the study approval has lapsed 90 days or less and the PI provides the required continuing review information, the existing protocol may be reviewed for consideration of continued IRB approval.

If the IRB requires modifications at the time of continuing review, and the approval expires before the IRB has reviewed and approved the PI response, all activities involving human subjects or their tissue/data must be stopped as described above.

3.13 Amendment of an Approval Protocol

Investigators may wish to modify or amend their approved applications. Investigators must seek approval from the IRB before making any changes in approved research - even though the changes are planned for the period for which the IRB approval has already been given - unless the change is necessary to eliminate an immediate hazard to the subject (in which case the IRB must be notified immediately).

Modifications may be approved if they are within the scope of what the IRB originally authorized. For example, if an investigator wishes to add a population to an existing study, but not alter the study procedures or purpose, a modification request is usually appropriate. Likewise, modifying a procedure without changing the study's purpose or study population may also be appropriate. If, however, the investigator wishes to add a population and revise study procedures, he or she may need to submit a new application for human subjects approval at the request of the IRB.

Investigators must submit to the IRB any and all revised documents that are impacted by the modification, as well as a justification and summary of changes, and track-changed materials whenever possible.

IRB staff will determine whether the proposed changes may be approved through an expedited review process (if the changes are minor and not increasing risk), or whether the modification warrants full board review. If expedited, the IRB reviewer(s) has the ultimate responsibility to determine that the
proposed changes may be approved through the expedited review procedure and, if not, must defer the protocol to full board review.

3.13.1 Expedited review of Protocol Modifications

The IRB may use expedited review procedures to review minor changes in ongoing previously-approved research during the period for which approval is authorized. An expedited review may be carried out by the IRB Chair and/or designee(s) among the IRB members.

The reviewer(s) complete the Amendment Review Sheet for CORIHS Members to determine whether the modifications meet the criteria allowing review of the amendment using the expedited procedure, and if so, whether the research with the proposed modifications continues to meet the regulatory criteria for approval.

The reviewer(s) will also consider whether information about those modifications might relate to subjects’ willingness to continue to take part in the research and if so, whether to provide that information to subjects

3.13.2 Full Board Review of Protocol Modifications

When a proposed change in a research study is not minor (e.g. procedures involving increased risk or discomfort are to be added), then the IRB must review and approve the proposed change at a convened meeting before the change can be implemented. The only exception is a change necessary to eliminate apparent immediate hazards to the research subjects. In such a case, the IRB should be promptly informed of the change following its implementation and should review the change to determine that it is consistent with ensuring the subjects' continued welfare.

All documents provided by the investigator are accessible to all IRB members.

At the meeting, the primary reviewer presents an overview of the modifications and leads the IRB through the completion of the regulatory criteria for approval. The IRB will determine whether the research with the proposed modifications continues to meet the regulatory criteria for approval.

When the IRB reviews modifications to previously approved research, the IRB consider whether information about those modifications might relate to subjects’ willingness to continue to take part in the research and if so, whether to provide that information to subjects.

3.14 Closure of Protocols

The completion or termination of the study, whether premature or not, is a change in activity and should be reported to the IRB via the electronic management system. Although subjects will no longer be "at risk" under the study, a final report to the IRB allows it to close its files as well as provides information that may be used by the IRB in the evaluation and approval of related studies.
3.15 Reporting IRB Actions

Barring extraordinary circumstances, all the IRB action letters are prepared by IRB staff in the electronic management system and accessed by the PI and research team within ten (10) working days of receipt of member review (for expedited studies) or meeting in which the study was reviewed (for full review studies). For an approval, along with written notification of approval, a copy of the approved consent/permission/assent document(s) containing the stamped approval with the dates of the approval and expiration on each sheet will be uploaded. For required modifications or deferrals, the notification will include the information that is required and the basis for requiring those modifications. For a disapproval, termination or suspension, the notification will include the basis for making that decision.

All correspondence between the IRB and investigators are retained in the electronic management system.

The IRB reports its findings and actions to the University in the form of its minutes, which are stored permanently and securely in the ORC Office, and on the electronic management system.

3.16 Appeal of the IRB Decisions

When a protocol presented at a convened IRB meeting is disapproved, deferred or requires modifications, the IRB will notify the PI in writing about the specific deficiencies and the modifications that are necessary for appropriate IRB approval. The IRB shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in writing.

In cases where there is disagreement between the IRB and the PI regarding the nature and extent of the requested changes and these disagreements cannot be resolved amicably in an informal manner, the PI and/or the IRB may make an appeal to the IO for a resolution of the matter. The IO may organize a meeting to help facilitate discussion between the IRB and the PI. While the IO may provide input and make recommendations to the IRB for expeditious resolution of the matter, final recommendations for approval remain under the purview of the IRB.

4 IRB Documentation and Records

4.1 Policy

The University shall prepare and maintain adequate documentation of the IRB’s activities. All records must be accessible for inspection and copying by authorized representatives of the FDA, OHRP, sponsors, and other authorized entities at reasonable times and in a reasonable manner.

4.2 IRB Records

The IRB records include, but are not limited to:
1. Written operating procedures.
2. IRB membership rosters.
3. Training records. The ORC maintains accurate records listing research investigators, IRB members, and IRB staff that have fulfilled the facility’s human subject training requirements.
4. IRB correspondence (other than protocol related).
5. IRB Study Files (See Section 4.3 for information included in study files)
6. Documentation of Emergency Exemption from Prospective IRB Approval. (21 CFR 56.104(c)).
8. Documentation of exemptions.
9. Documentation of convened IRB meetings minutes
10. Documentation of review by another institution’s IRB when appropriate.
11. Documentation of cooperative review agreements, e.g. Memoranda of Understanding (MOUs).
13. Protocol violations submitted to the IRB
14. Quality assurance reviews.

4.3 IRB Study Files

ORC will maintain an electronic study file for each IRB study submission that is submitted via the electronic management system for review.

All communications to and from the IRB are maintained. Depending on the type of communication, maintenance may be via the electronic management system, IRB staff e-mail, or paper. IRB study files include, but are not limited to:

1. Protocol and all other documents submitted as part of a new protocol application.
2. Protocol and all other documents submitted as part of a request for continuing review/termination of research application. This also includes progress reports, statements of significant new findings provided to subjects, reports of injuries to patients.
3. Documents submitted and reviewed after the study has been approved, including reports of modifications to research/amendments and adverse event reports.
4. Copy of the IRB-approved Consent/permission/assent forms
5. Sponsor-approved (including DHHS) sample consent form document and protocol, when they exist.
6. IRB reviewer forms (when expedited review procedures are used)
7. Documentation of type of IRB review.
8. For expedited review, documentation of any determinations required by the regulations and protocol-specific findings supporting those determinations, including: waiver or alteration of the consent process, research involving pregnant women, fetuses, and neonates, research involving prisoners, and research involving children.
9. Documentation of all IRB review actions.
10. Notification of expiration of IRB approval to the PI and instructions for submitting relevant continuing review materials.
11. Notification of suspension of research.
12. Correspondence pertaining to appeals.
13. Copies of approval letters and forms that describe what PI must have before beginning the study.
14. IRB correspondence to and from research investigators.
15. All other IRB correspondence related to the research.
16. Reports of unanticipated problems involving risk to subjects or others and adverse events.
17. Documentation of audits, investigations, reports of external site visits.
18. Scientific evaluations, if any, beyond the scientific merit attestations provided by departmental chairs/review committees.

4.4 IRB Minutes

1. Proceedings must be written and available for review by the next regularly scheduled IRB meeting date. The IRB minutes, once approved, may not be altered by any persons of authority except with the concurrence and approval of the convened IRB.

Minutes of the IRB meetings must contain sufficient detail to show:

2. Attendance.
   a) Names of members present;
   b) Names of members or alternate members who are participating through videoconference or teleconference (having received all pertinent material prior to the meeting and the ability to actively and equally participate in all discussions);
   c) Names of alternates attending in lieu of specified (named) absent members. (Alternates may substitute for specific absent members only as designated on the official IRB membership roster);
   d) Names of consultants present;
   e) Names of investigators present; and
   f) Names of guests present.

The vote on each action will reflect those members present for the vote on that item. Members who recuse themselves because of conflict of interest are listed by name and the reason documented.

3. The presence of a quorum throughout the meeting, including the presence of one member whose primary concern is in a non-scientific area.
4. Business Items discussed.
5. Continuing Education.
6. Actions taken, including separate deliberations, actions, and votes for each protocol undergoing initial review, continuing review, or review of modifications by the convened the IRB.
7. Votes on these actions (total number voting; number voting for; number voting against; number abstaining; number of those recused).
8. Basis or justification for these actions including required changes in research.
10. Approval period for initial and continuing approved protocols, including identification of research that warrants review more often than annually and the basis for that determination.
11. Risk level of initial and continuing approved protocols

12. Protocol-specific documentation that the research meets the required criteria [45 CFR 46.116(d)]
when approving a consent procedure that does not include or that alters some or all of the required elements of informed consent, or when waiving the requirement to obtain an informed consent. This documentation may alternatively be available in a supporting meeting document (“Final Meeting Determination Supplement: CONSENT WAIVERS”) available with the meeting minutes.

13. Protocol-specific documentation that the research meets the required criteria [45 CFR 46.117(c)]
when the requirements for documentation of consent are waived. This documentation may alternatively be available in a supporting meeting document (“Final Meeting Determination Supplement: CONSENT WAIVERS”) available with the meeting minutes.

14. When approving research that involves populations covered by Subparts B, C, or D of 45 CFR 46,
the minutes and/or supporting meeting document(s) will document the IRB’s justifications and findings regarding the determinations stated in the Subparts. These documents are: “Final Meeting Determination Supplement: Minors, Final Meeting Determination Supplement: Pregnant Women, or Final Meeting Determination Supplement: Prisoners”. Alternatively, the IRB may cite concurrence with the justifications as presented by the investigator on submission materials (or as modified per the IRB).

15. Special protections warranted in for other groups of subjects who are likely to be vulnerable to coercion or undue influence, such as mentally disabled persons, or economically or educationally disadvantaged persons, regardless of source of support for the research.

16. The rationale for significant risk/non-significant risk device determinations.

17. Determinations of conflict of interest and review of management plans.

18. Identification of any research for which there is need for verification from sources other than the investigator that no material changes are made in the research.

19. A list of research approved since the last meeting utilizing expedited review procedures.

20. An indication that, when a IRB member has a conflicting interest (see Section 2.9) with the research under review, the IRB member was not present during the deliberations or voting on the proposal, and that the quorum was maintained.

21. Key information provided by consultants will be documented in the minutes or in a report provided by the consultant.

22. Justification of any deletion or substantive modification of information concerning risks or alternative procedures contained in the DHHS-approved sample consent document.

4.5 IRB Membership Roster

A membership list of the IRB members must be maintained. It must identify members sufficiently to describe each member's chief anticipated contributions to IRB deliberations. The list must contain the following information about members:

1. Name.
2. Earned degrees.
3. Affiliated or non-affiliated status (neither the member nor an immediate family member of the member may be affiliated with the University).
4. Status as scientist or non-scientist (Per OHRP: “Members whose training, background, and occupation
would incline them to view scientific activities from the standpoint of someone within a behavioral or
biomedical research discipline should be considered a scientist, while members whose training,
background, and occupation would incline them to view research activities from a standpoint outside of
any biomedical or behavioral scientific discipline should be considered a nonscientist.”)

5. Indications of experience (specialties, etc.) sufficient to describe each member’s chief anticipated
contributions to the IRB deliberations.

6. Role on the IRB (Chair, Co-Chair, etc.).

7. Voting status (Any ex officio members are non-voting members).

8. For alternate members, the primary member for whom the member could substitute.

The ORC must keep IRB membership list current. The IO or designee promptly reports changes in IRB
membership to the Office for Human Research Protections, Departments of Health and Human
Services.

4.6 Documentation of Exemptions

Documentation of verified exemptions consists of the reviewer’s citation of a specific exemption
category and written concurrence that the activity described in the investigator’s request for satisfies
the conditions of the cited exemption category as detailed in Section 3.5.

4.7 Documentation of Expedited Reviews

IRB records for initial and continuing review by the expedited procedure must include the specific
permissible category and that the activity described by the investigator satisfies all of the criteria for
approval under expedited review as described in Section 3.8; the approval period and any
determinations required by the regulations including protocol-specific findings supporting those
determinations.

4.8 Access to IRB Records

The IRB has policies and procedures to protect the confidentiality of research information:

1. All paper IRB records are kept secure in the ORC, which is closed and locked when unattended.

2. The University’s IRB electronic management program, is hosted at a data center facility on the
Main Campus. Facilities are secure, data is mirrored, and data is backed up nightly. Authorized
users have restricted access to the facility. Security precautions are state of the art. Security
standards associated with user ids and passwords are in accordance with generally accepted
commercial and federal security. Certified SSL (256 bit Secured Socket Layer technology) encryption
is standard for all web-based transmissions. Strict permission rules ensure that only approved
individuals have access to the data.

3. Access to IRB records, whether paper or electronic, is limited to the IO, IRB Chair, IRB members, IRB
Administrators, IRB staff, AVP-RC, authorized institutional officials, and officials of Federal and state
regulatory agencies (OHRP, FDA). Appropriate accreditation bodies are provided access and may
recommend additional procedures for maintaining security of IRB records. All other access to IRB
records is limited to those who have legitimate need for them, as determined by the AVP-RC, or the IO.
4. Records are accessible for inspection and copying by authorized representatives of federal regulatory agencies during regular business hours.
5. Paper records may not be removed from the IRB Office; however, the IRB staff will provide copies of records for authorized personnel if requested.
6. All other access to IRB study files, paper or electronic, is prohibited.

4.9 Record Retention

Records pertaining to IRB-approved research must be retained for a defined time period once the research is permanently closed.

Research is permanently closed if all of the following conditions are met:

- No new subjects will be enrolled; and
- There will be no more intervention or interaction with enrolled subjects; and
- No further analysis of identifiable data/tissue will be conducted. Either analyses are complete or data/tissue have been permanently de-identified (i.e., with all identifiers and keys to codes destroyed).

The time period during which you must keep your records once the research is permanently closed depends on the study specifics:

- **For records that DO NOT include identifiable health information:** Records relating to the research must be retained for at least 3 years after completion of the research.

- **For records that DO include identifiable health information:** Records relating to the research must be retained for at least 7 years after completion of the research.

- **For Investigational New Drug (IND) research:** The FDA requires that sponsors and investigators retain “records and reports required by this part for 2 years after a marketing application is approved for the drug; or if an application is not approved for drug, until 2 years after shipment and delivery of the drug for investigational use is discontinued and the FDA so notified.”

- **For Investigational Device Exemption (IDE) research:** The FDA requires the investigator or sponsor to maintain the records “for a period of 2 years after the latter of the following two dates: The date on which the investigation is terminated or completed, or the date that the records are no longer required for purposes of supporting a premarket approval application or a notice of completion of a product development protocol.”
For research funded by industry or private foundations: The investigator should maintain the records for either the length of time required by the sponsor, or three (3) years, whichever is longer.

5 Obtaining Informed Consent from Research Subjects

5.1 Policy

No investigator conducting research under the auspices of the University may involve a human being as a subject in research without obtaining the legally effective informed consent of the subject or the subject’s legally authorized representative unless a waiver of consent has been approved by the IRB in accordance with Section 5.8 of these procedures. Except as provided in Section 5.12 of these procedures, informed consent must be documented by the use of a written consent form approved by the IRB (See Section 5.6).

The IRB will evaluate both the consent process and the procedures for documenting informed consent to ensure that adequate informed consent is obtained from subjects.

The following procedures describe the requirements for obtaining consent from subjects in research conducted under the auspices of the University.

5.2 Definitions

Legally authorized representative (LAR): Federal (45 CFR § 46.102(c): An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research.

NYS: Per the Family Health Care Decisions Act (FHCDCA), a person in the highest category on the following surrogate list who is available, willing and competent to make decisions for the incapable patient, and is identified when there is no health care agent:

1. A court-appointed guardian (per NYS Mental Health Law Article 81);
2. An individual designated as a representative/agent through a health care proxy that is appropriately executed. For a health care proxy to be effective, it must have been signed at a time when the subject had decision-making capacity. The subject’s wishes, if any, with regard to research as expressed in the health care proxy govern (e.g. prohibiting all research or permitting only research which may provide a direct benefit);
3. The spouse, if not legally separated from the patient, or the domestic partner;
4. A son or daughter eighteen years of age or older;
5. A parent;
6. A brother or sister eighteen years of age or older; or
7. A close friend (meaning a person eighteen (18) years of age or older who has maintained such regular contact with the subject as to be familiar with the subject’s activities, health and beliefs).

**Legal guardian**: A person appointed by a court of appropriate jurisdiction.

### 5.3 Basic Requirements

Investigators must obtain consent prior to entering a subject into a study and/or conducting any procedures required by the protocol, unless consent is waived by the IRB.

It is the PI’s responsibility to ensure that any team member who conducts a consent process and obtains consent from a potential subject is appropriately trained to perform this activity. The person so delegated must be knowledgeable about the research to be conducted and the consenting process, and must be able to answer questions about the study.

### 5.4 Informed Consent Process

Informed consent must be obtained under the following circumstances:

1. Informed consent may only be obtained from subjects who have the legal and mental capacity to give consent. For subjects without that capacity, consent must be obtained from a legal guardian or a legally authorized representative.
2. The informed consent process shall be sought under circumstances that provide the subject (or legally authorized representative) with sufficient opportunity to consider whether or not to participate.
3. The informed consent process shall be sought under circumstances that minimize the possibility of coercion or undue influence.
4. The informed consent information must be presented in language that is understandable to the subject (or legally authorized representative). To the extent possible, the language should be understandable by a person who is educated to 8th grade level and layman’s terms shall be used in the description of the research.
5. For subjects whose native language is not English, informed consent must be obtained in a language that is understandable to the subject (or to the subject’s legally authorized representative). In accordance with this policy, the IRB requires that informed consent conferences include a reliable translator when the prospective subject does not understand the language of the person who is obtaining consent.
   - *See section 17.8 for additional policy governing inclusion of non-English speakers.*
6. The informed consent process may not include any exculpatory language through which the subject is made to waive, or appear to waive any of the subject’s legal rights or through which the investigator, the sponsor, the University employees or agents are released from liability for negligence, or appear to be so released.
7. Although the PI may delegate the responsibility of obtaining consent from subjects to other members of his/her research team, the PI retains ultimate responsibility for insuring that each prospective subject is adequately informed about all aspects of the research and understands the
information provided. It is the PI’s responsibility to train and supervise the study personnel who are obtaining consent.

8. The individual who signs the consent form as the 'person obtaining consent' is responsible for leading the potential subject through the entire consent process. This means:
   a) All aspects of the study, as described in the consent form, are first discussed with the potential subject;
   b) The consent form is thoroughly reviewed with the potential subject and answers to the potential subject's questions are provided;
   c) While reviewing the consent form, the person obtaining consent asks questions designed to assess the potential subject's understanding of the material. The person will specifically state this intent to the potential subject (i.e. the person is making sure the potential subject appreciates what s/he is being asked to do, and why);
   d) The potential subject is given ample opportunity to decide, without coercion or undue influence, whether or not to be in the study; and
   e) The consent process does not end with the formal signing of the consent document. Rather, it is an ongoing process that continues throughout the subject's participation in the study. The person obtaining consent remains responsible for continued assessments of the subject's understanding of what is happening to him/her, his/her willingness to participate and for providing the subject with any new information that may affect their willingness to participate.

5.5 Determining a potential adult subject's ability to consent to research

For the purpose of this section, a subject has the capacity to consent to his or her own participation in a research activity if s/he demonstrates an appreciation:

1. That the activity is research, not standard treatment;
2. Of the risks and benefits of a study;
3. Of the alternatives that are available if s/he does not participate; and
4. That, if s/he chooses not to participate, this decision will be accepted without penalty, i.e. without jeopardizing clinical care.

In reaching a decision about participation, it is essential for the potential subject to demonstrate an ability to use this information in a rational manner. Thus, in considering risks, benefits, and available alternatives, subjects must show they understand the aspects of these factors that are unique to them as individuals. To highlight this distinction, a person who is suffering with severe depression may be able to demonstrate an appreciation of 1, 2, 3 and 4 above, but may not care, or may actually want to take risks. Such individuals should not be considered able to provide consent for themselves.

*See Section 6.9 for further discussion regarding adults who cannot consent for themselves.*

5.6 Basic Elements of Informed Consent

1. A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject’s participation, a description of the procedures to be followed,
and identification of any procedures which are experimental; a description of any reasonably foreseeable risks or discomforts to the subject;

2. A description of any benefits to the subject or to others which may reasonably be expected from the research;

3. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

4. A statement describing the extent, if any, to which confidentiality of records identifying the subject must be maintained;

5. For research involving more than minimal risk, an explanation as to the availability of medical treatment in the case of research-related injury, including who will pay for the treatment and whether other financial compensation is available (see section 17.6 for SBU policy on Industry-funded clinical trials);

6. An explanation of whom to contact on the research team for answers to pertinent questions about the research or to voice concerns or complaints about the research, and whom to contact in the event of a research-related injury to the subject;

7. Contact information for the IRB to obtain answers to questions about the research; to voice concerns or complaints about the research; to obtain answers to questions about their rights as a research subject; in the event the research staff could not be reached; and in the event the subject wishes to talk to someone other than the research staff.

8. A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled;

9. For FDA-regulated studies, the possibility that the Food and Drug Administration may inspect the records needs to be included in the statement regarding subject confidentiality.

Additional elements of informed consent to be applied, as appropriate:

1. A statement that the particular treatment or procedure may involve risks to the subject, which are currently unforeseeable. (e.g. include when the research involves investigational test articles or other procedures in which the risks to subjects is not well known)

2. A statement that if the subject is or becomes pregnant, the particular treatment or procedure may involve risks to the embryo or fetus, which are currently unforeseeable. (For example: Include when the research involves pregnant women or women of childbearing potential and the risk to fetuses of the drugs, devices, or other procedures involved in the research is not well known)

3. Anticipated circumstances under which the subject’s participation may be terminated by the investigator without regard to the subject’s consent. (e.g. include when there are anticipated circumstances under which the investigator may terminate participation of a subject)

4. Any additional costs to the subject that may result from participation in the research. (e.g. include when it is anticipated that subjects may have additional costs)

5. The consequences of a subject’s decision to withdraw from the research. (e.g. include when withdrawal from the research is associated with adverse consequences)

6. Procedures for orderly termination of participation by the subject. (e.g. include when the protocol describes such procedures)
7. A statement that significant new findings developed during the course of the research which may relate to the subject’s willingness to continue participation will be provided to the subject. (e.g. include when the research is long term and interim information is likely to be developed during the conduct of the research)

8. The approximate number of subjects involved in the study. (e.g. include when the research involves more than minimal risk)

5.7 Documentation of Informed Consent

Except as provided in Section 5.12 of this document, informed consent must be documented by the use of a written consent form approved by the IRB.

1. Informed consent is documented by the use of a written consent form approved by the IRB and signed and dated by the subject or the subject’s legally authorized representative at the time of consent. For those consent forms that must be translated into a foreign language, an affidavit of accurate translation from the IRB approved English version must be provided from an appropriate translator who is unaffiliated with the study. The translated consent form and affidavit must be submitted and approved by the IRB before its use. The individual obtaining a non-English speaking subject’s consent should either be a study investigator who is fluent in both languages, or a study investigator who is assisted by either a qualified translator or a recognized translation service. See section 17.8 for additional policy governing inclusion of non-English speakers.

2. A copy of the signed and dated consent form must be given to the person signing the form.

3. Documentation of consent must be either via:
   a) A written consent document that embodies the basic and required additional elements of informed consent. The consent form may be read to the subject or the subject's legally authorized representative, but the subject or representative must be given adequate opportunity to read it before it is signed; or
   b) A short form written consent document which states that the elements of informed consent have been presented orally to the subject or the subject's legally authorized representative. When this method is used:
      • There must be a witness to the oral presentation; and
      • The IRB must approve a written summary of what is to be signed by the subject or representative; and
      • The witness must sign both the short form and a copy of the summary; and
      • The person actually obtaining consent must sign a copy of the summary; and
      • A copy of the summary must be given to the subject or representative, in addition to a copy of the short form.

When this 'short form' procedure is used with subjects who do not speak English:

• The oral presentation and the short form written document should be in a language understandable to the subject;
• The IRB approved English language informed consent document may serve as the summary; and
• The witness should be fluent in both English and the language of the subject. When the person obtaining consent is assisted by a translator, the translator may serve as the witness, but must be unaffiliated with the study. The IRB must receive and approve all foreign language versions of the short form document (along with translator affidavit) prior to use.

• In addition to receiving a copy of the (English) summary and a copy of the short form at the time of consenting, the subject must receive a copy of the summary, translated into their native language, as soon as possible after their enrollment into the study.

**Note:** that English and Spanish versions of an IRB acceptable 'short form' document are available in the Forms Library within the electronic management system. Expedited review of these versions is acceptable if the protocol, the full English language informed consent document, and the English version of the short form document have already been approved by the convened IRB. **See section 17.8 for additional policy governing inclusion of non-English speakers.**

### 5.8 Special Consent Circumstances

#### 5.8.1 Non-English Speaking Subjects

*See section 17.8 for SBU policy on non-English speaking subjects*

#### 5.8.2 Braille consent

For blind subjects who read Braille, the IRB may approve a consent document prepared in Braille. In order to assure itself that a Braille consent document is accurate, the IRB may require a transcription into print text or review of the document by an IRB member or other person who reads Braille. If possible, the subject will sign the Braille consent; otherwise verbal consent will be obtained, witnessed and documented as described below in section 5.8.4.

#### 5.8.3 Consenting in American Sign Language (ASL)

For deaf subjects who are fluent in ASL, the IRB may approve a consent process using ASL and the IRB approved written consent form. When this process is approved, the individual authorized to consent prospective subjects must use an interpreter fluent in ASL to conduct the consent process and the documentation of the consent process must conform to the requirements set forth in Section 5.7.1.

#### 5.8.4 Verbal Consent

When subjects are unable to read a written consent form (such as blind or illiterate subjects), the IRB may approve a verbal consent process, provided the subject (1) retains the ability to understand the concepts of the study and evaluate the risk and benefit of being in the study when it is explained verbally and (2) is able to indicate approval or disapproval to study entry.

In this process, the consent form must be read to the subjects and the subjects must be given an opportunity to ask questions. An audiotape approved by the IRB may be used. If capable of doing so,
the subject signs, or marks an X to signify consent. If that is not possible, the subject will provide verbal consent. The person obtaining consent and a witness will sign the written study consent form with a statement that documents that an oral process was used and, if necessary, that the subject gave verbal consent. The consent process will also be documented in the medical record or in accord with the Institution’s policy. Signed copies of the consent form are given to the subject and, whenever possible, these documents should be provided to the subject on audio or video tape.

For research that is no more than minimal risk, documentation of consent may be waived if the criteria at Section 5.12 are met.

5.9 Consent Monitoring

The IRB has the authority under 45 CFR 46.109(e) and 21 CFR 56.109(f) to conduct special monitoring/observation the informed consent process for human research studies in order to protect the rights and welfare of research participants.

As part of our routine QA assessment program, the Office of Research Compliance notifies PI’s, via the IRB approval letter, to contact the office when the first subject is scheduled to be consented. If scheduling permits, an ORC staff member will observe the consent process to:

- Assure that the research teams satisfy all federal, state and institutional requirements for obtaining consent from research participants;
- Assure that an appropriate consent process is followed, appropriately completed and documented;
- Assure the approved consent process is being followed;
- Assure the information provided to the participant was accurate and conveyed in understandable language;
- Assure the participant had sufficient time to consider study participation;
- Assure the possibility of coercion and undue influence are not evident;
- Ensure that subjects are truly giving Informed Consent; and
- Assure the subject appeared to understand the information and gave their voluntary consent.

The consent monitoring process can also be done via general, random not-for-cause reasons, or it may be determined by the IRB that such consent monitoring is warranted.

The factors that the IRB may consider in making the determination that special monitoring of the consent process may include, e.g.:

- High risk studies;
- Studies that involve complex and complicated procedures or interventions;
- Studies involving Vulnerable Populations (e.g., children, adults unable to consent for themselves);
- Studies involving study staff with minimal experience in administering consent to study participants;
Concerns raised about study team performance, such as prior findings of noncompliance related to the consent process;

- Presence of study team conflicts of interest;

- Prior complaints about the consent process.

The consent monitoring may be conducted by IRB staff, IRB members or another party appointed by the IRB Chair. The PI will be notified of the pending consent monitoring process arrangements will be made with the PI for the monitoring of the consent process.

Following the monitoring, a report of the findings will be submitted to the IRB and reflected in the minutes. The Board can then take actions appropriate to the report (e.g., follow non-compliance procedure etc.). The PI will be notified by email regarding the outcome of the monitoring and any resulting IRB determinations (if any).

5.10 Subject Withdrawal or Termination

For a variety of reasons, a subject enrolled in a research study may decide to withdraw from the research, or an investigator may decide to terminate a subject’s participation in research regardless of whether the subject wishes to continue participating. In these circumstances, questions sometimes arise about:

1. Whether the investigator may use, study, or analyze already collected data about the subject who withdraws from the research or whose participation is terminated by the investigator; and

2. Whether the investigator can continue to obtain data about the subject and if so, under what circumstances. The following addresses these and related questions. Investigators must plan for the possibility that subjects will withdraw from research and include a discussion of what withdrawal will mean and how it will be handled in their research protocols and informed consent documents.

Regulatory requirements regarding the retention and use of data after subject withdrawal or termination differ depending on whether or not the research is subject to FDA regulations.

When seeking informed consent from subjects, the following information regarding data retention and use must be included:

- For FDA-regulated clinical trials, when a subject withdraws from a study, the data collected on the subject to the point of withdrawal remain part of the study database and may not be removed. The consent document cannot give the subject the option of having data removed.

- For research not subject to FDA regulations, the investigator should inform subjects whether the investigator intends to either: (1) retain and analyze already collected data relating to the subject up to the time of subject withdrawal; or (2) honor a research subject’s request that the investigator destroy the subject’s data or that the investigator exclude the subject’s data from any analysis.
Sometimes, a subject wants to withdraw from the primary interventional component of a study, but is willing to allow the investigator to continue other research activities described in the IRB-approved protocol and informed consent document that involve participation of the subject, such as:

- Obtaining data about the subject through interaction with the subject (e.g., through follow-up interviews, physical exams, blood tests, or radiographic imaging); or
- Obtaining identifiable private information from the subject’s medical, educational, or social services agency records or from the subject’s healthcare providers, teachers, or social worker.

When a subject’s withdrawal request is limited to discontinuation of the primary interventional component of a research study, research activities involving other types of participation for which the subject previously gave consent may continue. The investigator should ask a subject who is withdrawing whether the subject wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the subject would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through noninvasive chart review, and address the maintenance of privacy and confidentiality of the subject's information.

If a subject withdraws from the interventional portion of the study, but agrees to continued follow-up of associated clinical outcome information as described in the previous paragraph, the investigator must obtain the subject’s informed consent for this limited participation in the study (assuming such a situation was not described in the original informed consent form). IRB approval of informed consent documents would be required.

If a subject a) withdraws from the interventional portion of a study, (b) does not consent to continued follow-up of associated clinical outcome information, and (c) does not request removal of their data, the investigator must not access for purposes related to the study the subject’s medical record or other confidential records requiring the subject’s consent. However, an investigator may review study data related to the subject collected prior to the subject’s withdrawal from the study, and may consult public records, such as those establishing survival status.

5.11 Waiver of Informed Consent

The IRB may approve a consent procedure that does not include, or that alters, some or all of the elements of informed consent set forth above; or waive the requirements to obtain informed consent, provided the IRB finds and documents that:

1. The research involves no more than minimal risk to the subjects;
2. The waiver or alteration will not adversely affect the rights and welfare of the subjects;
3. The research could not practicably be carried out without the waiver or alteration; and
4. Whenever appropriate, the subjects must be provided with additional pertinent information after participation.
These criteria may be applied to research subject to FDA regulation as well.

In addition, the IRB may approve a consent procedure that does not include, or that alters, some or all of the elements of informed consent; or waive the requirements to obtain informed consent, provided the IRB finds and documents that:

1. The research or demonstration project is to be conducted by, or is subject to the approval of, state or local government officials and is designed to study, evaluate, or otherwise examine:
   a) Public benefit or service programs;
   b) Procedures for obtaining benefits or services under those programs;
   c) Possible changes in or alternatives to those programs or procedures; or
   d) Possible changes in methods or levels of payment for benefits or services under those programs.
2. The research could not practicably be carried out without the waiver or alteration.

5.12 Waiver of Documentation of Informed Consent

The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either that the:

1. Only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality; or
   - Note 1: Subjects must be asked whether they want documentation linking them with the research, and their wishes must govern. (Example: domestic violence research where the primary risk is discovery by the abuser that the subject is talking to investigators.)
   - Note 2: In order to waive written documentation of consent where the only record linking the subject and the research would be the consent document, the IRB has to determine that the research is not FDA-regulated.

   or

2. The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. Procedures such as non-sensitive surveys, questionnaires and interviews generally do not require written consent.

In cases in which the documentation requirement is waived, the IRB requires the investigator to provide in the application materials a written summary of the information to be communicated to the subject, and the IRB will consider whether to require the investigator to provide subjects with a written statement regarding the research.

5.13 Waiver of Informed Consent for Planned Emergency Research

In accordance with 21 CFR 50.24, the IRB will consider for review and approval planned research involving life-threatening emergencies where a waiver is proposed for requirement to obtain prospective informed consent.
The conduct of planned research in life-threatening emergencies where the requirement to obtain prospective informed consent has been waived by the IRB is covered by 21 CFR §50.24 for FDA regulated research and by the waiver articulated by HHS at 61 FR 51531-33 for non-FDA regulated research. Among other requirements, the research plan must be carried out under an approved IND or IDE, if applicable, and must be approved in advance by the IRB, and publicly disclosed to the community in which the research will be conducted. The waiver of informed consent is not applicable to research involving children (subpart D), fetuses, pregnant women and human in vitro fertilization (subpart B) and research involving prisoners (subpart C).

Research that proceeds according to this pathway is subject to prospective IRB approval, as opposed to Emergency Use research approved pursuant to 21 CFR §56.104(c).

5.13.1 Planned Emergency Research

The FDA exception from informed consent requirements for emergency research under FDA regulations, 21 CFR 50.24, permits planned research in an emergency setting when human subjects who are in need of emergency medical intervention cannot provide legally effective informed consent and the timing of the intervention is such that obtaining informed consent from legally authorized representatives (LARs) is not possible.

The Secretary of Health and Human Services (HHS) has implemented an Emergency Research Consent Waiver under 45 CFR 46.101(i) with provisions identical to those of the FDA with the exception of the IND/IDE requirement and the definition of family member includes spouses of brother/sisters. The waiver is not applicable to research involving prisoners, see 45 CFR 46.101(i) & 46.306(b).

An exception from consent in emergency medicine research supported by the DoD is prohibited unless a waiver is obtained from the Secretary of Defense.

Additional state requirements apply as well.

Most planned emergency research involves the use of an FDA regulated test article and therefore is subject to FDA regulations as listed above. The IRB recommends PIs who are planning emergency research contact the ORC for assistance at least 4-5 months prior to the planned start date. The requirements are very complex and include consultation within the University, the community in which the research is to be conducted, the FDA, and the Department of Health and Human Services (DHHS).

These Emergency Research policies and procedures apply to Planned Emergency Research. Planned Emergency Research is different from Emergency Single Time Use of a Test Article as regulated under FDA 21 CFR 56.104(c).

5.13.1.1 Definition

**Planned Emergency Research**: involves subjects who, because of their condition (e.g. unconsciousness) are in a life-threatening situation that makes intervention necessary, are unable to give informed consent, and in which obtaining informed consent from legally authorized representatives (LARs) is not possible.
consent, and to be effective, the intervention must need to be administered before obtaining informed consent from the subject’s legally authorized representative is reasonably possible.

5.13.1.2 Policy/Procedures

The IRB committee that initially reviews and approves the planned emergency research may approve the study without requiring informed consent of all research subjects prior to initiating the research intervention if the IRB (that includes a member who is a licensed physician and who is not otherwise participating in the clinical trial) finds that the following criteria from FDA 21 CFR 50.24 have been met:

1. The human subjects are in a life-threatening situation, available treatments are unproven or unsatisfactory, and the collection of valid scientific evidence, which may include evidence obtained through randomized placebo-controlled investigations, is necessary to determine the safety and effectiveness of particular interventions.

2. Obtaining informed consent is not feasible because:
   a) The subjects will not be able to give their informed consent as a result of their medical condition;
   b) The intervention under investigation must be administered before consent from the subjects' legally authorized representatives is feasible; and
   c) There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the clinical investigation.

3. Participation in the research holds out the prospect of direct benefit to the subjects because:
   a) Subjects are facing a life-threatening situation that necessitates intervention;
   b) Appropriate animal and other preclinical studies have been conducted, and the information derived from those studies and related evidence support the potential for the intervention to provide a direct benefit to the individual subjects; and
   c) Risks associated with the investigation are reasonable in relation to what is known about the medical condition of the potential class of subjects, the risks and benefits of standard therapy, if any, and what is known about the risks and benefits of the proposed intervention or activity.

4. The clinical investigation could not practicably be carried out without the waiver.

5. The proposed investigational plan defines the length of the potential therapeutic window based on scientific evidence, and the investigator has committed to attempting to contact a legally authorized representative for each subject within that window of time and, if feasible, to asking the legally authorized representative contacted for consent within that window rather than proceeding without consent. The investigator will summarize efforts made to contact legally authorized representatives and make this information available to the IRB at the time of continuing review.

6. The IRB has reviewed and approved informed consent procedures and an informed consent document consistent with 21 CFR 50.25. These procedures and the informed consent document are to be used with subjects or their legally authorized representatives in situations where use of such procedures and documents is feasible. The IRB has reviewed and approved procedures and information to be used when providing an opportunity for a family member to object to a subject's participation in the clinical investigation consistent with paragraph 7(e) of this section.

7. Additional protections of the rights and welfare of the subjects will be provided, including, at least:
a) Consultation (including, where appropriate, consultation carried out by the IRB) with representatives of the communities in which the clinical investigation will be conducted and from which the subjects will be drawn;
b) Public disclosure to the communities in which the clinical investigation will be conducted and from which the subjects will be drawn, prior to initiation of the clinical investigation, of plans for the investigation and its risks and expected benefits;
c) Public disclosure of sufficient information following completion of the clinical investigation to apprise the community and investigators of the study, including the demographic characteristics of the research population, and its results;
d) Establishment of an independent data monitoring committee to exercise oversight of the clinical investigation; and
e) If obtaining informed consent is not feasible and a legally authorized representative is not reasonably available, the investigator has committed, if feasible, to attempting to contact within the therapeutic window the subject's family member who is not a legally authorized representative, and asking whether he or she objects to the subject's participation in the clinical investigation. The investigator will summarize efforts made to contact family members and make this information available to the IRB at the time of continuing review.

8. The IRB is responsible for ensuring that procedures are in place to inform, at the earliest feasible opportunity, each subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, of the subject's inclusion in the clinical investigation, the details of the investigation and other information contained in the informed consent document. The IRB shall also ensure that there is a procedure to inform the subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, that he or she may discontinue the subject's participation at any time without penalty or loss of benefits to which the subject is otherwise entitled. If a legally authorized representative or family member is told about the clinical investigation and the subject's condition improves, the subject is also to be informed as soon as feasible. If a subject is entered into a clinical investigation with waived consent and the subject dies before a legally authorized representative or family member can be contacted, information about the clinical investigation is to be provided to the subject's legally authorized representative or family member, if feasible.

9. The IRB determinations required by this section and the documentation required by this section are to be retained by the IRB for at least three (3) years after completion of the clinical investigation, and the records shall be accessible for inspection and copying by FDA in accordance with 21 CFR 56.115(b).

10. Protocols involving an exception to the informed consent requirement under this section must be performed under a separate investigational new drug application (IND) or investigational device exemption (IDE) that clearly identifies such protocols as protocols that may include subjects who are unable to consent. The submission of those protocols in a separate IND/IDE is required even if an IND for the same drug product or an IDE for the same device already exists. Applications for investigations under this section may not be submitted as amendments under 21 CFR 312.30 or 21 CFR 812.35.

11. If the IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in the exception provided under this section or because of other relevant
ethical concerns, the IRB must document its findings and provide these findings promptly in writing to the clinical investigator and to the sponsor of the clinical investigation. The sponsor of the clinical investigation must promptly disclose this information to FDA and to the sponsor's clinical investigators who are participating or are asked to participate in this or a substantially equivalent clinical investigation of the sponsor, and to other IRBs that have been, or are, asked to review this or a substantially equivalent investigation by that sponsor.

5.13.1.3 Community Consultation

Community Consultation is an extremely important requirement for conducting planned emergency research. The community in which the research is to take place and the persons that would likely be affected by the research must be informed and must agree that it is acceptable to begin the planned emergency research. Consultation with the community must be conducted prior to full approval by the IRB.

Depending on the nature of the research, community consultation may consist of any of the following activities:
- survey(s);
- questionnaire(s);
- focus groups; and
- Community meetings.

The content of these activities/meetings must be reviewed and agreed upon prior to conducting the consultations by the IRB Chair or designee and the IO or designee.

In order to facilitate educating, informing and publicly disclosing the plans for the investigation and its risks and expected benefits to the community in which the clinical investigation will be conducted, and from which the subjects will be drawn, every effort must be made to engage a representative sampling of persons or organizations in the affected community consultation process to obtain their input and agreement that the research should go forward. The IRB cannot approve Planned Emergency Research without this part of the process being completed in a thorough manner. All community meetings must include the Principal Investigator. A representative from the ORC, and where appropriate, a member of the IRB, may also attend. Upon completion of the community consultation process, the PI must present a written report to the IRB citing any and all issues raised through the process and conclusions. The IRB will determine if there is community support based on the report.

The PI is expected to keep and maintain detailed documentation that all of the above required procedures for planned emergency research and emergency waiver of consent are met. The documentation should be included in the submission to the IRB for full approval.
6 Vulnerable Subjects in Research

6.1 Policy

When some or all of the subjects in research conducted under the auspices of University are likely to be vulnerable to coercion or undue influence or have diminished decision-making capacity, the research must include additional safeguards to protect the rights and welfare of these subjects. The IRB must ensure that all of the regulatory requirements for the protection of vulnerable subjects are met and that appropriate additional protections for vulnerable subjects are in place.

The following procedures describe the requirements for involving vulnerable subjects in research under the auspices of the University.

6.2 Definitions

Children: persons who have not attained the legal age for consent to treatments or procedures involved in research, under applicable law of the jurisdiction in which the research will be conducted. Consistent with New York State Law, the IRB generally defines children as persons under eighteen years of age. For the purposes of these SOPs, children and minors both imply persons under eighteen years of age. NYS Public Health Law, at section 2504 speaks to who may consent (to medical care in general, but NY state law does not specifically reference who may consent to participation in research) as follows:

1. (Any person) 18 or older, or is the parent of a child or is married may give effective consent for medical, dental health and hospital services for himself or herself and the consent of no other person shall be necessary.
2. Any person who has been married or who has borne a child may give effective consent for medical, dental health and hospital services for his or her child.
3. Any person who is pregnant may give effective consent for medical, dental health and hospital services related to the pregnancy.

While consent by ‘emancipated’ individuals is not the general rule, there are other statutory provisions relating to consent for minors who are in military service or are seeking treatment for AIDS (PHL ‘2781) and other sexually transmitted diseases (PHL ‘2305).

In general, where the individual is a minor, the presumption is that he or she is not emancipated and the burden of proof rests on the individual asserting it. Because New York State law does not specifically address consent of children with majority status by virtue of "emancipation" with respect to research, the IRB will review issues of consent related to enrollment of these minor children in research on a case-by-case basis.

Guardians: in New York, there are at least two separate and distinct types of guardian appointment. Generally, the power of a guardian is dictated by the ‘legally appointed guardian powers’, which are
determined in scope and duration by a court and described in the guardian papers. Guardian powers can be very limited (e.g. to financial matters only) or much broader. Prior to relying on guardian consent for a specific subject, a copy of the legal guardian papers must be sent to ORC who (in consultation with Counsel’s office) will assess whether the scope and powers (if any exist at all) of the Guardian do or do not include the authority to consent to research. Obtaining guardian consent without first obtaining approval from ORC constitutes noncompliance with these SOPs.

Delivery: complete separation of the fetus from the woman by expulsion, extraction, or any other means.

Fetus: product of conception from the time of implantation until delivery.

Viable fetus: now termed a “viable neonate.”

Nonviable fetus: a fetus ex utero that, although living, is not able to survive to the point of independently maintaining heart and respiration. NOTE: In 45 CFR 46 Subpart B, this definition is used as the definition of a non-viable neonate.

Dead fetus: a fetus, which exhibits neither heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord if still, attached.

In vitro fertilization: any fertilization either of human ova, which occurs outside the body of a female, through a mixture of donor human sperm and ova or by any other means.

Legally authorized representative (LAR):

Federal (45 CFR § 46.102(c) :

An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research.

NYS:

Per the Family Health Care Decisions Act (FHCDA), a person in the highest category on the following surrogate list who is available, willing and competent to make decisions for the incapable patient, and is identified when there is no health care agent:

1. A court-appointed guardian (per NYS Mental Health Law Article 81);
2. An individual designated as a representative/agent through a health care proxy that is appropriately executed. For a health care proxy to be effective, it must have been signed at a time when the subject had decision-making capacity. The subject’s wishes, if any, with regard to research as expressed in the health care proxy govern (e.g., prohibiting all research or permitting only research which may provide a direct benefit);
3. The spouse, if not legally separated from the patient, or the domestic partner;
4. A son or daughter eighteen years of age or older;
5. A parent;
6. A brother or sister eighteen years of age or older; or
7. A close friend (meaning a person eighteen (18) years of age or older who has maintained such regular contact with the subject as to be familiar with the subject’s activities, health and beliefs).

**Neonate**: newborn.

**Viable neonate**: being able, after delivery, to survive to the point of being independently maintaining heart and respiration (given the benefit of available medical therapy).

**Non-viable neonate**: same as a non-viable fetus.

**Pregnancy**: the period of time from confirmation of implantation (through any of the presumptive signs of pregnancy, such as missed menses, or by a medically acceptable pregnancy test), until expulsion or extraction of the fetus.

**Prisoner**: any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures that provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.

**Surrogate Consent**: obtained from a legally authorized representative on behalf of a subject determined to lack decision-making capacity.

### 6.3 Involvement of Vulnerable Populations

When some or all of the subjects in a protocol are likely to be vulnerable to coercion or undue influence, the IRB should include additional safeguards to protect the rights and welfare of these subjects. Some of the vulnerable populations that might be involved in research include children, pregnant women, fetuses, neonates, prisoners, adults who lack the ability to consent, students, employees, or homeless persons.

If the IRB reviews research that targets for enrollment categories of subjects vulnerable to coercion or undue influence, the review process will include one or more individuals who are knowledgeable about or experienced in working with these subjects. For example, the IRB will include one or more individuals who are knowledgeable about or experienced in working with children, prisoners, or adults with limited decision-making capacity, when reviewing research that involves individuals from these populations.
6.4 FWA and the 45 CFR 46 Subparts

45 CFR 46 has additional subparts designed to provide extra protections for vulnerable populations that also have additional requirements for the IRB.

Subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research

Subpart C - Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects

Subpart D - Additional Protections for Children Involved as Subjects in Research

Under the University’s FWA the subparts only apply to DHHS funded research and research funded by another federal agency that requires compliance with the subparts (FDA regulations include Subpart D, which applies to all FDA-regulated research). The following policies and procedures, which are based on the subparts, apply to all research regardless of funding. The individual sections describe how the subparts apply to DHHS funded research.

6.5 Procedures

Initial Review of Research Proposal:

1. The PI should identify the vulnerable subjects to be enrolled in the proposed research at initial review and provide the justification for their inclusion in the study.
2. The IRB evaluates the proposed plan for consent of the specific vulnerable populations involved. If the research involves adults unable to consent, the IRB evaluates the proposed plan for permission of legally authorized representatives.
3. The IRB evaluates and approves the proposed plan for the assent of subjects, if applicable.
4. The IRB evaluates the research to determine the need for additional protections.
5. The IRB assesses the adequacy of additional protections for vulnerable populations provided by the PI.

Continuing Review and Monitoring. At continuing review, the PI should identify the number of vulnerable subjects enrolled and any that needed an independent monitor in the progress report.

6.6 Research Involving Pregnant Women, Human Fetuses and Neonates

The following applies to all research regardless of funding source. Since, according to the University FWA, Subpart B of 45 CFR 46 applies only to DHHS funded research, the funding-source specific requirements are noted in the appropriate sections.
6.6.1 Research Involving Pregnant Women or Fetuses

6.6.1.1 Research Not Funded by DHHS

Where the risk to the fetus is no more than minimal, no additional safeguards are required and there are no restrictions on the involvement of pregnant women in research.

Where the risk to the fetus is more than minimal, pregnant women or fetuses may be involved in research if all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;
2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus;
3. Any risk is the least possible for achieving the objectives of the research;
4. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent;
5. If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest;
6. Each individual providing consent under paragraph 4 or 5 of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
7. For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent;
8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy;
9. Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and
10. Individuals engaged in the research will have no part in determining the viability of a neonate.

6.6.1.2 Research Funded by DHHS

For DHHS-funded research, 45 CFR Subpart B applies to all research involving pregnant women. Under 45 CFR Subpart B, pregnant women or fetuses may be involved in research funded by DHHS if all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risk to pregnant women and fetuses;
2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus or, if there is no such prospect of benefit, the risk to the
fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;

3. Any risk is the least possible for achieving the objectives of the research;
4. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent;
5. If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest;
6. Each individual providing consent under paragraph 4 or 5 of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
7. For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent in Section 6.8.2;
8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy;
9. Individuals engaged in the research will have no part in determining the viability of a neonate; and
10. Individuals engaged in the research will have no part in determining the viability of a neonate.

6.6.2 Research Involving Neonates of Uncertain Viability, and Nonviable Neonates

Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met:

1. Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates;
2. Each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the neonate;
3. Individuals engaged in the research will have no part in determining the viability of a neonate; and
4. The requirements of Neonates of Uncertain Viability or Nonviable Neonates (see below in this section) have been met as applicable.

**Neonates of Uncertain Viability.** Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research covered by this subpart unless the following additional conditions have been met:

The IRB determines that:

1. The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective, or
2. The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and

3. The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accord with the provisions of permission and assent, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

Nonviable Neonates. After delivery, nonviable neonates may not be involved in research covered by this subpart unless all of the following additional conditions are met:

1. Vital functions of the neonate will not be artificially maintained;
2. The research will not terminate the heartbeat or respiration of the neonate;
3. There will be no added risk to the neonate resulting from the research;
4. The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
5. The legally effective informed consent of both parents of the neonate is obtained in accord with the provisions of permission and assent, except that the waiver and alteration of the provisions of permission and assent do not apply. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements of this paragraph, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice to meet the requirements of this paragraph.

Viable Neonates. A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of CORIHS Review Process and Research Involving Children.

6.6.3 Research Involving, After Delivery, the Placenta, the Dead Fetus or Fetal Material

Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, must be conducted only in accord with any applicable federal, state, or local laws and regulations regarding such activities.

If information associated with material described above in this section is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research subjects and all pertinent sections of this manual are applicable.

6.6.4 Research Not Otherwise Approvable

6.6.4.1 Research Not Funded by DHHS
If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates, and, the research is not approvable under the above provisions, then the IRB will consult with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law). Based on the recommendation of the panel, the IRB may approve the research based on either:

1. That the research in fact satisfies the conditions of Section 6.6.2, as applicable; or
2. The following:
   a) The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates;
   b) The research will be conducted in accord with sound ethical principles; and
   c) Informed consent will be obtained in accord with the provisions for informed consent and other applicable sections of this manual.

6.6.4.2 Research Funded by DHHS

DHHS funded research that falls in this category must be approved by the Secretary of Health and Human Services. If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates and the research is not approvable under the above provisions, then the research will be sent to OHRP for DHHS review.

6.7 Research Involving Prisoners

Prisoners are another of the three classes that are deemed so vulnerable to exploitation in research that there are special rules protecting them. In the past, prisoners were viewed as a convenient research population. They are housed in a single location, constitute a large and relatively stable population, and live a routine life. Unfortunately, all the things that make a prison and prisoners a convenient research population also make prisoners ripe for exploitation.

The concern Subpart C and this policy based on Subpart C attempts to address is whether prisoners have any real choice in participation in research, or whether incarceration prohibits free choice.

The following applies to all research involving prisoners, regardless of funding source. The requirements in this section are consistent with Subpart C of 45 CFR 46, which applies to DHHS funded research.

Note that for Department of Defense-sponsored research, research involving prisoners of war (POW) is prohibited. This includes any person captured, detained, held or otherwise under the control of DoD personnel (military and civilian, or contractor employee).
6.7.1 Applicability

This policy applies to all biomedical and behavioral research conducted under the auspices of the University involving prisoners as subjects. Even though the IRB may approve a research protocol involving prisoners as subjects according to this policy, investigators are still subject to the Administrative Regulations of the New York State Department of Corrections and any other applicable State or local law. [45 CFR 46.301]

Note that for Department of Defense sponsored research, research involving prisoners of war (POW) is prohibited. This includes any person captured, detained, held or otherwise under the control of DoD personnel (military and civilian, or contractor employee).

6.7.2 Minimal Risk

The definition of minimal risk in the Subpart C is different than in the rest of the federal regulations. According to 45 CFR 46.303, minimal risk is the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons.

6.7.3 Composition of the IRB

[45 CFR 46.304]

In addition to satisfying the general requirements detailed in the IRB section of this manual, when reviewing research-involving prisoners, the IRB must also meet the following requirements:

- A majority of the IRB (exclusive of prisoner members) must have no association with the prison(s) involved, apart from their membership on the IRB.
- At least one member of the IRB must be a prisoner, or a prisoner representative with appropriate background and experience to serve in that capacity, except that where a particular research project is reviewed by more than one the IRB, only one the IRB need satisfy this requirement.
- At least one of the IRB committees will be duly constituted to review research involving prisoners. Consultation with ORC is strongly recommended if such research is proposed.

6.7.4 Review of Research Involving Prisoners

1. The prisoner representative must review research involving prisoners, focusing on the requirements in Subpart C.
2. The prisoner representative must receive all review materials pertaining to the research (same as primary reviewer).
3. The prisoner representative must be present at a convened meeting when the research involving prisoners is reviewed. If the prisoner representative is not present, research involving prisoners cannot be reviewed or approved. The prisoner representative may attend the meeting by phone,
video-conference, or webinar, as long as the representative is able to participate in the meeting as if they were present in person at the meeting.

4. The prisoner representative must present his/her review either orally or in writing at the convened meeting of the IRB when the research involving prisoners is reviewed.

5. Modifications.
   a) Minor modifications to research may be reviewed using the expedited procedure described below, using either of the two procedures described based on the type of modification.
   b) Modifications involving more than a minor change reviewed by the convened IRB must use the same procedures for initial review including the responsibility of the prisoner representative to review the modification and participate in the meeting (as described above).

6. Continuing review. Continuing review must use the same procedures for initial review including the responsibility of the prisoner representative to review the continuing review materials and participate in the meeting (as described above).

7. Expedited Review
   a) Research involving interaction with prisoners may be reviewed by the expedited procedure, if a determination is made that the research involves no greater than minimal risk for the prison population being studied. The prisoner representative must concur with the determination that the research involves no greater than minimal risk. The prisoner representative must review the research as a reviewer, designated by the chair, or consultant. This may be as the sole reviewer or in addition to another reviewer, as appropriate. Review of modifications and continuing review must use the same procedures for initial review using this expedited procedure including the responsibility of the prisoner representative.
   b) Research that does not involve interaction with prisoners (e.g. existing data, records review) may be reviewed by the expedited procedure, if a determination is made that the research involves no greater than minimal risk for the prison population being studied. Review by a prisoner representative is not required. The prisoner representative may review the research as a reviewer or consultant if designated by the IRB Chair. Review of modifications and continuing review must use the same procedures as initial review.

6.7.5 Incarceration of Enrolled Subjects

If a subject becomes a prisoner while enrolled in a research study that was not reviewed according to Subpart C and Subpart C applies, the IRB must:

1. Confirm that the subject meets the definition of a prisoner.
2. Terminate enrollment or review the research study under Subpart C if it is feasible for the subject to remain in the study.
3. Before terminating the enrollment of the incarcerated subject the IRB should consider the risks associated with terminating participation in the study. If the subject cannot be terminated for health or safety reasons, one of two options are available:
   a) Keep the subject enrolled in the study and review the research under Subpart C. If some of the requirements of Subpart C cannot be met, but it is in the best interests of the subject to remain in the study, keep the subject enrolled and inform OHRP of the decision along with the justification; or
b) Remove the subject from the study and keep the subject on the study intervention under an alternate mechanism such as compassionate use, off label use, etc.

4. If a subject is incarcerated temporarily while enrolled in a study:
   a) If the temporary incarceration has no effect on the study, keep the subject enrolled; or
   b) If the temporary incarceration has an effect on the study, handle according to the above guidance.

Otherwise, the IRB Chair shall require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB can review this request to approve a change in the research protocol.

The convened IRB, upon receipt of notification that a previously enrolled human subject has become a prisoner, shall promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy. The IRB should consult with a subject matter expert having the expertise of a prisoner representative if the IRB reviewing the research protocol does not have a prisoner representative.

If the prisoner-subject can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner-subject’s confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human subjects from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner-subject to continue to participate in the research.

6.7.6 Additional Duties of the IRB

[45 CFR 46.305]

In addition to all other responsibilities prescribed for IRB in the SBU Institutional Review Board and CORIHS Review Process sections of this manual, the IRB will review research involving prisoners and approve such research only if it finds that:

1. The research falls into one of the following permitted categories [45 CFR 46.306]:
   a) Study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
   b) Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
   c) Research on conditions particularly affecting prisoners as a class (for example, research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults); or
   d) Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject.

2. Any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and
opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh
the risks of the research against the value of such advantages in the limited choice environment of
the prison is impaired;
3. The risks involved in the research are commensurate with risks that would be accepted by non-
prisoner volunteers;
4. Procedures for the selection of subjects within the prison are fair to all prisoners and immune from
arbitrary intervention by prison authorities or prisoners. Unless the principal investigator provides
to the IRB justification in writing for following some other procedures, control subjects must be
selected randomly from the group of available prisoners who meet the characteristics needed for
that particular research project;
5. The information is presented in language which is understandable to the subject population;
6. Adequate assurance exists that parole Board will not take into account a prisoner's participation in
the research in making decisions regarding parole, and each prisoner is clearly informed in advance
that participation in the research will have no effect on his or her parole; and
7. Where the IRB finds there may be a need for follow-up examination or care of subjects after the
end of their participation, adequate provision has been made for such examination or care, taking
into account the varying lengths of individual prisoners' sentences, and for informing subjects of
this fact.

6.7.7 Certification to HHS

Under 45 CFR 46.305(c), the institution responsible for conducting research involving prisoners that is
supported by HHS shall certify to the Secretary (through OHRP) that the IRB has made the seven
findings required under 45 CFR 46.305(a). For all HHS conducted or supported research the University
will send to OHRP a certification letter to this effect, which will also include the name and address of
the institution and specifically identify the research protocol in question and any relevant HHS grant
application or protocol. HHS conducted or supported research involving prisoners as subjects may not
proceed until OHRP issues its approval in writing to the University on behalf of the Secretary under 45
CFR 46.306(a)(2).

Under its authority at 45 CFR 46.115(b), OHRP requires that the institution responsible for the conduct
of the proposed research also submit to OHRP a copy of the research proposal so that OHRP can
determine whether the proposed research involves one of the categories of research permissible
under 45 CFR 46.306(a)(2), and if so, which one. The term "research proposal" includes the IRB
approved protocol, any relevant HHS grant application or proposal, any IRB application forms required
by the IRB, and any other information requested or required by the IRB to be considered during initial
IRB review.

The above requirement does not apply to research that is not HHS conducted or supported.
6.7.8 Waiver for Epidemiology Research

The Secretary of DHHS has waived the applicability of 45 CFR 46.305(a)(1) and 46.306(a)(2) for certain research conducted or supported by DHHS that involves epidemiologic studies that meet the following criteria:

1. In which the sole purposes are:
   a) To describe the prevalence or incidence of a disease by identifying all cases, or
   b) To study potential risk factor associations for a disease, and

2. Where the IRB has approved the research and fulfilled its duties under 45 CFR 46.305(a)(2)–(7) and determined and documented that:
   a) The research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects, and
   b) Prisoners are not a particular focus of the research.

3. The specific type of epidemiological research subject to the waiver involves no more than minimal risk and no more than inconvenience to the human subjects. The waiver would allow the conduct of minimal risk research that does not now fall within the categories set out in 45 CFR 46.306(a)(2).

4. The range of studies to which the waiver would apply includes epidemiological research related to chronic diseases, injuries, and environmental health. This type of research uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than minimal risk to the subjects.

5. In order for a study to be approved under this waiver, the IRB would need to ensure that, among other things, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data.

6.8 Research Involving Children

The following applies to all research involving children, regardless of funding source. The requirements in this section are consistent with Subpart D of 45 CFR 46, which applies to DHHS funded research and Subpart D of 21 CFR 50, which applies to FDA regulated research involving children.

6.8.1 Allowable Categories

Research on children must be reviewed and categorized by the IRB into one of the following groups (and if there is more than one possible study arm, a component analysis should be done to assess risk for each arm):

45 CFR 46.404; OHRP and if applicable, 21 CFR 50.51; FDA

Research not involving physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (i.e., minimal risk).

- Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in Section 6.8.2.

45 CFR 46.405; OHRP, and if applicable 21 CFR 50.52; FDA

...
Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subject.

- The risk is justified by the anticipated benefit to the subjects;
- Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in Section 6.8.2.

45 CFR 46.406; OHRP and if applicable 21 CFR 50.53; FDA

Research involving greater than minimal risk and no reasonable prospect of direct benefit to the individual subject, but likely to yield generalizable knowledge about the subject’s disorder or condition.

- The risk represents a minor increase over minimal risk;
- The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
- Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in Section 6.8.2.

Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children.

a) Federally-funded research in this category must be approved by the Secretary of Health and Human Services.

b) FDA-regulated research in this category must be approved by the Commissioner of Food and Drugs.

c) For non-federally-funded, non-FDA research, the IRB will consult with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law). Based on the recommendation of the panel, the IRB may approve the research based on either:

1. That the research in fact satisfies the conditions of the previous categories, as applicable; or
2. The following:
   - The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;
   - The research will be conducted in accord with sound ethical principles; and
   - Informed consent will be obtained in accord with the provisions for informed consent and other applicable sections of this manual.

d) Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in Section 6.8.2.

6.8.2 Parental Permission and Assent

6.8.2.1 Parental Permission

The IRB must determine that adequate provisions have been made for soliciting the permission of each child’s parent or guardian.

Parents or guardians must be provided with the basic elements of consent and any additional elements the IRB deems necessary, as described in Section 5.6.
The IRB may find that the permission of one parent is sufficient for research to be conducted under .404 & .405 above. IRB’s determination of whether permission must be obtained from one or both parents will be documented in the electronic record when a protocol receives expedited review, and in meeting minutes when reviewed by the convened committee.

Consent from both parents is required for research to be conducted under .406 & ‘Research not otherwise approvable’ above unless:
1. One parent is deceased, unknown, incompetent, or not reasonably available; or
2. When only one parent has legal responsibility for the care and custody of the child.

The IRB may waive the requirement for obtaining permission from a parent or legal guardian if:
1. The research meets the provisions for waiver in Section 5.9; or
2. If the IRB determines that the research protocol is designed for conditions or a subject population for which parental or guardian permission is not a reasonable requirements to protect the subjects (e.g. neglected or abused children) provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and that the waiver is not inconsistent with federal, state, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.

Permission from parents or legal guardians must be documented in accordance with and to the extent required by Section 5.7 and 5.10.

6.8.2.2 Assent from Children

Because “assent” means a child’s affirmative agreement to participate in research, the child must actively show his or her willingness to participate in the research, rather than just complying with directions to participate and not resisting in any way. When judging whether children are capable of assent, as well as the assent process, the IRB is charged with taking into account nature of the proposed research activity, the ages, maturity, and psychological state of the children involved. The minor population to be studied may have a wide range of ability to provide assent. Some potential subjects may lack the cognitive or developmental ability to provide assent, regardless of chronologic age. Some children will have the capacity to assent, while others will not. In this situation, the IRB may require the PI to have a plan of assessing and documenting each child’s capability of assenting, and of being able to comply with the study procedures. If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research. Even when the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances detailed in the Waiver of Informed Consent section of this manual.
Each protocol is unique and is reviewed by the IRB accordingly. As such, the IRB’s decision regarding assent (and documentation thereof) may necessarily vary from the general parameters below.

But, in general:

**Assent will be required for:**

1. **Non-therapeutic protocols.** Assent must be documented as follows:
   a) For 12-17 year olds: via a ‘full’ assent form (containing highly simplified 'consent' information—see section below "About Full Assent Form") that the child signs; and
   b) For 7-11 year olds: a note in the subject's research record that the assent discussion has occurred and the child's agreement has been obtained.

2. **Potentially therapeutic protocols (FDA-approved or investigational) where there are alternatives available outside of the research with similar risk/benefit profiles.** Assent must be documented as follows:
   a) For 12-17 year olds: via a ‘full’ assent form (containing highly simplified 'consent' information—see section below "About Full Assent Form") that the child signs; and
   b) For 7-11 year olds: via a note in the subject's research record that the assent discussion has occurred and the child's agreement has been obtained.

3. **Potentially therapeutic protocol involving FDA-approved drugs, devices, radiation, procedures, etc. used in an experimental way (dosages, scheduling etc).** Assent must be documented as follows:
   a) For 12-17 year olds: via a ‘full’ assent form (containing highly simplified 'consent' information—see section below "About Full Assent Form") that the child signs, or alternatively, via an assent 'short form' (see section below 'About the Short assent form'-this latter method must be specifically approved by the IRB for this category of research); and
   b) For 7-11 year olds: via a note in the subject's research record that the discussion has occurred and the child's agreement has been obtained.

4. **Protocols that do not fit into categories (1), (2), or (3) above, but where assent is none-the-less required by NCI CIRB (for cooperative oncology protocols), or as otherwise required by the IRB.** Assent must be documented as follows:
   a) For 12-17 year olds: via an assent 'short form' (see section below, 'About the Short assent form'); and
   b) For 7-11 year olds: via a note in the subject's research record that the discussion has occurred and the child's agreement has been obtained.

**Assent is waived for:**

1. **Non-therapeutic protocols where results of biological tests are required in order to determine eligibility for potentially therapeutic protocols (certain COG protocols).**
2. **Potentially therapeutic protocols involving an experimental drug or procedure where there are no standard alternatives available, or where the risk/benefit profile of the standard alternatives that are available are such that participation in the protocol would be important to the health or well-being of the children.”
3. Studies where the subject population is too young, or the capability of some or all of the children is so limited, that they cannot reasonably be consulted

Whether assent is required or waived, no physical or chemical means of restraint may be used on a minor subject unless specifically approved prior to use by the IRB.

6.8.2.2.1 Full Assent Form:

This document must be an accurate and complete, but highly simplified version of the approved consent form/permission form for the study. It must be understandable to a twelve (12) year old (approximately 7th grade).

Investigators should try to draft a form that is age appropriate and study specific, taking into account the typical child's experience and level of understanding, and composing a document that treats the child respectfully and conveys the essential information about the study. The assent form should:
1. Tell why the research is being conducted;
2. Describe what will happen and for how long or how often;
3. Say it's up to the child to participate and that it's okay to say no;
4. Explain if it will hurt and if so for how long and how often;
5. Say what the child's other choices are;
6. Describe any good things that might happen;
7. Say whether there is any compensation for participating; and
8. Ask for questions.

6.8.2.2.2 Short Assent Form:

Where the IRB approves use of a short assent form process, an assent discussion is held with the minor subject. The 'script' to be followed in that discussion must be reviewed and approved by the IRB. If the minor agrees to be in the study, the short form is signed, along with a witness (not the person assessing ability and obtaining assent). The witness should also sign a copy of the script that was used in the process. A sample short assent form is accessible to investigators in the electronic management system’s Forms Library.

6.8.2.3 Children who are Wards ('Foster Children”)

Children who are wards of the State or any other agency, institution, or entity must be specifically permitted by the IRB for inclusion in research involving greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition. Such research must be:

1. Related to their status as wards; or
2. Conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.
If the research meets the condition(s) above, the IRB will require that an advocate must be appointed for each child who is a ward (one individual may serve as advocate for more than one child), in addition to any other individual acting on behalf of the child as legal guardian or in *loco parentis*.

The advocate must be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization.

### 6.9 Persons with Impaired Decision Making Capacity

The requirements in this section apply to all research involving adults with impaired decision-making capacity regardless of funding source. Section 5.5 should be reviewed for required processes to be followed to ascertain a subject’s capacity to consent for research.

In order to include such a population in research, the investigator must demonstrate to the IRB that there is a compelling reason to do so, and that the aims of the research cannot be accomplished without their inclusion.

An appropriate legally authorized representative (LAR), as defined above, must give surrogate permission for the patient’s inclusion in the research. The LAR must be told that their obligation is to try to determine what the subject would do if competent, or if the subject’s wishes cannot be determined, what they think is in the incompetent person's best interest. The subject’s assent should also be obtained whenever possible. If the subject’s condition is such that decision-making capacity may be regained, the investigator is obligated to repeat the consent process with the subject, and obtain the subject’s consent to continue in the study.

### 6.9.1 IRB Composition and Additional Protections

**For research constituting more than minimal risk** at least one IRB member who is knowledgeable about, or experienced in working with subjects who are decisionally-impaired, will be present for the review.

**For research involving more than minimal risk, without the prospect of direct benefit to the subject,** additional protections to the subjects may include one or both of the requirements below, as deemed appropriate by the IRB:

1. A documented determination by the IRB that the research is of **vital importance**, i.e., there is clear and significant evidence that the use of such a procedure or intervention presents a reasonable opportunity to further the understanding of the etiology, prevention, diagnosis, pathophysiology, or alleviation or treatment of a condition or disorder; and/or
2. Consultation with one or more representatives of a relevant advocacy group.

As with any study, the IRB retains the right to have a member of the IRB or ORC to monitor/witness the consent processes with the patient’s LAR.
6.9.2 Determining Decision Making Capacity

(See Section 5.5 for general discussion of the consent process required to determine the decision-making capacity of all potential research subjects.)

1. Certain individuals, such as those with severe dementia, or severe mental retardation, will have a diminished capacity to provide consent. For these individuals, see the section on 'Surrogate Consent,' below.

2. For other individuals, it will not always be easy to predict whether capacity will be diminished given the following:
   - Many individuals with psychiatric illnesses have the capacity to provide consent.
   - Medical illnesses (e.g. cerebral insult) may be accompanied by an impaired capacity to consent.
   - Upon learning of a serious diagnosis (e.g. cancer), psychological "shock" may temporarily impair a person's capacity to provide consent, although the illness does not affect decisional capacity in and of itself.
   - Individuals who are intoxicated with alcohol or with drugs may be unable to consent to research until the intoxication resolves.

In assessing capacity, it is important to note that capacity is neither a constant nor an absolute. For example:
   - Stroke victims may not have the capacity to consent to research immediately after the onset of stroke, but may develop capacity as recovery progresses.
   - Patients in the early stages of Alzheimer's disease may initially have the capacity to consent to research, but as the disease progresses, may lose the ability to decide to continue or withdraw from that research.
   - Patients with schizophrenia often experience acute psychotic episodes followed by periods of lucidity.
   - Patients who learn they are terminally ill, often experience an initial short-lived period of emotional shock and denial which impairs their capacity to provide consent.

The requisite level of capacity will necessarily vary from study to study and will depend on:
   - The complexity of the information being presented, and
   - The relative risks and benefits of the study (deciding to participate in a blood drawing protocol is 'easier' than deciding to participate in an experimental drug trial).

Therefore, when developing a research proposal, the investigator must determine whether the study will include any subjects who may not have the capacity to consent to the research, either initially, or at some point during the course of the study. If some or all subjects may have a diminished capacity to consent, the investigator must further determine if the potential impairment is temporary (e.g. 'shock' at the discovery of a medical diagnosis, intoxication), permanent (e.g. severe mental retardation), progressive (e.g. Alzheimer's dementia) or fluctuating (e.g. bipolar disorder).
For research protocols involving subjects who have fluctuating or limited decision-making capacity the IRB may ensure that investigators establish and maintain ongoing communication with involved caregivers. Periodic re-consent should be considered in some cases. Third party consent monitors may be used during the recruitment and consenting process, or waiting periods may be required to allow more time for the subject to consider the information that has been presented.

It is often possible for investigators and others to enable persons with some decisional impairments to make voluntary and informed decisions to consent or refuse participation in research. Potential measures include repetitive teaching, group sessions, audiovisual presentations, and oral or written recall tests. Other measures might include follow-up questions to assess subject understanding, videotaping or audio-taping of consent interviews, second opinions, use of independent consent observers, interpreter for hearing-impaired subjects, allowing a waiting period before enrollment, or involvement of a trusted family member or friend in the disclosure and decision making process.

Both investigators and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision making capacity or those with decreasing capacity to give consent, a re-consenting process with surrogate consent may be necessary.

In the event research subjects become incompetent or impaired in decision making capacity after enrollment, the PI is responsible for notifying the IRB and ORC. The PI is responsible for developing a monitoring plan which follows the guidelines outlined above for impaired decision making research subjects.

Depending on the study, associated risk/benefit ratio, and likelihood of inclusion of adults who can and cannot consent for themselves, the IRB may require investigators to use independent and qualified professionals (not associated with the study, with familiarity concerning capacity to consent issues) to assess whether potential subjects have the capacity to give voluntary, informed consent.

If the IRB requires such formal documentation of a subject's capacity, the following statement is added to the end of the consent form:

"My signature below attests to the fact that I am a licensed health care provider and I have interviewed (name of patient) on ______ (date). I have determined that s/he does_____ does not_____ have the capacity to consent to participation in this research activity, in that s/he is____ is not____ capable of appreciating a) that the activity described in this consent document constitutes research, not standard treatment, b) the risks and benefits of this study c) the alternatives that are available if s/he chooses not to participate, and d) that the decision to not participate will be accepted without penalty, i.e., without jeopardizing his/her clinical care."

Although unable to provide informed consent, some persons may resist participating in a research protocol for which permission has been given by their LAR. Under no circumstances may subjects be forced or coerced to participate.
When subjects lack the capacity to give consent, investigators may obtain permission from the legally authorized representative of a subject as described below.

A person who has been determined to lack capacity to consent to participate in a research study should be informed about the trial to the extent compatible with the subject’s understanding and, if possible, the subject should give their assent to participate, sign and date the written informed consent or a separate assent form. If the person objects to participating, this objection should be heeded.

Where subjects lack the capacity to give consent, surrogate consent may be obtained from the subject’s legally authorized/empowered representative (as defined in Section 5.2).

7 Investigational Drugs & Devices in Research

7.1 Policy

FDA regulations apply to any research that involves a test article in a clinical investigation involving human subjects as defined by the FDA regulations. For FDA regulated research, the IRB must apply the FDA regulations at 21 CFR 50 and 21 CFR 56, in addition to applicable regulations at 45 CFR 46.

Use of investigational drugs must be conducted according to FDA IND regulations, 21 CFR Part 312, and other applicable FDA regulations. Use of an investigational device in a clinical trial to obtain safety and effectiveness data must be conducted according to FDA’s IDE regulations, 21 CFR Part 812, and other applicable FDA regulations.

The following procedures describe the review of FDA regulated research under the auspices of the University.

7.2 Definitions

Investigational Drug: a drug for which the PI or a sponsor has filed an IND application (21 CFR Part 312) or an approved drug that is being studied for an unapproved or approved use in a controlled, randomized, or blinded clinical trial.

Investigational Device: a medical device that is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device. As further stated, a device is any healthcare product that does not achieve its primary intended purpose by chemical action or by being metabolized.

IND: investigational new drug application in accordance with 21 CFR Part 312.

IDE: investigational device exemption in accordance with 21 CFR 812.
**Emergency Use:** the use of an investigational drug or biological product with a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain CORIHS approval.

**Significant Risk (SR) [Device]:** an investigational device that:
1. Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject; or
2. Is purported or represented to be for a use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject; or
3. Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or
4. Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

**Non-Significant Risk (NSR) [Device]:** an investigational device other than a significant risk device.

**Humanitarian Use Device (HUD):** a device intended to benefit patients by treating or diagnosing a disease that affects fewer than 8,000 individuals in the United States per year.

### 7.3 FDA Exemptions

The following categories of clinical investigations are exempt from the requirements of FDA regulations for prospective IRB review:

1. Emergency use of a test article, provided that such emergency use is reported to the IRB within 5 working days. Any subsequent use of the test article at the University is subject to IRB review. [21 CFR §56.104(c)]
2. Taste and food quality evaluations and consumer acceptance studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. [21 CFR §56.104(d)]

### 7.4 IND/IDE Requirements

The PI must indicate in the electronic management system whether the research involves investigational drugs or devices. If so, the PI must indicate if there is an IND/IDE for the research and provide appropriate documentation of such, e.g.:

- Industry sponsored protocol with IND/IDE.
- Letter from FDA.
- Letter from industry sponsor.
- Other document and/or communication verifying the IND/IDE.
For investigational devices, NSR device studies follow abbreviated IDE requirements and do not have to have an IDE application approved by the FDA. If a sponsor has identified a study as NSR, then the IRB must review and concur, and justify the decision. If the FDA has determined that the study is NSR, documentation of that determination must be provided.

The IRB will review the IRB submission and determine:
1. Whether there is an IND/IDE and if so, whether there is appropriate supporting documentation.
2. If the research involves drugs or devices with no IND/IDE, and whether the research meets the criteria below.

7.4.1 Possible IND Exemptions

For clinical investigations involving an FDA-approved drug, an IND is not necessary if all of the following conditions are met:
1. The research is not intended to be reported to FDA in support of a new indication for use or to support any other significant change in the labeling for the drug;
2. The research is not intended to support a significant change in the advertising for the product;
3. The research does not involve a route of administration or dosage level, use in a subject population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product;
4. The research is conducted in compliance with the requirements for CORIHS review and informed consent (21 CFR parts 56 and 50, respectively);
5. The research is conducted in compliance with the requirements concerning the promotion and sale of drugs (21 CFR 312.7); and
6. The research does not intend to invoke 21 CFR 50.24 (Exception from informed consent requirements for emergency research).

For clinical investigations involving an in vitro diagnostic biological product, an IND is not necessary if:
1. It involves one or more of the following: (a) Blood grouping serum, (b) Reagent red blood cells or (c) Anti-human globulin;
2. It is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure; and
3. It is shipped in compliance with 312.160

For bioavailability or bioequivalence studies of drugs not lawfully marketed in the US, an IND is not necessary if all of the following conditions are met:
1. The drug product does not contain a new chemical entity, is not radioactively labeled, and is not cytotoxic,
2. The dose (single dose or total daily dose) does not exceed the dose specified in the labeling of the approved version of the drug product,
3. The investigation is conducted in compliance with the requirements for review by an IRB (21 CFR part 56) and with the requirements for informed consent (21 CFR part 50), and
4. The sponsor meets the requirements for retention of test article samples (21 CFR 320.31(d)(1)) and safety reporting (21 CFR 320.31(d)(3)).
7.4.2 Exempted IDE Investigations

For devices, an IDE is not necessary if:

1. The research involves a device, other than a transitional device, in commercial distribution immediately before May 28, 1976, when used or investigated in accordance with the indications in labeling in effect at that time;
2. The research involves a device other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of 21 CFR 807 in determining substantial equivalence;
3. The research involves a diagnostic device, if the sponsor complies with applicable requirements in 21 CFR 809.10(c) and if the testing:
   - Is noninvasive,
   - Does not require an invasive sampling procedure that presents significant risk,
   - Does not by design or intention introduce energy into a subject, and
   - Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure;
4. The research involves a device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution, if the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk;
5. The research involves a device intended solely for veterinary use;
6. The research involves a device shipped solely for research on/or with laboratory animals and labeled in accordance with 21 CFR 812.5(c);
7. The research involves a custom device as defined in 21 CFR 812.3(b), unless the device is being used to determine safety or effectiveness for commercial distribution.

7.5 Responsibilities for FDA-Regulated Research

7.5.1 Principal Investigators (“Clinical Investigators” in FDA regulation)

7.5.1.1 General

1. Under FDA regulations and guidance, clinical investigators must be qualified by training and experience. They are responsible for the conduct of the study and for leading the team of individuals conducting the study. Before beginning participation in a clinical investigation, the clinical investigator must commit to the sponsor that he/she will follow federal regulations governing investigational drugs (including biologics) and devices.
2. Ensuring the informed consent is obtained from subjects in accordance with IRB approval
3. Retaining records for two years following the date the marketing application is approved by FDA or withdrawn and making those records available for inspection
4. Furnishing the required reports to the sponsor, including reports of adverse events and study completion
5. Providing timely reports to the IRB, including reports of changes in the research activity needed to avoid immediate hazards to participants, protocol deviations, unanticipated problems involving risks to participants or others (see Section 8 of these SOPs).

6. Inform any potential participants that the test article(s) (i.e., drugs) are being used for investigational purposes and will ensure that the requirements relating to obtaining informed consent and IRB review and approval are met.

7. Ensuring that changes are not implemented without prospective IRB approval, unless required to eliminate immediate hazard to participants.

8. Complying with the requirements of the Controlled Substances Act.

9. Complying with all FDA test article requirements.

10. Adequately maintaining control of test articles, including appropriate tracking documentation for test articles to the extent that such control and documentation are not centrally administered.

11. Supervising the use and disposition of the test article.

12. Disclosing relevant financial information and conflicts of interest.

13. Ensuring that all associates, colleagues, and employees assisting in the conduct of the investigation(s) are informed about their obligations in meeting the above commitments.

14. The PI is additionally responsible for all requirements in 7.5.1.1, 7.5.1.2, and 7.5.1.3, as applicable to the type of research conducted.

7.5.1.2 Drug/Biologic Research

1. The clinical investigator must comply with the requirements specified in FDA Form 1572:
   - Personally conduct or supervise the described investigation(s).
   - Conduct the studies in accordance with the current IRB-approved protocol(s) and will only make changes in a protocol after notifying the sponsor, except when necessary to protect the safety, the rights, or welfare of participants.
   - Comply with all requirements regarding the obligations of clinical investigators and all other pertinent regulatory requirements.
   - Immediately report to the sponsor any serious adverse event, whether or not considered drug related, including those listed in the protocol or investigator brochure and must include an assessment of whether there is a reasonable possibility that the drug caused the event. Study endpoints that are serious adverse events (e.g., all-cause mortality) must be reported in accordance with the protocol unless there is evidence suggesting a causal relationship between the drug and the event (e.g., death from anaphylaxis). In that case, the investigator must immediately report the event to the sponsor. The investigator must record nonserious adverse events and report them to the sponsor according to the timetable for reporting specified in the protocol. §312.64; (b)
   - Read and understand the information in the investigator's brochure, including the potential risks and side effects of the drug.
   - Ensure that all associates, colleagues, and employees assisting in the conduct of the study(ies) are informed about their obligations in meeting the above commitments.
   - Ensure that an investigation is conducted according to the signed statement (Form FDA 1572), the investigational plan, and applicable regulations.
• Protecting the rights, safety, and welfare of participants under the clinical investigator’s care.

2. The clinical investigator proposing drug/biologic research will be required to comply with the University’s Investigational Drug Service plan for storage, security, and dispensing of the drug/biologics, and will be responsible for accounting, return, disposition, and records of accountability per the study protocol.
   • For research conducted in the University Hospital, Health Sciences Center, Cancer Center, and Ambulatory Surgery Building, The PI will delegate the responsibility for drugs/biologics accountability, including storage, dispensing, labeling, and distribution, to the Investigational Drug Service in the Pharmacy Department.
   • For research conducted in any other campus site, the plan will be provided to, and evaluated by the IRB, in consultation with the Investigational Drug Service at the time of submission review.
   • The PI conducting investigational drug studies is required to share the study for ancillary review in the electronic management system with the Investigational Drug Service so that status of the IRB approval can be monitored and confirmed.
   • The PI must inform the IRB and Pharmacy Service when a study involving investigational drugs has been terminated by the sponsor.

3. The clinical investigator will administer the drug only to participants under the clinical investigator’s personal supervision or under the supervision of a sub-investigator responsible to the clinical investigator.

4. The clinical investigator will not supply the investigational drug to any person not authorized to receive it.

5. The clinical investigator is required to maintain adequate records of the disposition of the drug, including dates, quantity, and use by participants (in accordance with any requirements set forth by the Investigational Drug Service).

6. If the investigation is terminated, suspended, discontinued, or completed, the clinical investigator must return the unused supplies of the drug to the sponsor, or otherwise provide for disposition of the unused supplies of the drug if authorized by the sponsor.

7. A clinical investigator is required to prepare and maintain adequate and accurate case histories that record all observations and other data pertinent to the investigation on each individual administered the investigational drug or employed as a control in the investigation.
   • Case histories include the case report forms and supporting data (e.g., signed and dated consent forms and medical records including, for example, progress notes of the physician, the individual's hospital chart(s), and the nurses' notes). The case history for each individual will document that informed consent was obtained prior to participation in the study.

8. Clinical investigator must retain records for a period of 2 years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and FDA is notified. [21 CFR §312.62]

9. Clinical Investigator must maintain the following:
   • Current curriculum vitae (CV)
   • Protocol
• Records of receipt and disposition of drugs
• List of any co-investigators with their curriculum vitae
• Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation, and
• Case histories with particular documentation on evidence of drug effects. Emphasis is on toxicity and possible untoward happenings. All unanticipated problems involving risk to subjects or others are reportable, in accordance with Section 8.
• IRB letters of approval.
• Other documents as outlined in the Human Subject Protection Program Standard Operating Procedures.

7.5.1.3 Device Research

1. The clinical investigator must sign an agreement with the sponsor that includes a statement of the clinical investigator’s commitment to: [21 CFR §812.43(c)(4)]
   • Conduct the investigation in accordance with the agreement, the investigational plan, applicable FDA regulations, and conditions of approval imposed by the reviewing IRB or FDA;
   • Supervise all testing of the device involving human participants; and
   • Ensure that the requirements for obtaining informed consent are met.

2. The clinical investigator must ensure that an investigation is conducted according to the signed agreement, the investigational plan and applicable FDA regulations.

3. The Clinical Investigator is responsible for the control of devices under investigation and will therefore be required to provide a plan – to be evaluated by the IRB - that includes storage, security, and dispensing of the device, and will be responsible for accounting, return, disposition, and records of accountability per the study protocol. If the IRB determines that it does not have the necessary expertise to evaluate the plan, outside consultation will be used (e.g., Biomedical Engineering).

4. All devices received for a study must be stored in a locked environment under secure control with limited access. The area must be within an area of PI’s control. Proper instructions on the use of the device must be provided to the subjects. A log must be kept regarding the receipt, use, and/or dispensing of the device (identification/serial number of the device, name of subject, date dispensed, by whom it was dispensed, and amount remaining) as well as the disposition of used and unused devices at the conclusion of the investigation. Details: [21 CFR §812.140] VIT D2 1.25 MG The clinical Investigator will maintain records of each participant's case history and exposure to the device. Case histories include the case report forms and supporting data (e.g., signed and dated consent forms and medical records, progress notes of the physician, the individual's hospital chart(s), and the nurses' notes). Such records will include:
   • Documents evidencing informed consent and, for any use of a device by the clinical investigator without informed consent, any written concurrence of a licensed physician and a brief description of the circumstances justifying the failure to obtain informed consent. The case history for each individual will document that informed consent was obtained prior to participation in the study.
• All relevant observations, including records concerning adverse device effects (whether anticipated or unanticipated), information and data on the condition of each participant upon entering, and during the course of, the investigation, including information about relevant previous medical history and the results of all diagnostic tests.
• A record of the exposure of each participant to the investigational device, including the date and time of each use, and any other therapy.
• The protocol, with documents showing the dates of and reasons for each deviation from the protocol.
• Any other records that FDA requires to be maintained by regulation or by specific requirement for a category of investigations or a particular investigation.

5. Device investigators must report to the sponsor and the SBU IRB-of-record:
• Unanticipated adverse device effects
• Withdrawal of IRB approval
• Reports of deviations from the approved investigational plan
• Progress reports (at least annually) and a final report
• Other reports as required/requested by the sponsor or IRB

6. If a device is considered NSR by the PI or sponsor, but after review the IRB determines the device to have significant risk, upon receipt of written notice the PI is responsible for notifying the sponsor of the IRB’s determination. The PI must provide the IRB with confirmation of this action.

7. The PI will maintain the following:
• Current curriculum vitae (CV),
• Protocol of the study,
• Records of animal study reports
• Records of receipt and disposition of devices
• List of any co-investigators with their curriculum vitae,
• Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation,
• Case histories with particular documentation on evidence of effects. Emphasis is on safety and possible untoward happenings. All unanticipated adverse device effects are reportable, per Section 8, SOPs
• IRB letters of approval
• Device training.
• Other documents as required in these Standard Operating Procedures.

7.5.1.4 Additional Responsibilities When the Clinical Investigator is also the Sponsor of the IND or IDE (“Sponsor-Investigator”)

These studies in question are typically investigator-initiated studies that use an investigational drug or device or use an approved drug or device for investigational purposes.

1. Sponsors-Investigators: General

• The investigator has both investigator responsibilities (as above), and sponsor responsibilities, which include:
• Selecting qualified investigators;
• Providing investigators with the information they need to conduct the investigation properly;
• Ensuring proper monitoring of the investigation and document monitoring activities;
• Ensuring that the FDA and (for devices) any reviewing IRBs or (for drugs) all participating investigators are promptly informed of significant new information about an investigation; and
• Reporting requirements to the FDA.

• Sponsor-investigators who submit protocols to SBU’s IRBs involving FDA test articles must include supporting FDA documentation for their IND or IDE.
• If the IND or IDE product will be manufactured at Stony Brook University, the clinical investigator must submit documentation that the product preparation and manufacture meets the standards for current Good Manufacturing Practice (GMP), or any modification to those standards approved by the FDA in issuing the IND or IDE. This documentation will be subject to review by appropriate SBU entities, as determined by the Office of Research Compliance.
• The IND or IDE product must be stored, secured, dispensed, and documented as indicated in the submission materials to the IRB, and in accordance with the requirements referenced in the preceding sections.
• Comply with the University Support Services submission requirements below (See section 7.5.1.5 below)

2. Sponsors-Investigators: IDE’s

• A sponsor-investigator for an IDE protocol must follow the FDA regulations in 21 CFR 812 applicable to sponsor responsibilities, particularly Subpart C. This includes:
  • The record keeping requirements of 21 CFR 812.140(b), and
  • The required notification under 21 CFR 812.150(b)(1) to the FDA and all participating investigators of any evaluation of an unanticipated device effect within 10 days of first receiving notice of the effect.
• An investigation of a device other than a significant risk device is considered to have an approved application for IDE, unless FDA has given notice under 812.20(a) that approval of an application is required, if the device is not a banned device and the sponsor:
  i. Labels the device in accordance with 812.5;
  ii. Obtains IRB approval of the investigation after presenting the reviewing IRB with a brief explanation of why the device is not a significant risk device, and maintains such approval;
  iii. (Ensures that each investigator participating in an investigation of the device obtains from each subject under the investigator’s care, informed consent under part 50 and documents it, unless documentation is waived by an IRB under 56.109(c).
  iv. Complies with the requirements of 812.46 with respect to monitoring investigations;
  v. Maintains the records required under 812.140(b) (4) and (5) and makes the reports required under 812.150(b) (1) through (3) and (5) through (10);
vi. Ensures that participating investigators maintain the records required by 812.140(a)(3)(i) and make the reports required under 812.150(a) (1), (2), (5), and (7); and
vii. Complies with the prohibitions in 812.7 against promotion and other practices.

3. Sponsor-Investigators: IND’s

- A sponsor-investigator for an IND protocol must follow the FDA regulations in 21 CFR 312 applicable to sponsor responsibilities, particularly Subpart D. This includes:
  - The record keeping requirements of 21 CFR 312.57, and
  - Promptly reporting as required in 21 CFR 312.55(b) to the FDA and all participating investigators of significant new adverse effects or risks with respect to the drug or biologic.

4. FDA regulations for investigators assuming the sponsor function by holding an IND or IDE

Drugs or devices:

- * 21 CFR §11 (Electronic records and electronic signature)
- * 21 CFR §54 (Financial Disclosure by Clinical Investigators)

Drugs and Biologics:

- * 21 CFR §210 (Current Good Manufacturing Practice In Manufacturing, Processing, Packing, Or Holding of Drugs; General)
- * 21 CFR §211 (Current Good Manufacturing Practice for Finished Pharmaceuticals)
- * 21 CFR §312 (Investigational New Drug Application)
- * 21 CFR §314 (Drugs for Human Use)
- * 21 CFR §320 (Bioavailability and Bioequivalence Requirements)
- * 21 CFR §330 (Over-The-Counter (OTC) Human Drugs Which are Generally Recognized as Safe and Effective and Not Misbranded)
- * 21 CFR §601 (Biologics Licensing)

Devices:

- * 21 CFR §812 (Establishment Registration and Device Listing for Manufacturers and Initial Importers Of Devices)
- * 21 CFR §812 (Investigational Device Exemptions)
- * 21 CFR §814 (Premarket Approval of Medical Devices)
- * 21 CFR §820 (Quality System Regulation)
7.5.1.5 University Support Services for Sponsor-Investigators

The Office of Research Compliance provides support services for investigators who also act as a Sponsor of INDS (and IND-BB’s), and IDEs. Regulatory support includes guidance and assistance on pre-submission FDA interactions, IND and IDE submissions and associated reports to the FDA and the IRB.

The following assistance is provided upon request:

- Determination of applicability of an IND or IDE (IRB oversight continues to apply)
- Training in the obligations of a sponsor-investigator
- Pre-IND, IDE consultation with FDA and participating in on-going communication with the agency as required

Assistance with submission of IND, IDE to FDA to ensure all required forms are included.

Assistance with fulfilling IND reporting requirements to ensure the study is conducted according to the current approved protocol.

The University has accountability obligations for all sponsor-investigator drug, device, or biologic research at the University. **To promote compliance with FDA, IND, and IDE regulations the following documents must be submitted with the IRB protocol through the electronic management system and shared with the IND Administrator for Ancillary Review:**

- FDA Form 1571 – Investigational New Drug Application
- FDA Form 1572 – Statement of Investigator
- FDA Form 3674 – Certificate of Compliance
- OR
- FDA Form 3926 – Individual Patient Expanded Access Application with Physician CV to confirm qualifications
- IND Annual renewal report
- Copy of SAE report within 3 days of submission to FDA

7.5.2 IRB

1. The IRB will review the research in accordance with the following requirements and the same criteria it would use in considering approval of any research involving an FDA-regulated product (21 CFR 56.111).
2. For research involving investigational devices:
   - Unless the FDA has already made a risk determination for the study, the IRB will review NSR studies and determine if the device represents significant or non-significant risk and will document its findings. The IRB will consider the risks and benefits of the medical device compared to the risks and benefits of alternative devices or procedures. Non-significant risk

* 21 CFR §860 (Medical Device Classification Procedures)
device studies do not require submission of an IDE application but must be conducted in accordance with the abbreviated requirements of IDE regulations:

- The device is not a banned device.
- The sponsor labels the device in accordance with 21 CFR 812.5.
- The sponsor obtains IRB approval of the investigation after presenting the reviewing IRB with a brief explanation of why the device was not a significant risk device, and maintains such approval.
- The sponsor ensures that each investigator participating in an investigation of the device obtains from each subject under the investigator’s care, consent under 21 CFR 50 and documents it, unless documentation was waived.
- The sponsor complies with the requirements of 21 CFR 812.46 with respect to monitoring investigations.
- The sponsor maintains the records required under 21 CFR 812.140(b)(4) and (5) and makes the reports required under 21 CFR 812.150 (b)(1) through (3) and (5) through (10).
- The sponsor ensures that participating investigators maintain the records required by 21 CFR 812.140(a)(3)(i) and make the reports required under 812.150(a)(1), (2), (5) and (7).
- The sponsor complies with the prohibitions in 21 CFR 812.7 against promotion and other practices.
- If the study that has been submitted as NSR is considered SR, the IRB may approve the study, but the study cannot begin until an IDE is obtained.

3. The IRB will not review protocols involving significant risk devices under expedited review.
4. The IRB will document in the minutes the rationale for determining whether a device is classified as NSR/SR.
5. If the FDA has already made the SR or NSR determination for the study, the agency’s determination is final and the IRB does not need to make a risk determination.

7.6 Emergency Use of Test Articles

7.6.1 Emergency Exemption from Prospective CORIHS Approval.

HHS regulations do not permit human subjects research activities to be started, even in an emergency, without prior approval from the IRB. When emergency medical care is initiated without prior review and approval from the IRB, the patient may not be considered a research subject under 45 CFR Part 46. However, nothing in the HHS regulations at 45 CFR Part 46 is intended to limit the authority of a physician to provide emergency medical care, to the extent the physician is permitted to do so under applicable federal, state or local law.

FDA defines emergency use (21CFR56.102(d) as the use of a test article (e.g., investigational drug, biologic, device) with a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is no sufficient time to obtain approval from the IRB. If all these conditions exist, with documented concurrence with the applicable departmental chair, then the emergency exemption from prospective approval from the IRB found at 21 CFR 56.104(c) may be utilized.
Informed consent must be obtained in accordance with and to the extent required by 21 CFR 50. Informed consent must be documented in writing in accordance with and to the extent required by 21 CFR 50.27. See Section 7.6.2 for waiver criteria from this informed consent requirement.

It is required that, after the emergency use of a test article, the physician evaluate the likelihood of a similar need for the test article occurring again, and if future use is likely, immediately initiate efforts to obtain approval from the IRB and an approved IND/IDE for the device's subsequent use.

7.6.2 Emergency Waiver of Informed Consent

An exception under FDA regulations at 21 CFR 50.23 permits the emergency use of an investigational drug, device, or biologic without informed consent where the investigator and an independent physician who is not otherwise participating in the clinical investigation (at the University, the department chair) certify in writing within five (5) working days all four (4) of the following specific conditions:

1. The subject is confronted by a life-threatening situation necessitating the use of the test article;
2. Informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject;
3. Time is not sufficient to obtain consent form the subject’s legally authorized representative;
4. No alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject’s life.

If time is not sufficient to obtain the department chair concurrence before use of the test article, the actions of the investigator must be reviewed and evaluated in writing by the chair within five (5) working days.

7.6.3 Emergency Use of Investigational Drugs or Biologics

In addition to information provided in 7.6.1 and 7.6.2, note the following:

The emergency use of an unapproved investigational drug, agent, or biologic requires an emergency IND. The FDA has established mechanisms and guidance for obtaining an Emergency IND for the use of investigational drugs, agents, or biologics.

FDA regulations at 21 CFR 312.34, 312.35, and 312.36 address the need for an investigational drug to be used in an emergency situation that does not allow time for submission of an IND. The FDA may authorize shipment of the drug for a specific use in such a circumstance in advance of submission of an IND. All applicable regulations must be met including those at 21 CFR Parts 50 and 56, and 21 CFR 312.34 and 312.35.

7.6.4 Emergency Use of Investigational Devices

In addition to information provided in 7.6.1 and 7.6.2, note the following:

Before the use:
The device developer should notify the Center for Devices and Radiological Health (CDRH), Program Operation Staff immediately after shipment of the device is made.

The physician should, if possible, obtain authorization from the IDE holder, if an approved IDE for the device exists.

After the use, if an IDE for the use does exist, notify the sponsor of the emergency use, or if an IDE does not exist, notify CDRH/FDA of the emergency use and provide FDA with a written summary of the conditions constituting the emergency, subject protection measures, and results.

7.6.5 IRB Notification Requirements for Emergency Use/Emergency Informed Consent Waiver Situations

The IRB must be notified within five (5) working days when an emergency exemption and/or emergency informed consent waiver is used. Notification should include patient medical history that warranted the emergency use, patient current health status, supported statements concerning meeting all criteria at 21CFR 56.102(d), and departmental chair concurrence. Any subsequent use of the test article at the institution is subject to IRB review. This notification must not be construed as an approval for the emergency use by the IRB. The IO or designee will review the report to verify that circumstances of the emergency use conformed to FDA regulations.

7.7 Expanded Access to Investigational Drugs, Biologics, Devices

FDA regulations and/or guidance allow certain individuals not enrolled in clinical trials to obtain non-emergency access to investigational drugs, biologics, or devices through methods described below.

**IRB approval** (full review if possible, or via IRB chair or designee) will be required before a patient/subject can be treated or enrolled into one of these access programs. This requirement for the IRB approval is in place even where the FDA has granted a waiver (e.g., where FDA has determined that central IRB review is adequate protection for the patients). Finally, prior approval from the sponsor and FDA is required before submitting to the IRB.

7.7.1 Expanded Access to Investigational drugs, biologics:

**Group C Treatment Investigational New Drug (IND):** A means for the distribution of investigational drugs, agents, or biologics to oncologists for the treatment of cancer under protocols outside controlled clinical trials. Group C drugs, agents, or biologics usually have shown evidence of relative and reproducible efficacy in a specific tumor type.

**Open – Label Protocol:** A study designed to obtain additional safety data, typically done when the controlled trial has ended and treatment continues. The purpose of such a study is to allow subjects to continue to receive the benefits of the investigational drug, agent, or biologic until marketing approval is obtained.

**Parallel Track:** A method approved by the FDA that expands the availability of investigational drugs, agents, or biologics as quickly as possible to persons with AIDS and other HIV-related diseases. These
drugs, agents or biologics are utilized in separate protocols that “parallel” the controlled clinical trials and are essential to establish the safety and effectiveness of these new drugs, agents, or biologics.

**Treatment IND:** A mechanism for providing eligible subjects with investigational drugs (as early in the drug development process as possible) for the treatment of serious and life-threatening illnesses for which there are no satisfactory alternative treatments. The FDA defines an immediately life-threatening disease as a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment. The FDA will permit an investigational drug to be used under a treatment IND after sufficient data have been collected to show that the drug “may be effective” and does not have unreasonable risks.

- There are four requirements that must be met before a treatment IND can be issued:
  1. The drug is intended to treat a serious or immediately life-threatening disease;
  2. There is no satisfactory alternative treatment available;
  3. The drug is already under investigation or trials have been completed; and
  4. The trial sponsor is actively pursuing marketing approval.

- The FDA identifies two (2) special considerations when a patient is to be treated under a Treatment IND:
  - Informed Consent. Informed consent is especially important in treatment use situations because the subjects are desperately ill and particularly vulnerable. They will be receiving medications which have not been proven either safe or effective in a clinical setting. Both the setting and their desperation may work against their ability to make an informed assessment of the risk involved. Therefore, CORIHS should ensure that potential subjects are fully aware of the risks involved in participation.
  - Charging for Treatment INDS. The FDA permits charging for the drug, agent, or biologic when used in a Treatment IND. Therefore, CORIHS should pay particular attention to Treatment INDS in which the subjects will be charged for the cost of the drugs. If subjects will be charged for use of the test article, economically disadvantaged persons will likely be excluded from participation. Charging for participation may preclude economically disadvantaged persons as a class from receiving access to test articles. CORIHS should balance this interest against the possibility that unless the sponsor can charge for the drug, it will not be available for treatment use until it receives full FDA approval.

**Single-Patient Use:** The use of an investigational drug outside of a controlled clinical trial for a patient, usually in a desperate situation, who is unresponsive to other therapies or in a situation where no approved or generally recognized treatment is available. There is usually little evidence that the proposed therapy is useful, but may be plausible on theoretical grounds or anecdotes of success. Access to investigational drugs for use by a single, identified patient may be gained either through the sponsor under a treatment protocol, or through the FDA, by first obtaining the drug from the sponsor and then submitting a treatment IND to the FDA requesting authorization to use the investigational drug for treatment use.
7.7.2 Expanded Access to Investigational Devices

**Treatment IDE:** Used when no approved or cleared comparable or satisfactory alternative treatment exists, a patient does not meet the eligibility requirements of any clinical trial, and the device is not approved for marketing but is under clinical investigation by a company seeking clearance or approval to treat a serious or immediately life threatening condition. This provision is intended to facilitate the availability of promising new devices to desperately ill patients as early in the device development process as possible, and to obtain additional data on the device's safety and effectiveness.

As described above, under 21 C.F.R. § 812.36, FDA requires meeting the following four conditions to consider the use of an investigational device under a **Treatment IDE**:

- The device is intended to treat or diagnose a serious or immediately life-threatening disease or condition (defined as a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment)
- There is no comparable or satisfactory alternative device or other therapy available to treat or diagnose that stage of the disease or condition in the intended patient population;
- The device is under investigation in a controlled clinical trial for the same use under an approved IDE, or such clinical trials have been completed; and
- The sponsor of the investigation is actively pursuing marketing approval/clearance of the investigational device with due diligence.

An investigator interested in a treatment IDE should contact the sponsor directly to request approval for use under the sponsor’s IDE. An investigator-sponsor can submit an IDE supplement seeking FDA approval for the treatment use. After the sponsor obtains FDA approval for a treatment IDE, the investigator should apply approval by the IRB and must obtain the informed consent of the treated individual.

**Compassionate Use IDE:** A use intended for patients with a serious, but not life threatening, condition who do not meet the requirements for inclusion in a clinical investigation and for whom no acceptable approved or cleared alternative exists, but for whom the treating physician believes the device may provide a benefit in treating and/or diagnosing their disease or condition. This provision is typically approved for individual patients, but may be approved to treat a small group.

Prior FDA approval is needed before compassionate use occurs. In order to obtain Agency approval, the sponsor (or sponsor-investigator) should submit an IDE supplement requesting approval for a protocol deviation under section §812.35(a) in order to treat the patient.

If the request is approved, the attending physician should devise an appropriate schedule for monitoring the patient to detect any possible problems arising from the use of the device, taking into consideration the investigational nature of the device and the specific needs of the patient.

Documentation of FDA approval of the IDE supplement, and relevant information pertaining to health status of the patient(s) to be treated should be submitted to the IRB for review as above.
Following the compassionate use of the device, a follow-up report should be submitted to FDA as an IDE supplement in which summary information regarding patient outcome is presented. This should be sent to the IRB as well. If any problems occurred as a result of device use, these should be discussed in the supplement and reported to the reviewing IRB as soon as possible.

**Emergency Use of Devices:** If a physician determines that IRB and FDA approval cannot be obtained in time to prevent serious harm or death to a patient, and there is no generally acceptable alternative treatment, that physician may treat the patient with an investigational device on an emergency basis even if the patient would not qualify for the investigational study. While the physician may use the device without prior approval, the physician should employ as many patient protection measures as possible under the circumstances, including: gaining informed consent from the patient or a legal representative; clearance from the institution; concurrence of the IRB chairperson; an independent assessment from an uninvolved physician; and authorization from the IDE sponsor. After treating the patient the physician should provide the IDE sponsor with sufficient patient follow-up information to comply with IDE reporting obligations. This information should be provided immediately, in accordance with 21 C.F.R. § 812.35(a)(2) and the FDA Guidance for Emergency Use of Unapproved Medical Devices, as the sponsor has only 5 days to report the use to FDA. The investigator is also required to provide written notification of the use to CORIHS within five days after use of the device. CORIHS requires that written notification include identification (specification without identifiers) of the patient, the date on which the device was used, the reason for the use, current health status of the patient, and concurrence for use by the departmental chair.

**Humanitarian Use Devices (HUD).** In accordance with 21 CFR 814.124, treatment with a HUD is subject to full board initial and continuing review by CORIHS. At the time of review, the IRB will determine if written consent from subjects for use of the HUD is necessary.

Investigators are reminded that Humanitarian Device Exemptions are for clinical use only and HUDs can be used only for purposes, and in the population, specified in the approved IRB application.

If a physician in an emergency situation determines that the IRB approval cannot be obtained in time to prevent serious harm or death to a patient, a HUD may be administered without prior IRB approval. In this instance, approval must be obtained from the departmental chair, and the investigator is required to provide written notification of the use to the IRB within five (5) days after use of the device. The IRB requires that written notification include identification (specification without identifiers) of the patient, the date on which the device was used, and the reason for the use. It is the responsibility of the investigator to notify the FDA if the IRB were ever to withdraw approval for use of a HUD. The FDA should be notified within five days of notification of the withdrawal of approval.

**7.8 Policy on Research with Dietary Supplements**

Research on dietary supplements is an important area of study for obvious reasons, most notably better understanding, through rigorous scientific investigation, of their mechanisms of actions, pharmacokinetic and clinical effects, etc.
Any submission to the IRB in which dietary supplements are being studied must include either proof of an approved IND from the FDA, or a written statement from the FDA certifying that an IND is not needed.

8 Unanticipated Problems Involving Risks to Subjects or Others (a type of ‘Reportable New Information-RNI’)  

8.1 Policy

The University complies with DHHS and FDA regulations which state that institutions must have written policies on reporting unanticipated problems involving risks to subjects or others to the IRB, institutional officials and relevant federal agencies and departments.

The following procedures describe how unanticipated problems involving risk to subjects or others are handled in research conducted under the auspices of the University.

8.2 Definitions

Unanticipated problems involving risk to subjects or others: refers to any problem, event, or new information that:
1. Is unexpected (in terms of nature, severity, or frequency) given the research procedures that are described in the protocol-related documents, such as the IRB approved research protocol and informed consent documents; and the characteristics of the subject population being studied; and
2. Indicates that subjects or others are at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

Note: Unanticipated problems occurring in subjects whose participation in the study ended within 30 days of the unanticipated problems are considered applicable to this policy

Adverse Event (AE): Any untoward physical or psychological occurrence in a human subject participating in research. An AE can be any unfavorable or unintended event including abnormal laboratory finding, symptom or disease associated with the research or the use of a medical investigational test article.

Serious Adverse Event (SAE): A life threatening experience; hospitalization (for a person not already hospitalized); prolongation of hospitalization (for a patient already hospitalized); persistent or significant disability or incapacity; congenital anomaly and/or birth defects; or an event that jeopardizes the subject and may require medical or surgical treatment to prevent one of the preceding outcomes.

Unexpected Adverse Event (UAE): Any adverse event and/or reaction, the specificity or severity of which is not consistent with the informed consent, current investigator brochure or product labeling.
Further, it is not consistent with the risk information described in the general investigational plan or proposal.

**Adverse Device Effect (ADE):** Any adverse event/effect caused by or associated with the use of a device that is unanticipated and has not been included in the protocol or the Investigator’s Brochure.

**Related:** An event is “related” if it is likely to have been caused by the research procedures.

**Unexpected Death:** The death of a research subject in which a high risk of death is not projected, as indicated by the written protocol, informed consent form, or sponsor brochure. This definition does not include deaths associated with a terminal condition unless the research intervention clearly hastened the subject’s death. A subject’s death that is determined to be clearly not associated with the research is also not an “unexpected death” for purposes of the reporting requirements of these procedures.

### 8.3 Procedures

#### 8.3.1 What must be reported

Investigators must report the following problems to the IRB (see Section 8.3.2 for timelines)

1. Serious adverse events which in the opinion of the principal investigator are both unexpected and related to the research activity.
2. Adverse events (other than SAEs) which in the opinion of the principal investigator meet the criteria for an unanticipated problem involving risk to subjects or others (unanticipated, related to the research and increase risk to subjects).
3. An unanticipated event related to the research that exposes subjects to potential risk.
4. An unanticipated event related to the research that exposes individuals other than the research subjects (e.g., investigators, research assistants, students, the public, etc.) to potential risk.
5. Information that indicates a change to the risks or potential benefits of the research. For example:
   - An interim analysis or safety monitoring report indicates that frequency or magnitude of harms or benefits may be different than initially presented to the IRB.
   - A paper is published from another study that shows that the risks or potential benefits of the research may be different than initially presented to the IRB.
6. A breach of confidentiality.
7. Incarceration of a subject in a protocol not approved to enroll prisoners.
8. Changes increasing the risk to subjects and/or affecting significantly the conduct of the trial.
9. Change to the protocol taken without prior IRB review to eliminate an apparent immediate hazard to a research subject.
10. Complaint of a subject when the complaint indicates unexpected risks or cannot be resolved by the research team.
11. Protocol violation (meaning an accidental or unintentional change to the IRB approved protocol) that harmed subjects or others or that indicates subjects or others may be at increased risk of harm.
12. Event that requires prompt reporting to the sponsor.
13. Sponsor imposed suspension for risk.
14. Change in FDA labeling or withdrawal from marketing of a drug, device, or biologic used in a research protocol.
15. Unanticipated adverse device effect - Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects (21 CFR 812.150(a).
Any other event that indicates subject or others might be at risk of serious, unanticipated harms that are reasonably related to the research.

8.3.2 Report Filing Deadlines

Unanticipated Problem (‘Reportable New Information’) Reports should be submitted to ORC as soon as possible after they have occurred, but within five (5) working days of occurrence, or of receipt by University Investigator (if non-University subject).

Problems/AE’s/SAE’s that occur that are anticipated should be submitted as a Cumulative summary report (by sponsor, if applicable) required at time of Continuing Review.

8.3.3 IRB Procedures for Handling Reports of Possible Unanticipated Problems

8.3.3.1 Review of Unanticipated Problem Reports: University Subjects

Unanticipated Problem Reports will be reviewed by IRB staff to confirm that the reported incident constitutes an unanticipated problem (in consultation with the IRB Chair or AVP-RC, as needed), and will make an initial determination regarding action.

If it is determined that immediate action may be required, the unanticipated problem will be forwarded to the chair for review. If the IRB Chair deems it necessary to take action before the IRB meeting (e.g., suspension etc.), PI will be notified regarding steps to be taken to ensure protection of rights/welfare of subjects (or staff, as appropriate), pending review and action by the full committee. If the IRB Chair is not available, the AVP-RC or the IO will make the determination regarding immediate actions to be taken to protect subjects. If immediate action is not required, the unanticipated problem will be placed in the agenda for full review at the next IRB meeting. Pre-review may be conducted by one (1) or more IRB members.

8.3.3.2 Review of UP Reports: non-SBU Subjects

Unanticipated Problem Reports concerning subjects or others not enrolled through the University will be reviewed by IRB staff. If the definition of a UP is met, review will be conducted to confirm that sponsor and FDA have been notified (per unanticipated problem (UP)/USAE form). OHRP will be notified by the IO per the requirements of the FWA, and the report and study history will be
placed on the agenda for the applicable IRB meeting. If regarding a study with External IRB oversight, the report will be placed on the next available meeting agenda and the form will be filed in the applicable IRB file. ORC reviewer may, at his/her discretion, send the USAE to an IRB member or full committee for review. An acknowledgement letter regarding these submitted USAE’s will not be sent to PI unless the IRB determines that further action or clarification is required.

8.3.4 Review Outcomes

1. If the IRB finds that the event is an unanticipated problem involving risks to subjects or others, according to the definition in the policy, the IRB may recommend any of the following actions:
   - Requiring modifications to the protocol
   - Revising the continuing review timetable
   - Modifying the consent process
   - Modifying the consent document
   - Providing additional information to current subjects (e.g. whenever the information may relate to the subject’s willingness to continue participation)
   - Providing additional information to past subjects
   - Requiring additional training of the investigator and/or study staff
   - Reconsidering approval
   - Requirement that current subjects re-consent to participation
   - Monitoring of the research
   - Monitoring of the consent
   - Referral to other organizational entities (e.g., legal counsel, risk management, institutional official)
   - Suspending the research
   - Terminating the research
   - Other actions appropriate for the local context

2. If a report suggests that subject safety is at risk, the IRB may immediately suspend or terminate the research. Any suspension or termination of research by the IRB will be promptly reported in writing to OHRP, and FDA (if FDA-regulated research) through the IO.

3. If, after reviewing a report, the IRB finds that the event is an unanticipated problem involving risks to subjects or others or that suspension or termination of approval is warranted, the IRB will:
   1. Notify the investigator in writing of its findings, with copies to the chair of the investigator’s department and/or research unit, and the investigator’s supervisor; and
   2. Report its findings and recommendations to the IO for further reporting to the appropriate federal officials (OHRP, and FDA).

Any unanticipated problems involving risks to subjects or others occurring in DoD-supported research will be reported within thirty (30) days to the DoD human research protection officer.
9 Protocol Exceptions or Deviations

9.1 Policy

It is the policy of the IRB to be notified of any protocol deviations or exceptions that result in an increase in risk or a decrease in benefit to subjects.

The following procedures describe how protocol exceptions and deviations are reported to the IRB.

9.2 Protocol Exceptions

Protocol exceptions: Circumstances in which the specific procedures called for in a protocol are not in the best interests of a specific subject (e.g. subject is allergic to one of the medications provided as supportive care).

Exceptions are planned, and the investigator gets approval from the sponsor and the IRB ahead of time. These should be submitted in the electronic management system. Depending on the nature of the exception, an expedited review is possible. In order to be approved by the IRB, exceptions must not increase risk or decrease benefit, affect the subject’s rights, safety, welfare, or affect the integrity of the resulting data.

The only time a protocol exception would not require prior sponsor and IRB approval is when it is done to avoid an immediate hazard to the subject. The above application should be used to report the incident for IRB review.

9.3 Protocol Deviations (a type of ‘Reportable New Information; RNI’)

Protocol deviations: Circumstances that are unanticipated and happen without any prior sponsor or IRB approval. (e.g. protocol visit scheduled outside protocol window, blood work drawn outside protocol window, etc.).

All deviations:
• Must be reported to ORC (unless the deviation consists of minor scheduling deviations of study visits that are unavoidable and do not impact subject safety) in the electronic management system.
• Are reviewed to determine if they:
  o Are minor, and don’t impact subject safety (these are acknowledged by ORC), or
  o Constitute noncompliance. In these cases, the deviations would be reviewed by the IRB for determination of non-serious, serious, or continuing noncompliance; the latter 2 must be reported to OHRP, and other federal agencies (e.g. FDA etc.) and sponsors (as applicable), and/or
  o Constitute unanticipated problems involving risks to subjects or others (UP). In these cases, the deviations are reviewed by the IRB for confirmation of UP status. If confirmed, they must be reported to are reported to OHRP, and other federal agencies (e.g. FDA, etc.) and sponsors (as applicable). See section 8 for additional information on UPs.
9.4 Reporting & Review

The IRB staff will review the submitted information, and either process for expedited review, IRB chair review, or full committee review as applicable. Outcome of review will be uploaded into the electronic management system for investigator review and action, if necessary. If the information provided is of serious concern, the staff will involve the Chair and/or AVP-RC and/or IO as soon as possible, before the IRB meeting, for any action deemed necessary to protect enrolled subjects.

10 Complaints and Non-compliance (types of ‘Reportable New Information- RNI’)

10.1 Policy

As part of its commitment to protecting the rights and welfare of human subjects in research, the University reviews all complaints and allegations of non-compliance and takes any necessary action to ensure the ethical conduct of research.

The following procedures describe how complaints and allegations of non-compliance are handled by the IRB.

10.2 Definitions

Non-compliance: Failure to comply with any of the regulations and policies described in this document and/or failure to follow the determinations of the IRB. Non-compliance may be minor or sporadic or it may be serious or continuing.

Serious non-compliance: Failure to follow regulations and policies described in this document or failure to follow the determinations of the IRB and which, in the judgment of either the IRB Chair or the convened IRB, increases risks to subjects, decreases potential benefits, or compromises the integrity of the human research protection program. Non-exempt research being conducted without prior IRB approval, or participation of subjects in research activities without their prior consent (in studies where consent was not specifically waived by the IRB) is always considered serious noncompliance.

Continuing non-compliance: A pattern of non-compliance that, in the judgment of the IRB Chair or convened IRB, suggests a likelihood that instances of non-compliance will continue without intervention, or where instances of non-compliance have continued even where intervention by the IRB has occurred. Continuing non-compliance also includes failure to respond to a request to resolve an episode of non-compliance.

Allegation of Non-Compliance: An unproved assertion of non-compliance.

Finding of Non-Compliance: An allegation of non-compliance that is proven true or a report of non-compliance that is clearly true. (i.e. a finding on an audit of an unsigned consent document, or an
admission of an investigator of that the protocol was willfully not followed would represent reports of non-compliance that would require no further action to determine their truth and would therefore represent findings of non-compliance. Once a finding of non-compliance is proven, it must be categorized as serious, non-serious, or continuing.

10.3 Complaints

Complaints and concerns received by ORC from investigators, subjects, and others will be reviewed, in consultation with the IRB Chair, AVP-RC and/or IO as applicable. Upon referral to the IRB Chair she/he will make a preliminary assessment whether the complaint warrants immediate suspension of the research project. If a suspension is warranted, the procedures in Section 3.11.1 will be followed.

If the complaint meets the definition of non-compliance, it will be considered an allegation of non-compliance according to Section 10.4

If the complaint meets the definition of an unanticipated problem involving risk to subjects or others, it will be handled according to Section 8.

10.4 Non-compliance

Investigators and their study staff are required to report instances of possible non-compliance. The PI is responsible for reporting any possible non-compliance by study personnel to the ORC. Any individual or employee may report observed or apparent instances of noncompliance to the ORC. In such cases, the reporting party is responsible for making these reports in good faith, maintaining confidentiality and cooperating with any ORC, IRB, and/or institutional review of these reports.

If an individual, whether investigator, study staff or other, is uncertain whether there is cause to report noncompliance, he or she may contact the ORC Staff to discuss the situation informally.

Reports of non-compliance must be submitted to the ORC within ten (10) working days of discovery of the noncompliance. The report may be verbal or written, and must include a complete description of the noncompliance, and the personnel involved. Complainants may choose to remain anonymous.

10.4.1 Review of Allegations of Non-compliance

Allegations of non-compliance will be pre-reviewed by the applicable the IRB Chair for merit. Where the allegation involves multiple studies, or a study with off-site IRB oversight, the IRB with the next scheduled meeting will conduct the review. The IRB Chair will consider all documents relevant to the allegation, and all documents pertaining to the study (available in the electronic management system). Where there exists a situation in which the noncompliance may affect subject safety, the IRB Chair and (in his or her absence), the AVP-RC or the IO are empowered to require immediate, appropriate action (e.g. study suspension, enrollment suspension) prior to full committee review.
Allegations of non-compliance deemed by the IRB chair to have merit will be brought to the next meeting of the full committee for review. Where the allegation is made against a specific individual, that individual will be notified that an allegation of non-compliance has been made against him/her, and will be given opportunity to respond before the meeting, if possible.

The IRB will review the allegation and make a determination as to the truthfulness of the allegation. In addition to possibly requesting more information from the reporting party, the IRB may determine that additional expertise or assistance is required to make these determinations and may form an ad hoc committee to audit the research in question, or assist with the review and fact gathering process. The ad hoc committee results are transmitted via a written report to be read at a convened meeting, or the report can be verbal, where the ad hoc committee consists of ORC and/or IRB members.

When a determination is made that the noncompliance did not occur because the incident was within the limits of an approved protocol for the research involved, the determination is reported in writing to the PI and the reporting party (if applicable). The determination letter will be copied to the IO in cases where the IO and any other parties had been notified at the outset.

If a determination is made that the reported allegation of non-compliance is true, the non-compliance will be processed according to Section 10.4.2 Review of Findings of Non-compliance.

10.4.2 Review of Findings of Non-compliance

Noncompliance is not serious or continuing:

When the IRB determines that the noncompliance occurred, but the noncompliance does not meet definition of serious or continuing noncompliance, the determination is reported in writing to the PI (and if applicable the reporting party), with requirement for the development of a corrective action plan, as deemed necessary, to prevent future noncompliance. If the PI refuses to cooperative with the corrective action plan, the matter is referred to a convened meeting of the IRB with notification to the IO if deemed appropriate.

Serious or Continuing Noncompliance

When the IRB determines that noncompliance has occurred and that the noncompliance meets the definition of serious or continuing noncompliance, they may:
1. Require submission of a corrective action plan from the PI;
2. Require re-training in human subject protections;
3. Direct that a for-cause (directed) audit be conducted of all the PI’s research activities, and/or;
4. In cases where other University policies may have been violated (e.g. scholarly misconduct, financial disclosure/COI, etc.), notify appropriate institutional officials according to those policies;
5. An increase in data and safety monitoring of the research activity;
6. Request a status report after each subject receives intervention
7. Modify the study’s continuing review cycle;
8. Notify current subjects, if the information about the non-compliance might affect their willingness to continue participation;
9. Require modification of the protocol;
10. Require modification of the information disclosed during the consent process;
11. Require current subjects to re-consent to participation;
12. Suspend the study (See below); or
13. Terminate the study (See below)

In cases where the IRB determines that the event of noncompliance also meets the definition of unanticipated problem involving risks to subjects or others, the policy and procedure for review of such events will also be followed.

The investigator is informed of the IRB determination and the basis for the determination in writing.

11 Reporting to Regulatory Agencies and Institutional Officials

11.1 Policy

Federal regulations require prompt reporting to appropriate institutional officials, and the department or agency head of (i) any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and (ii) any suspension or termination of the IRB approval. The University HRPP will comply with this requirement and the following procedures describe how these reports are handled.

11.2 Procedures

1. The IRB staff will notify the IO of ‘reportable’ determinations by the IRBs (i.e., unanticipated problems involving risks to subjects or others, serious/continuing non-compliance, suspensions, terminations) as soon as possible after the meeting in question.
2. The IO or designee is responsible for preparing reports or letters which includes the following information:
   • The nature of the event (unanticipated problem involving risks to subjects or others, serious or continuing non-compliance, suspension or termination of approval of research);
   • Title of the research project and/or grant proposal in which the problem occurred;
   • Name of the principal investigator on the protocol;
   • Number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
   • A detailed description of the problem including the findings of the organization and the reasons for the IRB’s decision;
• Actions the institution is taking or plans to take to address the problem (e.g., revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.); and
• Plans, if any, to send a follow-up or final report by the earlier of
  o A specific date, or
  o When an investigation has been completed or a corrective action plan has been implemented.

3. The IO is the signatory for all correspondence from the University.

4. The IO or designee sends a copy of the report to the following federal agencies:
   • OHRP, if the study is subject to DHHS regulations or subject to a DHHS federalwide assurance.
   • FDA, if the study is subject to FDA regulations.
   • DoD, if the study is supported by that agency. (Report is sent specifically to the DoD human research protection officer.)
   • If the study is conducted or funded by any Federal Agency other than DHHS that is subject to “The Common Rule”, the report is sent to OHRP or the head of the agency as required by the agency.
     o Reporting to a regulatory agency is not required if the event occurred at a site that was not subject to the direct oversight of the organization, and the agency has been notified of the event by the investigator, sponsor, another organization, or other mechanisms.
   • Others as deemed appropriate by the IO.

The AVP-RC, on behalf of the IO ensures that all steps of this policy are completed within thirty (30) days of the convened IRB’s determination of an unanticipated problem, serious or continuing noncompliance, suspension, or termination.

12 Investigator Responsibilities

12.1 Policy

PIs are ultimately responsible for the compliant and ethical conduct of research. PIs may delegate aspects of the research across the study team, consistent with specific requirements for licensures or training for specific procedures (i.e. performing venipuncture, administering medication). However, PIs must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibility.

The following procedures describe the investigator responsibilities in the conduct of research involving human subjects.

12.2 Investigators

12.2.1 Principal Investigators (PI)
Only **faculty** may serve as the PI on a research project involving human subjects. The IRB may, on a case-by-case basis, permit University staff to serve as PIs based on, but not limited to, the following criteria:

- The individual is not a student;
- Nature of the study; study must be deemed minimal risk to human subjects;
- The individual's training in conducting research involving human subjects;
- The individual's experience in conducting research involving human subjects;
- The individual's education level, masters or doctorate preferred;
- The individual's motivation in performing research (e.g. must not be doing the research toward a degree or certification);
- Approval and signatory certification of, and oversight by their supervisor.

Those wishing a waiver from the faculty PI requirement must address each criterion above, provide a resume/CV, and submit to the ORC for forwarding to the IRB for review.

The IRB recognizes one PI for each study. The PI has ultimate responsibility for the research activities.

Protocols that require skills beyond those held by the PI must be modified to meet the investigator's skills or have one or more additional qualified faculty as co-investigator(s).

### 12.2.2 Student Investigators

Students may not serve as PIs. They must have a faculty sponsor who fulfills the PI eligibility criteria and who will serve as PI and faculty advisor on the study.

### 12.2.3 Research Team

The research team consists of individuals who intervene or interact directly with subjects (including the recruitment or consenting thereof), or who analyze data and/or tissue derived from humans for the purposes of the activity in question.

### 12.3 Responsibilities

In order to satisfy the requirements of this policy, investigators who conduct research involving human subjects must:

1. Develop and conduct research that is in accordance with the ethical principles in the Belmont Report;
2. Develop a research plan that is scientifically sound and minimizes risk to the subjects;
3. Have sufficient resources necessary to protect human subjects, including:
   a) Access to a population that would allow recruitment of the required number of subjects.
   b) Sufficient time to conduct and complete the research.
   c) Adequate numbers of qualified staff.
d) Adequate facilities.

e) A process to ensure that all persons assisting with the research are adequately informed about the protocol and their research-related duties and functions.

f) Availability of medical or psychological resources that subjects might require as a consequence of the research.

4. Assure that all procedures in a study are performed with the appropriate level of supervision and only by individuals who are licensed or otherwise qualified to perform such under the laws of New York and the policies of SBU;

5. Assure that all key personnel are educated in the regulatory requirements regarding the conduct of research and the ethical principles upon which they are based;

6. Protect the rights and welfare of prospective subjects;

7. Ensure that risks to subjects are minimized: (i) by using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes;

8. Recruit subjects in a fair and equitable manner;

9. Obtain and document informed consent as required by the IRB and ensure that no research procedure is performed prior to obtaining and documenting consent from the human subject;

10. Have plans to monitor the data collected for the safety of research subjects;

11. Protect the privacy of subjects and maintain the confidentiality of data;

12. When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, include additional safeguards in the study to protect the rights and welfare of these subjects;

13. Have a procedure to receive complaints or requests for additional information from subjects and respond appropriately;

14. Ensure that pertinent laws, regulations, and institution procedures and guidelines are observed by participating investigators and research staff;

15. Ensure that all research involving human subjects receives the IRB review and approval in writing before commencement of the research;

16. Comply with all the IRB decisions, conditions, and requirements;

17. Ensure that protocols receive timely continuing IRB review and approval;

18. Report deviations, noncompliance, and unanticipated problems involving risks to subjects or others in accordance with these SOPs;

19. Obtain the IRB review and approval in writing before changes are made to approved protocols or consent forms; and

20. Seek the IRB assistance when in doubt about whether proposed research requires the IRB review.

12.4 Training/ Ongoing Education of Investigators and Research Team

As stated above, one component of a comprehensive human research protection program is an education program for all individuals involved with human subjects. The University is committed to providing training and an on-going educational process for investigators and members of their research team related to ethical concerns and regulatory and institutional requirements for the protection of
human subjects. As an example, initial and continuing research ethics education is required for all personnel who conduct, review, approve, oversee, support, or manage human subjects research sponsored by the Department of Defense.

Approval of new and continuing review submissions will be withheld unless all individuals listed in the electronic submission form as part of the study team are current in their certification to conduct human subject research, as defined in this document. ORC maintains the database of training certifications.

12.4.1 Initial Education

- All PIs and members of their research team must: review core training documentation including the “SBU Standard Operating Policies and Procedures for Human Research Protection” and the “Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research”;
- Be familiar with the University HRPP website, and the availability of links and other information contained within;
- Complete the University-required Basic Modules in CITI Course in the Protection of Human Research Subjects, and pass the required quizzes with a score of 80 or better
- Additional training:
  - Study Coordinators on file with the Office of Clinical Trials must satisfy a one-time completion of the CITI course on Clinical Research Coordinators (CRC)
  - NIH-funded investigators and clinical trial site staff who are responsible for the conduct, management and oversight of NIH-funded clinical trials must complete training in GCP (every three years).

12.4.1.1 The Collaborative Institutional Training Initiative (CITI)

The University offers access to the CITI program to all University faculty, staff, and students. Non-University investigators can use the CITI program if they are on file with the IRB as an investigator on an IRB application (approved or pending). Unauthorized use of the CITI program is prohibited.

The CITI web-based program is available at http://www.citiprogram.org. Investigators register under SUNY University at Stony Brook. After login, questions will be asked to assess what type of training you require based on certain criteria; it is the investigator’s responsibility to choose the answers that most accurately addresses:

- Your level of University training (initial, refresher);
- Your type of research (biomedical, social behavioral); and
- Your role in the research activities (data/tissues only, interaction with subjects, etc.).

Completion of the initial training through CITI will take approximately four to six (4-6) hours, although the trainee can go back over multiple sessions to complete training.
The Biomedical Research Alliance of New York (BRANY; which provides the IT, administrative support, and home to the CITI Program) issues CME/CEU credits for a fee. In order to qualify for CME/CEU credits, you must take and pass all required modules for the group you choose. Click the link for CME/CEU credits on the Learner's Menu for detailed information.

12.4.2 Waiver of Initial Education

If investigators or members of their research team are new to the University, and can verify that they have successfully completed the CITI Course at their former institution (involving equivalent modules to that required by the University), they may request a waiver of that aspect of Initial Education. However, they still must confirm review of the “SBU Standard Operating Policies and Procedures for Human Research Protection” and website materials.

12.4.3 Continuing Education and Recertification

All investigators and members of their research teams must meet University continuing education requirement every three (3) years after certification of Initial Education for as long as they are involved in human subject research. There is no exception to this requirement. Acceptable training includes:

- The University required CITI Refresher Modules (chosen in accordance with the criteria referenced above in Section 12.4.1.1), with a passing score on the required quizzes with a score of 80 or better.

Or

- A refresher course in human research protections offered by ORC (available for groups of twenty or more trainees). This option also requires completion of modified CITI refresher course for the purposes of assessing competency with the course material, via a score of 80 or better on the required quizzes.

And

- Thorough review of all HRPP Updates/Reminders/Guidance/Hot Topics sent regularly by e-mail to the campus community from the ORC, or via the Vice President for Research’s quarterly ‘Research News’, and/or
- Attendance at PRIMR or OHRP seminars, conferences and webinars, and/or attendance at an ORC sponsored workshop is strongly recommended, and/or
- Investigators who are also IRB Chair, IRB members, or ORC staff will satisfy the training requirements for IRB members and staff described in this policy under Section 2.13.

12.4.4 Additional Resources

Human research protection information will be made available on the ORC website, and via the IRB updates referenced above, on an ongoing basis to ensure that the University research community is apprised of current regulatory and policy requirements and training opportunities.
**12.5 Investigator Concerns**

Investigators who have concerns or suggestions regarding the University’s human research protection program should convey them to the AVP-RC, the IO, or other responsible parties (e.g. college dean, departmental chair) regarding the issue, when appropriate. The AVP-RC will research the issue, and when deemed necessary, convene the parties involved to form a response for the investigator or make necessary procedural or policy modifications, as warranted. In addition, the IRB Chair, AVP-RC, or the IO will be available to address investigators’ questions, concerns and suggestions.

**12.6 Investigator Disclosures of Significant Financial Interest**

The responsibilities and obligations of investigators to the University must be clearly separated from personal financial interests or other obligations. Prudent stewardship of public funds requires protecting University research, education and public service from being compromised by the private interests or obligations of any investigator.

Investigators will follow these SOPs at Section 14, which sets forth requirements and guidelines for:

- Disclosure of outside interests by investigators at the University who engage in University activities funded by specified internal and external entities;
- Review of Investigator disclosures by University officials; and
- Identifying, reporting and managing conflicts of interest.

**13 Sponsored Research**

**13.1 Policy**

It is University policy that any sponsored research conducted under the auspices of the University is conducted in accordance with federal guidelines and ethical standards.

The following describe the procedures required to ensure that all sponsored research meets this requirement.

**13.2 Definitions**

**Sponsor:** The company, institution, individual donor, or organization responsible for the initiation, management or financing of a research study.

**Sponsored research:** Research funded by external entities through a grant or contract that involves a specified statement of work (e.g. the research proposal) with a related transfer of value to the sponsor, including clinical trials involving investigational drugs, devices or biologics.
13.3 Responsibility

All sponsor contracts for research involving human subjects are reviewed by the Office of Sponsored Programs (OSP). ORC and OSP will share contract and study information as necessary for each sponsored protocol to ensure that protocol, consent, and contract language are consistent. Additionally, OSP reviews sponsor contracts to ensure the following:

1. All sponsor contracts will indicate that the University will follow the protocol, applicable regulations and its ethical standards;
2. All sponsor contracts will define who will be responsible for research related injuries, where applicable (see section 13.4 below for University policy);
3. If the sponsor will monitor the conduct of the research, the contract will be required to state that if the study monitor uncovers information that could affect the safety of subjects or their willingness to continue participation, influence the conduct of the study, or alter the IRB’s approval to continue the study, the sponsor will make sure that the information is communicated to the IRB;
4. If the sponsor discovers results that could affect the safety or medical care, the sponsor will make sure the IRB is notified;
5. When the sponsor is responsible for conducting data and safety monitoring, the agreement will require the sponsor to provide data and safety monitoring reports to the IRB and to report findings to the IRB that could affect the safety of subjects or influence the conduct of the research during or after the closure of the study;
6. Sponsor contracts will contain provisions regarding the dissemination of research results including the right of the University investigator to publish results. The sponsor may retain the right to review prior to publication and in certain circumstances to delay publication for a reasonable time period; and
7. Contracts or other funding agreements require the sponsor to promptly (no longer than within thirty (30) days report to the organization any findings that could affect the safety of subjects, influence the conduct of the study, or alter the IRB’s approval to continue the study.

13.4 Policy on Payment of Research-related Injury Costs in Industry-funded and Initiated Clinical Trials

The University’s role as a participating site in clinical trials that are funded and initiated by industry (e.g., pharmaceutical companies, device companies etc.) is critical in facilitating the evaluation and marketing of promising investigational (and new indications for approved) drugs, devices and biologics.

Given our patients’ important contribution in assisting industry companies in their quest to market such test products for public good and financial gain, it is expected that costs associated with research-related injuries occurring in SBU subjects volunteering in such trials must be borne by those companies. Subjects shall not be responsible, either directly or through their insurance, for payment of research-related injury costs in industry clinical trials.

This policy is not intended to waive any of a research subject’s legal rights; or release the investigator, the sponsor, the University or its agents from liability for negligence.
Waivers of this policy will be considered on a case by case basis by the AVP-RC, the IO, and other University Officials as deemed necessary.

Research-related injuries are those directly resulting from the test product or directly from properly performed study procedures. Such injury does not include normal progression of a subject’s underlying disease, or injury resulting from interventions that would have been conducted whether or not the subject participated in the industry clinical trial.

14 Conflict of Interest in Research

14.1 Policy

The responsibilities and obligations of Investigators to the University must be clearly separated from personal financial interests or other obligations. Prudent stewardship of public funds requires protecting University research, education and public service from being compromised by the private interests or obligations of any Investigator.

This policy sets forth requirements and guidelines for:

- Disclosure of outside interests by Investigators at the University who engage in University activities funded by specified internal and external entities;
- Review of Investigator disclosures by University officials; and
- Identifying, reporting and managing conflicts of interest.

14.2 Definitions

Conflict of Interest: When an Investigator is, or may be, in a position to influence activities or decisions in the conduct of externally and applicable internally supported activities in ways that could lead to personal financial gain for the Investigator (and/or the Investigator’s Immediate Family Member), or give an improper advantage to third parties in their dealings with the University.

Conflicts of interest may also arise when Investigators (and/or the Investigator’s Immediate Family Member) have outside obligations of any kind that are in substantial conflict with the Investigator's University responsibilities or the public interest.

Designated Institutional Official (DIO): The DIO is responsible for soliciting and reviewing Certifications from Investigators and developing Management Plans that specify the actions that have been and shall be taken to manage the Financial Conflict of Interest or Significant Obligation. The Vice-President for Research (VPR) appoints the DIO and serves as the final arbiter in the appeals process.

Financial Conflict of Interest (FCOI): A Significant Financial Interest (SFI) that is related to, and that could (or could be perceived to) directly and significantly affect, the design, conduct, or reporting of externally and applicable- internally supported activities. The DIO makes the determination that an SFI
constitutes a FCOI. When the activity involves human subjects, per OHRP and/or FDA as applicable, the IRB will also make an independent decision regarding presence of FCOI.

Financial Interest:
1. Any remuneration to the Investigator (and/or those of the Investigator’s Immediate Family Member) from outside the University, and/or
2. Any equity holdings or ownerships of the Investigator (and/or those of the Investigator’s Immediate Family Member), and/or
3. Intellectual property rights and interests (e.g., new technology disclosures, patents, copyrights) where a company has entered into an option to license, or license, such rights and interests from the University.
4. Intellectual property rights and interests upon receipt of income related to such rights and interests.

Note: At this University, all royalties, including those received by the Investigator from this University, are to be disclosed.

Financial Interest (FI) Exclusions:
- Income from investment vehicles, such as mutual funds and retirement accounts, as long as the Investigator does not directly control the investment decisions made in these vehicles;
- Income from seminars, lectures or teaching engagements sponsored by a federal, state or local government agency, a (United States) institution of higher education as defined at 20 U.S.C. 1001 (a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an institution of higher education; or
- Income from service on advisory committees or review panels for a federal, state or local government agency, a (United States) institution of higher education as defined at 20 U.S.C. 1001 (a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an institution of higher education.

Institutional responsibilities: All professional responsibilities and activities for which the investigator was hired to perform at, and is paid by, this University, including but not limited to research, research consultation, teaching, professional practice, institutional committee memberships, and service on panels such as Institutional Review Boards or Data and Safety Monitoring Boards.

Investigator (specific to IRB submissions only): All study team members listed in the electronic management system for a project submitted to the IRB. For the purposes of this policy, "Investigator" shall include the Investigator’s spouse and all dependent children.

Obligation: An unpaid position - held as an officer, trustee, director, adjunct professor, advisor, scientific advisor, board member or consultant - of a for-profit or not-for-profit entity.

Significant Financial Interest (SFI): One or more of the following types of Financial Interests of the Investigator (and/or those of the Investigator’s Immediate Family Member) that reasonably appears to be related to the Investigator’s Institutional Responsibilities is considered an SFI:
Publicly Traded Entity: Value of any remuneration received from the entity in the twelve months preceding the disclosure and/or the value of any equity interest in the entity as of the date of disclosure, when aggregated, exceeds $5,000.

Non-Publicly Traded Entity: Value of any remuneration received from the entity in the twelve months preceding the disclosure, when aggregated, exceeds $5,000, and/or the Investigator (and/or the Investigator’s Immediate Family Member) holds any equity interest.

Intellectual Property: rights and interests (e.g., patents, copyrights), royalties from such rights, and agreements to share in royalties related to such rights (upon receipt of income related to such rights and interests). At SBU, all royalties are to be disclosed, including those received by the Investigator from this University.

Travel (PHS/NIH only): Investigators also must disclose the occurrence (over the preceding 12 months) of reimbursed travel or sponsored travel (i.e., that which is paid on behalf of the Investigator) that is related to their Institutional Responsibilities and which totals > $5,000 per reimbursing / paying entity. The disclosure must include the sponsor, destination, duration, and purpose of the travel. Excluded from this requirement are travels that are reimbursed or sponsored by federal, state or local government agency, an institution of higher education as defined at 20 U.S.C. 1001(a), an academic teaching hospital, a medical center or a research institute that is affiliated with an Institution of higher education.

Significant Obligations (SO): Significant Obligations (SO) includes Obligations that would reasonably appear to be related to an Investigator’s Institutional Responsibilities.

14.3 Procedures for Financial Disclosure

Where the research activity involves human subjects, the DIO and the IRB retain responsibility for reviewing investigator financial disclosure and for promulgating conflict management plans. The IRB Staff liaises with the DIO. The AVP-RC also serves as a non-voting ex officio member of the COI Committee.

University Policy P209 (Investigator Conflict of Interest Policy) is followed regarding requirements for certification submissions, review, determinations of when significant financial interests and/or significant obligations constitute conflicts of interest, the development of conflict management plans, and reporting requirements.

In any such case where human subjects research is involved, the QA Administrator in ORC notifies the DIO of all funded studies submitted to the IRB, and the DIO advises if any named investigator on the submission has an SFI or SO. These cases are brought to the full committee for review of conflict and management plan (if required) to ensure the protection of human subjects.

If any of the Investigators on the protocol have an FCOI or SO the IRB requires (where it is determined that the conflict can, in fact, be managed) that:
• The DIO provides written confirmation that the conflict of interest can be managed, and provides a proposed management plan. The IRB will review the plan, and may modify and/or add to it, as below. Where there is discrepancy or disagreement, the IRB’s decision will supersede that of the DIO.

• The Investigator cannot be involved in the recruitment or consenting of subjects, and disclosure of such must be provided in the consent documents. If she/he is named in the consent form as not involved in recruitment or consenting of subjects, it means that the discussion of any details concerning the research protocol in question must be conducted by an IRB approved co-investigator. In the case where the Investigator may be a patient's treating physician, she/he may state that there are standard therapies available, as well as research studies that the patient may be interested in hearing about. If the patient is interested in hearing more about his/her research options, referral to the IRB approved co-investigator must occur.

• The Investigator cannot place undue pressure on, or offer incentives to, other investigators to enroll subjects.

• A section of the consent form must be added that:
  o is titled ‘Notice of Investigator Conflict of Interest’
  o names the Investigator(s) with the FCOI or SO
  o describes, in lay language, the nature of the FCOI or SO
  o states that the named Investigator(s) will not be involved in recruitment or consenting of subjects
  o describes any other aspects of a management plan as required by the IRB.

• In addition, as with any study, the consent processes for any or all subjects may be witnessed by an IRB or ORC representative.

For clinical studies involving the use of new human drugs and biological products or medical devices, certifications and disclosure requirements are defined in Food and Drug Administration (FDA) regulations, Title 21 CFR Part 54.

14.4 Institutional Conflict of Interest

As an organization that conducts and reviews research involving human subjects, the University recognizes its obligation to protect the rights and welfare of those subjects, and ensure the integrity of the research and the human research protection program. Toward this end, the financial interests of the University or senior administrative officials at the campus/central levels must be identified, evaluated, managed, and minimized or eliminated in order to ensure that meeting that obligation is not jeopardized.

14.4.1 Definition of Institutional Financial Conflicts of Interest

An “Institutional Financial Conflict of Interest” arises in human subjects’ research when a financial interest of SBU may affect or appear to affect the design, conduct, reporting, review, or oversight of the human subjects' research. Institutional financial conflicts of interest are of significant concern when they create the potential for inappropriate influence over a human subjects’ research project, particularly to the integrity of the research and the safety and care of subjects enrolled in the research.
All forms of potential Institutional Financial Conflicts of Interest in human subjects’ research require disclosure, evaluation, and either management or elimination under this Policy.

An “**Institutional Financial Conflict of Interest**” (IFCOI) exists when:

1. The University receives or might reasonably be expected to receive royalty income from the sale of a product covered by any patent, license or copyright, whether issued or pending, held by SUNY/RF and is proposed to be used in human subjects’ research projects at SBU;
2. The University holds or proposes to hold, directly or indirectly, any equity interests of any amount (or entitlement to the same), in research sponsors of human subjects’ research projects, whether such research sponsor is public or non-public, through its technology licensing activities or investments related to such activities;
3. The University has received substantial gifts (including gifts in kind) from a potential commercial sponsor of human subjects research or a company that owns or controls products being studied or tested in human subjects research; and/or
4. Senior Administrative Officials with direct responsibility for human subject research (or their spouse, dependent children), as defined in Section II below:
   - Hold positions such as an officer, trustee, director, employee or consultant in commercial research sponsors, or any company that owns or controls products being studied or tested in human subjects
   - Receive remuneration from commercial research sponsors, or any company that owns or controls products being studied or tested in human subjects. **Remuneration includes** salary and any payment for services not otherwise identified as salary (e.g., consulting fees, honoraria, paid authorship);
   - Hold any equity interest (e.g., stock, stock option, or other ownership interest) in commercial research sponsors, or any company that owns or controls products being studied or tested in human subjects
   - Hold intellectual property rights and interests (e.g., patents, copyrights), royalties from such rights, etc. relating to products being studied or tested in human subjects

14.4.2 Reporting

The following offices report at least semi-annually to the QA Administrator within ORC on interests described above:

1. Technology Licensing and Industry Relations Office:
   - to report licensing arrangements, patents, invention disclosures;
2. Advancement Office/Stony Brook Foundation
   - to report gifts

The following institutional officials are considered senior administrative officials and must provide initial disclosure of their significant financial interests relating to human research and then receive reminders on an annual basis that if details have changed a new disclosure form needs to be submitted and reviewed for IFCOI, with resulting management plans:
14.4.3 Review and Evaluation

IRB proposals submitted to the Office of Research Compliance in advance of IRB review and approval will be assessed by the QA Administrator for potential IFCOI by assessing applicability of information contained within the reports and forms referred to above.

As a matter of policy, the University will not participate in a human subjects’ research project when it has an IFCOI. An exception to this policy may be made only when the Institutional Review Board, in consultation as deemed necessary with the COI Administrator, and/or Conflict of Interest Committee (as identified in University Policy P209) determines that:

- Circumstances exist to justify SBU’s participation in the project while still maintaining the protection of human subjects, and
- A conflict management plan is adopted to maintain research integrity and serve the best interests of subjects enrolled in the research.

These circumstances and conflict management plans will be documented.

14.4.4 Conflict Management Plan

If the University’s participation in a project is permitted notwithstanding the IFCOI, the University’s participation will be subject to a conflict management plan developed and approved by the IRB as above. In the case of senior administrative officials, the conflict management plan shall be agreed to by the conflicted individual. The IRB has the final authority to determine whether any IFCOI and its management allows the research to be approved.

Options for managing institutional conflict of interest, include but are not limited to the following:

- Disclosing the institutional conflict of interest to research subjects in the consent process and documents.
- Disclosing the institutional conflict of interest to any journals or other publications for which the results of the research will be submitted.
- Recusing of conflicted senior administrative officials from scientific merit review of human research
- Having an external, independent IRB review the research in question
- Monitoring of research by independent reviewers
- Divestiture of financial conflicts of interests
• Severance of relationships that create actual or potential conflicts.
• Prohibition of the conduct of the research at the University

14.4.5 Timing

The review, evaluation, and where applicable, management of an IFCOI shall be completed prior to the account establishment of an award for the human subjects’ research project or any commencement of the project (including enrollment of any research subjects), whichever comes first. IRB proposals will remain unapproved, pending approval by IRB of the conflict management plan.

14.4 Investigator Conflict of Interest Unrelated to Current Financial Conflict of Interest

There are instances where a member of the study team has a vested personal interest in the future commercial success of the drug, device, etc. under study (e.g., was involved in discovery, patent, licensing, IND/IDE filings etc.), but does not, at this time, have a significant financial interest that would trigger a review for FCOI, as defined above. In this situation, although recruiting or consenting of potential subjects by the affected Investigator is acceptable, a section should be added to the consent form that reads:

"Investigator’s Personal Interest in this Study"

Dr. _____________, who is one of the investigators conducting this study has a personal commercial interest in, or may financially benefit in the future from, the development of the [drug, device, etc.] being tested in this study.

15 Subject Outreach

15.1 Policy

The University is committed to ensuring that educational opportunities are offered to research subjects, prospective research subjects, and community members which will enhance their understanding of activities involving human participation in research at SBU.

15.2 Research Subject Advocate (RSA)

The commitment of the Institution to our future and current research subjects is evident in the promotion in 2016 of an ORC IRB staff member to serve as the Institution’s Research Subject Advocate (RSA). This individual will:

• Work within University Hospital to promote educational efforts for patients regarding participation in research, and assist with, and streamline, procedures relating to recruitment of patients into research studies.
• Assist patients with navigating the research informed consent process.
• Disseminate materials, and organize educational events to train research volunteers, investigators, and staff regarding participant rights and protections. Serve as institutional liaison for ResearchMatch, the national recruitment registry that matches researchers to individuals who are interested in participating in research. (see Section 17.13 for more details on process)

15.3 Outreach Resources and Educational Materials

The RSA efforts include revising and augmenting a section of the Human Research website dedicated to informative outreach resources, now entitled “Volunteering in Research”. This area on the website includes an overview of what it means to be a volunteer in research, and addresses Frequently Asked Questions (FAQs), as well as Institutional, and other relevant source brochures. The website provides several relevant links to the Office for Human Research Protections (OHRP) campaign to inform the general public about research participation. Direct research-related links are provided to increase public awareness and educate the surrounding community regarding the importance of research, as well as the importance of their role in scientific advances.

The RSA participates in outreach activities (e.g., presence at health fairs, at University Hospital etc.) for community education efforts.

15.4 Evaluation

The RSA periodically evaluates outreach activities and revises efforts as deemed appropriate. These evaluations take place in an informal, ongoing manner. One such assessment of effectiveness is done via review of hits to the above-referenced website after various initiatives. RSA documents these assessments and revisions to the outreach program, and periodically meets with the AVP-RC to provide an update on the outreach program effectiveness and to address proposed activities and required resources moving forward.

16 Health Insurance Portability and Accountability Act (HIPAA)

16.1 Policy

Protected Health Information obtained by the University may not be used internally or disclosed to any outside person or organization for research purposes without prior approval of the IRB, and any other applicable HIPAA privacy and security policies in place at the University resulting from our University’s status as a ‘hybrid’ covered entity.

The following describe the procedures for conducting research at the University in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
16.2 Definitions

Access: The mechanism of obtaining or using information electronically, on paper, or other medium for the purpose of performing an official function.

Authorization: A detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual.

Covered entity: The term applied to institutions that must comply with the Privacy Rule. These include:
- Health plans
- Health care clearinghouses
- Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

Common Rule: A federal policy on human subject protection that provides for the primary source of regulation of research.

De-Identified Information: Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. If information is de-identified it no longer is subject to the Privacy Rule and exempt from HIPAA.

Deletion: The removal, erasing, or expunging information or data from a record.

Disclosure: The release, transfer, provision of access to, or divulging in any other manner information outside of the covered entity.

Health Information. Any information created or received by a health care provider or health plan that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or payment for the provision of health care to an individual.

Individually Identifiable Health Information (IIHI): A subset of health information, including demographic information collected from an individual that identifies the individual (either directly, or through codes/identifiers).

Limited Data Set: Protected health information that excludes specific direct identifiers of the individual or of relatives, employees or household members of an individual. A limited data set can only be used for the purposes of research, public health, or healthcare operations, and disclosed for the purpose of research.

Minimum Necessary: The principle that any access should be limited to the minimum amount of information needed to accomplish the intended purpose of the use or disclosure.
**Privacy Board:** The term used to describe a board comprised of members of varying backgrounds and appropriate professional competencies, as necessary, to review individual’s private rights. The IRB is the University’s privacy board.

**Privacy Act:** An act that provides for the confidentiality of individually identified and retrieved information about living individuals that is maintained in a system of records and permits the disclosure of records only when specifically authorized by the statute. The Act provides that the collection of information about individuals is limited to that which is legally authorized, relevant, and necessary.

**Privacy Rule:** Provides guidance on the use of protected health information in the conduct of research. It imposes requirements on those involved in research, both individuals and institutions. Privacy refers to a person’s desire to control the access of others to themselves. The evaluation of privacy involves consideration of how the investigator will access information from or about subjects. The CORIHS members should know strategies to protect privacy interests relating to contact with potential subjects, and access to private information.

**Protected Health Information:** Individually identifiable health information transmitted or maintained electronically or in any other form or medium, except for education records or employment records, as excluded in the Privacy Rule.

**Preparatory Research:** The method applied to developing or designing a research study.

**Waiver of Authorization:** A means of requesting approval from the IRB (as the Privacy Board) rather than asking each research subject for an authorization to access protected health information.

### 16.3 Historical Background

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) required the creation of a Privacy Rule for identifiable health information. The resulting Privacy Rule, finalized in August 2002, set a compliance date of April 14, 2003. While the main impact of the Privacy Rule will be on the routine provision of and billing for health care, the Rule will also affect the conduct and oversight of research. Investigators, IRB staff and IRB members, as well as research administration, must be aware of these changes.

### 16.4 Research under HIPAA

HIPAA defines research as "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge." This definition is identical with the one used in the “Common Rule.”
16.4.1 Effects of HIPAA on Research

The Privacy Rule does not make any changes to the Common Rule. However, it does contain several provisions that resemble provisions of the Common Rule and does make reference to those provisions.

The University is a hybrid covered entity under HIPAA because it consists of components that are (e.g. health care providers in the University Hospital) and components that are not (e.g. academic departments in the College of Arts and Sciences, etc.) considered covered entities under HIPAA.

- Where the investigator is also a covered entity, i.e. a health care provider, then she/he is legally mandated to comply with all provisions of HIPAA when accessing or generating PHI.
- Where the investigator is not a covered entity (i.e. not a health care provider), the University requires that HIPAA procedures be followed as ‘best practices’, as described in this document.

In general, the Privacy Rule permits covered entities to use or disclose protected health information for research purposes when the individual who is the subject of the information authorizes the use or disclosure (exceptions are addressed below). Where authorization is required, the IRB uses a combined authorization/informed consent form which should be completed by the investigator and submitted to the IRB for review and approval.

16.4.2 Review Preparatory to Research

The Privacy Rule permits a covered entity to use or disclose protected health information to an investigator without authorization or waiver for the limited purpose of a “review preparatory to research.” Such reviews may be used to prepare a research protocol, or to determine whether a research site has a sufficient population of potential research subjects. Prior to permitting the investigator to access the protected health information, the IRB must first receive and approve the HIPAA Preparatory to Research Form.

Investigators may, as part of their IRB submission, propose a recruitment plan that allows for the preparatory to research activity, with subsequent documentation of the identified patients' health care providers (who must be a part of SBU’s HIPAA covered entity ‘umbrella’ (the Organized Health Care Arrangement; OHCA; see description in https://www.stonybrookmedicine.edu/patientcare/privacy). Information sheets (to be submitted and approved by the IRB) could then be given to said health care providers who may, in turn, give or mail them to the eligible identified patients. Such information sheets would contain the contact information of the researcher if the patient wishes to obtain more information.

16.4.3 Use and/or Disclosure of De-identified Health Information: NOT subject to HIPAA

Where the investigator proposes use of PHI from which the following 18 identifiers are removed, HIPAA does not apply to the research:

- Name,
• Address (street address, city, county, zip code -with certain exceptions),
• Dates (e.g. birth date, admission date, discharge date, date of death) and individual ages if over 89,
• Telephone numbers,
• Fax numbers,
• Electronic mail addresses,
• Social security numbers,
• Medical record numbers,
• Health plan beneficiary numbers,
• Account numbers,
• Certificate/license numbers,
• Vin and serial numbers, license plate numbers
• Device identifiers and serial numbers,
• Web Universal Resource Locators (URL's),
• Internet Protocol (IP) address numbers,
• Biometric identifiers (including finger and voice prints),
• Full face photographic images and any comparable images, and
• Any other unique identifying number, characteristic, or code.

Although HIPAA is not applicable, the IRB (as the IRB, not the privacy board) approval must be obtained before commencement of the proposed activity. A HIPAA De-Identification Form must be submitted along with the standard IRB submission paperwork.

16.4.4 Research on Protected Health Information of Decedents

The protections of the Common Rule apply only to living human beings; by contrast, the Privacy Rule also protects the identifiable health information of deceased persons (“decedents”). The Privacy Rule contains an exception to the authorization requirement for research that involves the protected health information of decedents. A covered entity may use or disclose decedents’ protected health information for research if the entity obtains representations from the investigator that the use or disclosure being sought is solely for research on the protected health information of decedents, that the protected health information being sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is being sought. Investigators should submit the CORIHS HIPAA Research on Decedent PHI Form for the IRB review and approval when they intend to conduct research involving decedents’ protected health information.

16.4.5 Limited Data Sets with a Data Use Agreement

When an investigator requires certain data elements that are otherwise not permitted in de-identified data, as above, the Privacy Rule permits disclosure of a “limited data set” to the investigator without obtaining patient authorization, provided that the investigator has signed a data use agreement. The limited data set is still considered to be protected health information, but cannot include any of the following 16 identifiers:
• Names,
• Postal address info. (if other than city, state and zip),
• Telephone numbers,
• fax numbers,
• Email addresses,
• Social Security numbers,
• Medical record numbers,
• Health plan beneficiary numbers,
• Account numbers,
• Certificate/license numbers,
• Vin and serial numbers, license plate numbers,
• Device identifiers, serial numbers,
• Web URLs,
• IP address numbers,
• Biometric identifiers (finger prints), or
• Full face, comparable photo images.

The Privacy Rule requires that the data use agreement used in conjunction with the limited data set contain provisions that:
1. Establish the permitted uses and disclosures of the limited data set by the recipient, consistent with the purposes of the research, and which may not include any use or disclosure that would violate the Rule if done by the covered entity;
2. Limit who can use or receive the data; and
3. Require the recipient to agree to the following:
4. Not to use or disclose the information other than as permitted by the data use agreement or as otherwise required by law;
5. Use appropriate safeguards to prevent the use or disclosure of the information other than as provided for in the data use agreement;
6. Report to the covered entity any use or disclosure of the information not provided for by the data use agreement of which the recipient becomes aware; ensure that any agents, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set; and
7. Not to identify the information or contact the individual.
8. Investigators who will be receiving limited data sets must submit a signed copy of the covered entity’s data use agreement to the IRB for approval, prior to initiating the research.

Transition Provisions
The Privacy Rule contains certain grandfathering provisions that permit a covered entity to use and disclose protected health information for research approved before the Rule’s compliance date of April 14, 2003. The ORC should be contacted for further information pertaining to these provisions.
16.4.6 Waiver of Authorization for Use or Disclosure of Protected Health Information in Research

Under the Privacy Rule, covered entities are permitted to use and disclose protected health information for research with individual authorization, or without individual authorization under limited circumstances. A covered entity may use or disclose protected health information for research without individual authorization, when presented with documentation that the IRB has granted a waiver of authorization [see 45 CFR 164.512(i)(1)(i)]. This provision of the Privacy Rule might be used, for example, to conduct records research, epidemiological studies, or other research where de-identified data is unavailable or not suited to the research purpose.

The waiver documentation presented to the covered entity must include the following:
1. Identification of the IRB and the date on which the alteration or waiver of authorization was approved;
2. A statement that the IRB has determined that the alteration or waiver of authorization, in whole or in part, satisfies the three criteria in the Rule;
3. A brief description of the protected health information for which use or access has been determined to be necessary by the IRB;
4. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures; and
5. The e-signature of the IRB Chair or other IRB member, as designated by the IRB Chair.

The following criteria must be satisfied for the IRB to approve a waiver of authorization under the Privacy Rule:

**Note:** The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:

1. An adequate plan to protect the identifiers from improper use and disclosure;
2. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law;
3. Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart;
4. The research could not practicably be conducted without the waiver or alteration; and
5. The research could not practicably be conducted without access to and use of the protected health information.

Patient Rights and Research
Under HIPAA, patients have certain rights. Those that may affect research include the right to receive a Notice of Privacy Practices, the right to access, inspect, and receive a copy of one’s own PHI, the right to request an amendment to one’s own PHI, and the right to an accounting of certain disclosures of PHI that occur outside the scope of treatment, payment and health care operations that have not been authorized.
16.5 HIPAA and Documentation Requirements

Where health information is proposed for use or disclosure in a research activity, applicable HIPAA documents must be included with the IRB submission, e.g.:

- Consent/authorization form,
- HIPAA Waiver of Authorization Form,
- HIPAA Limited Data Set Form,
- HIPAA Research on Decedents Form,
- HIPAA Preparatory to Research Form, or
- HIPAA Deidentification Form

For investigators using University Hospital facilities and/or patients, the ‘Application for Approval to Conduct Research Activities At Stony Brook University Hospital Inpatient or Outpatient Facilities’ (available in the electronic management system’s forms library) must be uploaded, and the HIPAA Privacy Officer must e-certify to approve data disclosure to the study sponsor.

17 Special Topics

17.1 Quality Assurance/Quality Improvement (QA/QI) Activities vs. Research Activities

QA/QI initiatives are a mandated function of the University hospital. Some of these initiatives are implemented after thorough evidenced-based best practices are identified, in response to an identified safety issue, or to improve the delivery of care and avoid potential safety issues. The overarching intent of the initiatives is continuous monitoring of hospital operations and improved care of our patients here at Stony Brook University Medical Center.

Please note that the 'Application for Designation of Activity as Quality Assurance/Quality Improvement or Research" is available in the electronic management system in the Forms and Documents Library to assist the investigator in the proper designation for the activity.

QA/QI initiatives

The following activities are not considered research activities at the University. The responsible conduct of the activities below falls under the jurisdiction of SBUMC’s Division of Medical and Regulatory Affairs and/or a hospital-recognized departmental quality assurance committee (collectively referred to from this point on as ‘Hospital QA’):

- Any hospital QA initiatives, and presentation/publication of results thereof, that are conducted within SBUMC only, and that serve to:
  - Measure or improve SBU’s ability to meet or exceed an existing national standard of care or benchmark (Joint Commission, etc.). OR
  - Develop a standard of care or benchmark for applicability within SBUMC.
  - Submission of data to a national or state registry/database:
- That is mandated at the state or federal level. OR
- That directly impacts reimbursements and funding available from the state, Department of Health, or federal Centers for Medicare & Medicaid Services (CMS) based on performance and/or clinical or quality outcomes, OR
- That is maintained by an organization/consortium, formally recognized by SBUMC’s Division of Medical and Regulatory Affairs, the principal purpose of which is benchmarking and/or performance improvement, the use of which is for internal University activities.

- Hospital QA use of data from a registry/database, meeting any of the criteria above, for the purpose of:
  - Measuring or improving SBU’s ability to meet or exceed an existing national standard of care or benchmark (JCAHO, etc.). OR
  - Developing a standard of care or benchmark for applicability within SBUMC.

17.1.1 Research Activities

The following activities are considered research activities. The responsible conduct of the activities below fall under the jurisdiction of ORC and/or Institutional Review Board (IRB):

- Any hospital QA initiative, conducted within SBUMC only, designed to develop a standard of care or benchmark for general applicability (i.e. not only for operations within SBUMC, but to outside entities as well).
- Any QA or QI initiatives (including those proposing to develop an operational standard of care of benchmark) that are “investigator-initiated”, i.e., that have not been vetted through, and endorsed by, SBUMC’s Division of Medical and Regulatory Affairs and/or a hospital-recognized departmental QA committee).
- Submission of data to a registry/database that is not covered by those described above.
- Use of data from any registry/database for the purpose of measuring, improving or developing a standard or benchmark, under any condition not covered in the section above, including the use of registry data for the purpose of research.
- Any activity that proposes comparisons of one or more prospective interventions that are deliberately administered or made available (through a randomization or other process) to some patients (if within the University) or some hospitals (if part of a consortium or organizational effort) and not to others. This does not include, e.g. initiating a QI process in a small percentage of patients at SBUMC first to ensure feasibility, before introducing it to the entire patient population.

17.1.2 Activities that have a mix of both QA/QI and Research Components

Where your activity involves a mix of activities from Sections A and B, you will need to ensure compliance with the applicable entity, i.e. SBUMC’s Division of Medical and Regulatory Affairs for the QA/QI aspects and ORC/IRB for the research aspects of the activity (including securing approval prior to conducting the research aspect).

For any ‘questionable’ (QA vs. Research) activity not described above, please consult with the ORC and/or the Division of Medical and Regulatory Affairs for assistance.
17.2 Data/ Tissue Registries/ Banks

17.2.1 Mandated Registries and Biobanks

Mandated registries and biobanks are those:

- That are required by a state or federal agency, or
- That directly impact reimbursements and funding available from the state, Department of Health, or federal Centers for Medicare & Medicaid Services (CMS) based on performance and/or clinical or quality outcomes, or
- That are required to meet Joint Commission and other written standards for the treatment, payment, and/or operation of SBU’s University Hospital (SBUH) or SBUH departments or SBU Clinical Practice Management Plan (CPMP).

These activities are not under IRB jurisdiction.

However, proposed research on identifiable data or specimens from such registries or biobanks would require prior review and approval or exemption by an SBU IRB.

17.2.2 Non-Mandated Registries and Biobanks:

Non-mandated registries and biobanks are those that are not listed above as mandatory. IRB oversight is dependent on the intent of the registry or biobank.

If the primary intent of the registry/biobank is for SBU-recognized quality assurance activities, then the creation of the registry/biobank does not fall under the jurisdiction of the IRB. The creation, and subsequent QA use of data or tissue from, the registry or biobank, must not commence without prior written approval by an appropriate authority (see Section 17.1 for additional guidance on QA activities at the University).

If there is any intent of the registry or biobank to bank data or tissue for future use in research activities, IRB approval is required for the creation of the registry or biobank, and IRB review and approval (or exemption) is required for the individual research activities that use the banked data or tissue. This includes:

- Informed Consent: Patients must consent to their data and/or tissue being banked in a non-mandated registry/biobank. Their consent is for the banking process only, and the consent process must be clear that each subsequent research use of the patient’s (now subject’s) data or tissue will undergo an ethics review to determine ethical and scientific merits of the proposed research.

- HIPAA Authorization: Patients must provide HIPAA authorization for their data and/or tissue to be banked in a non-mandated, non-QA registry/biobank.
• Confidentiality: Certificates of Confidentiality (https://grants.nih.gov/grants/policy/coc/index.htm) should be obtained for each registry and biobank to protect the confidentiality of the stored data and tissues.

• Licensure: Biobanks must operate under appropriate licensure from the NYS Department of Health; See section 17.2.3 below for more information.

17.2.3 Stony Brook University BioBank

Stony Brook University operates a licensed BioBank, currently under the oversight of Dr. Kenneth Shroyer, Chair of Pathology. Any biobank that is proposed must be specifically added to the University’s license on file with the NYS Department of Health

17.3 International Research

The IRB will review all international research utilizing human subjects to assure adequate provisions are in place to protect the rights and welfare of the subjects.

Approval of research is permitted if “the procedures prescribed by the foreign institution afford protections that are at least equivalent to those provided in 45 CFR 46.”

All policies and procedures that are applied to research conducted domestically should be applied to research conducted in other countries, as appropriate.

For international research, the IRB seeks sufficient knowledge of the local research context by requesting approval for the project from local IRBs or ethics committees (which may or may not be OHRP-registered) and/or local letters of support. The source of this information will depend on the nature of the study, on the country and on the resources available to the PI. Where there is a local IRB/IEC, the IRB must receive and review the foreign institution or site’s IRB/IEC review and approval of each study prior to the commencement of the research at the foreign institution or site.

In some circumstances where research may be performed internationally and/or in settings where there are no IRBs, the IRB may, prior to approval of the research, require additional verification and information from people outside the particular research project who are familiar with the customs, practices, or standards of care where the research will be taking place, such as local IRBs or ethics committees, other IRB investigators with knowledge of the region, or other experts on the region. The AVP-RC, on behalf of the IO, will review all transnational research proposals to determine whether the IRB has the qualifications to review the proposed research, or require expertise of a consultant. Use of consultants will be required when none of the investigators are from the international site and there is no local site/contact. These consultants may either provide a written review of a particular protocol or attend an IRB meeting to provide the IRB with recommendations based on his or her expertise.
For federally funded research, approval of research for foreign institutions or sites “engaged” in research is only permitted if the foreign institution or site holds an Assurance with OHRP and local IRB review and approval is obtained.

Approval of research for foreign institutions or sites “not engaged” in research is only permitted if one or more of the following circumstances exist:

- When the foreign institution or site has an established IRB/IEC, the Investigator must obtain approval to conduct the research at the "not engaged" site from the site’s IRB/IEC or provide documentation that the site’s IRB/IEC has determined that approval is not necessary for the Investigator to conduct the proposed research at the site.
- When the foreign institution or site does not have an established IRB/IEC, a letter of cooperation must be obtained demonstrating that the appropriate institutional or oversight officials are permitting the research to be conducted at the performance site.
- IRB approval to conduct research at the foreign institution or site is contingent upon receiving documentation of the performance site’s IRB/IEC determination, or letter of cooperation, as applicable.

17.3.1 Responsibilities

1. It is the responsibility of the University investigator and the foreign institution or site to assure that the resources and facilities are appropriate for the nature of the research.
2. It is the responsibility of the University investigator and the foreign institution or site to confirm the qualifications of the investigators and research staff for conducting research in that country(ies).
3. It is the responsibility of the University investigator and the foreign institution or site to ensure that the following activities will occur:
   a) Initial review, continuing review, and review of modification;
   b) Post-approval monitoring;
   c) Handling of complaints, non-compliance and unanticipated problems involving risk to subjects or others; and
   d) The IRB will not rely on a local ethics committee that does not have policies and procedures for the activities listed above.
4. It is the responsibility of the University investigator and the foreign institution or site to notify the IRB promptly if a change in research activities alters the performance site’s engagement in the research (e.g., performance site “not engaged” begins consenting research subjects, etc.).

17.3.2 Consent Documents

The informed consent documents must be in a language understandable to the proposed subjects, with the credentials of the translator detailed in the IRB application or amendment form.

17.3.3 Monitoring of Approved International Research

The IRB is responsible for the ongoing review of international research conducted under its jurisdiction through the continuing review process in accordance with all applicable federal regulations.
When the IRB and a local ethics committee will both be involved in the review of research, the PI will be responsible for ensuring coordination and communication with the local IRB/IECs.

The PI will be required to review and confirm compliance with any cited provisions provided in the current International Compilation of Human Subject Research Protections available through OHRP at [http://www.hhs.gov/ohrp/international/index.html](http://www.hhs.gov/ohrp/international/index.html). When the foreign institution or site does not have an established IRB, a letter of cooperation must be obtained demonstrating that the appropriate institutional or oversight officials are permitting the research to be conducted at the performance site.

For Federally funded research, approval of research for foreign institutions or sites “engaged” in research is only permitted if the foreign institution or site holds an Assurance with OHRP and local IRB review and approval is obtained.

17.4 Registration of Clinical Trials

This institution requires PIs of certain investigator-initiated clinical trials to comply with federal requirements concerning registration of their studies on [www.clinicaltrials.gov](http://www.clinicaltrials.gov), no later than 21 days after enrollment of the first participant, if their study is described by any of the following:

- Funded (wholly or in part) by NIH, and meets the NIH definition of a clinical trial, i.e., the answer to all four of the following questions is yes:
  1) Does the study involve human participants?
  2) Are the participants prospectively assigned to an intervention?
  3) Is the study designed to evaluate the effect of the intervention on the participants?
  4) Is the effect that will be evaluated a health-related biomedical or behavioral outcome?


- Not funded by NIH, and is (1) a clinical trial of drugs and/or biological products that is a controlled, clinical investigation, other than a Phase I investigation, of a product subject to FDA regulation (see [https://clinicaltrials.gov/ct2/manage-recs/fdaaa](https://clinicaltrials.gov/ct2/manage-recs/fdaaa));

- Not funded by NIH, and is a prospective clinical study of health outcomes comparing an intervention with a device product against a control in humans (other than a small feasibility study), or any pediatric post-market surveillance study, as required under the Federal Food, Drug and Cosmetic Act (see [https://clinicaltrials.gov/ct2/manage-recs/fdaaa](https://clinicaltrials.gov/ct2/manage-recs/fdaaa))

In addition, many ICMJE journals ([http://www.icmje.org/](http://www.icmje.org/)) require clinicaltrials.gov registration in order to consider articles for publication. See [http://www.icmje.org/about-icmje/faqs/clinical-trials-registration/](http://www.icmje.org/about-icmje/faqs/clinical-trials-registration/) for full detail. **Note that for these journals, registration must occur before the first patient is enrolled.**

Contact the Office of Research Compliance for first-time access to the clinicaltrials.gov site.
17.5 Guidance on Research (only) Involving Coded Private Information or Biological Specimens

When dealing with the review of biological specimen use in research activities, the IRB must balance two factors: the need for protection of the rights and welfare of the person from whom the specimen was/will be obtained and the need to not impede the research activities conducted at Stony Brook University.

The reader should also review Section 17.2, which addresses research involving tissue registries/tissue banks.

Discussion of the definition of ‘human subject’: Is identifiable private information or specimens being obtained?

“Under the definition of human subject at 45 CFR 46.102(f), obtaining identifiable private information or identifiable specimens for research purposes constitutes human subjects research. Obtaining identifiable private information or identifiable specimens includes, but is not limited to:

1. Using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that have been provided to investigators from any source; and
2. Using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that were already in the possession of the investigator.

In general, OHRP considers private information or specimens to be individually identifiable as defined at 45 CFR 46.102(f) when they can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

Conversely, OHRP considers private information or specimens not to be individually identifiable when they cannot be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

For example, OHRP does not consider research involving only coded private information or specimens to involve human subjects as defined under 45 CFR 46.102(f) if the following conditions are both met:

1. The private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals; and
2. The investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:
   a) The investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the HHS regulations do not require the IRB to review and approve this agreement); or
   b) There are IRB-approved written policies and operating procedures for a repository or data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased; or
c) There are other legal requirements prohibiting the release of the key to the investigators, until the individuals are deceased. “

If the definition of ‘human subject’ is met, will consent need to be obtained?

The IRB operates under the general rule that if an investigator can get consent from a prospective subject, than she/he should get consent from that subject. This is the case in most instances of research proposing prospective collection of biological specimens. Exceptions to this general requirement (e.g. in the case of future discarded surgical specimen, etc.) may be granted only if the consent waiver criteria below are submitted, and deemed appropriate by the IRB.

For biological specimen research: Will the activity generate information that has known clinical significance for diagnosis or prediction of a disease state for either the subject or the subject’s family members?

If the answer is NO, the (non-physical) risks for the activity are deemed minimal, i.e. they are theoretical in that clinical significance may be determined in the future. The possible risk then becomes one of a breach of confidentiality and/or the subject not knowing that this significant, private information now exists.

Where consent is required by the IRB, possible consent language in the procedures section (where consent is required) includes:

“Results from testing of your tissue will not be understood unless we pool it together with data from other study subjects. Because this is research, the clinical significance (if any) of your individual results may not be understood for years. Therefore, individual test results will not be shared with you or your doctor.”

If the PI wishes to contact subjects if and when the clinical significance of the results becomes clear, possible consent language includes:

If, in the future, findings from this study are confirmed by the scientific community and have definite implications for your health (or your children or future offspring), we will make a best effort to send you a letter describing the general results and offering ways to obtain care and/or counseling. If you initial here________, it means you do not want to be contacted if future findings become relevant to you.”

If the answer is YES, the (non-physical) risks associated with the study are deemed more than minimal. These risks are as follows (and should be considered when drafting the foreseeable risks section of the consent document):

When subjects already have the disorder for which biological testing is being done: Risks may include possible breaches of confidentiality (affecting insurability, employability, etc.) and (where applicable) unintentionally uncovering unintended incidental genetic information (e.g.
non-paternity, hereditary risks, risks of future diseases). Benefits could include confirmation of clinical diagnosis, where applicable, or else indicate clearly that no direct benefit exists for the subject.

**When subjects are not yet known to have the disorder for which biological testing is done:** Risks include those above, as well as (where applicable) psychological risks, determination of the possible presence of a heritable disorder (in themselves or their current/future offspring, accordingly). This research activity could also be of direct benefit, e.g. giving the subject the ability to inform family and to make appropriate lifestyle and reproductive choices; offering the potential for more effective intervention).

**Further:**
- If there are hereditary implications, genetic counseling by a genetic counselor or other qualified health care provider is required prior to participation in the study. Consent should indicate who will cover the cost of the counseling.
- There is an obligation to inform the subject of the test results in a timely manner after they are known. However, the subject should be offered an opt-out option (to not be told).
- Consent document must indicate that the results of the research testing must not be used as the basis for clinical decision making, and the subject should seek confirmation of research test results in a certified clinical laboratory.

**What about the information generated from specimen analysis?**

Another important aspect of specimen research to consider is that fact that the information that will be generated from analysis of the tissue will likely constitute ‘health information’, therefore requiring that the study be in compliance with privacy regulations, i.e. HIPAA. Section 16 must be reviewed to ensure that either:

- HIPAA authorization language is included in the Confidentiality/Privacy section of the subjects’ consent documents; OR
- One of three HIPAA forms is provided with the IRB submission so that the Investigator can attest to the fact that authorization from the subject is not required. Either:
  - A HIPAA De-identification Form, OR
  - A Limited Data Set Form, OR
  - A HIPAA Waiver of Authorization Form

**17.5.1 General Issues to Consider in Biological Specimens Research**

If the banking of biological specimens is proposed within the context of a larger (multi-center) research study, the following issues can be addressed within the main research consent form, but the actual request for consent to bank the tissue must be separated out from the request to consent for the main study. This can be achieved by adding yes/no statements (with a signature or initial lines) right before the signature lines of the main consent.
For example:

1. Do you agree to allow use of extra blood obtained from this study/extra tumor from your surgery for use in future research, the purposes of which are unknown at this time? If you agree, any future studies using your sample will be subject to further regulatory review.

2. Do you agree to allow someone to contact you in the future to ask you questions about your health or to ask you to participate in more research?

3. At the time of the proposed activity, is it the intent of the investigator or the company collaborator/sponsor to produce a commercially valuable product? If yes, disclose in the consent form whether or not the subject or his/her heirs will receive a portion of the profits. Note that consent forms cannot contain language through which the subject is made to waive, or appear to waive, any of his/her legal rights. An acceptable example of consent language is:
   - “We may, in the future, be able to produce a commercially valuable product from the work done on samples collected from subjects in this study. It is not our intention to pay you or your heirs, for profits derived from such a product.”

4. What happens to the specimen(s), and the data derived thereof, if the subject decides to withdraw from the study? Is the tissue removed from the study analysis or from the tissue bank? If so, state so in the consent. If it is not the intention to remove the sample or any data derived from it, state so in the consent. What about cell lines that have been generated?

5. How long will the biological specimen be kept? (It is acceptable to indicate, in the consent form, that the specimen will be kept for an indefinite amount of time).

6. If a new study proposes secondary use of biological specimens, i.e., use of samples collected for a previously conducted study, an assessment will be made by the IRB regarding whether or not the consent that was obtained for the first study is applicable to the second. If the purpose of the new study differs significantly from the purposes stated in the original study, and the specimens are identifiable, obtaining new consent will be required, unless the consent waiver criteria are met. The IRB therefore recommends obtaining the initial consent for research with as broad a stated purpose as possible such as, e.g. “the causes and treatments of lung cancer” etc..

7. Given the study aims and risks, should the investigator obtain a study-specific Certificate of Confidentiality from the NIH to protect against disclosure required by issuance of a subpoena. This is an extra protection for confidentiality if the study can potentially generate information that is particularly sensitive (e.g. HIV status, history of alcoholism, possible mental illness, etc.) For more information, visit: https://humansubjects.nih.gov/coc/index

17.6 Policy on Payment of Research Related Injury Costs Due in Industry-funded and initiated Clinical Trials

The IRB supports University’s role as a participating site in clinical trials that are funded and initiated by industry (‘Industry Clinical Trials’ e.g. pharmaceutical companies, device companies etc.). Such participation is critical in facilitating the evaluation and marketing of promising investigational (and new indications for approved) drugs, devices and biologics.

Given our subjects’ important contribution in assisting industry companies in their quest to market such test products for public good and financial gain, it is expected that costs associated with research-
related injuries* occurring in University subjects volunteering in such trials must be borne by those companies. Subjects shall not be responsible, either directly or through their insurance, for payment of research-related injury costs in industry clinical trials. Waivers of this policy will be considered on a case by case basis through consultation with the IO, Office of Sponsored Program (Clinical Trials Contracts division), and the AVP-RC as required.

This policy formalizes a long-standing procedural requirement of the IRB Committees and is not intended to waive any of a research subject’s legal rights; or release the investigator, the sponsor, the University or its agents from liability for negligence.

*Research-related injuries are those directly resulting from the test product or directly from properly performed study procedures. Such injury does not include normal progression of a subject’s underlying disease, or injury resulting from interventions that would have been conducted whether or not the subject participated in the industry clinical trial.

17.7 Application of ICH-Good Clinical Practice (GCP)

The IRB reviews research, and investigators conduct research in accordance with “Guidance for Industry E6 Good Clinical Practice: Consolidated Guidance” when the sponsor funding the research requires such compliance, per citation in the study protocol. When this is the case:

The investigator will confirm compliance with these requirements, via review, completion, and uploading of the Supplemental Form D: ICH-GCP into the applicable electronic management system package.

The IRB will:

- Follow these standard operating procedures that are in compliance with sections 3.1-3.4 of the above document and additionally confirm, for the study in question:
  - All payments are prorated
  - Alternatives are provided with risks/benefits assessment
  - Costs and treatment in case of injury are clearly addressed
  - Subject responsibilities are addressed (distinct section)
  - Subjects will be given a SIGNED and DATED copy of the ICF

17.8 Policy on Non-English Speakers as Research Subjects

17.8.1 Inclusion of Non-English Speakers

The IRBs have been deliberating for some time regarding the conditions under which non-English speakers must be offered inclusion in research activities. The committees have concluded that non-English speakers must be offered inclusion in studies where there is a potential for therapeutic benefit and no reasonable alternative or option is available outside of the research (i.e., in clinical care). For example:
Many of the cooperative oncology group protocols would qualify in this category, i.e. testing experimental drugs that do not have a reasonable alternative in clinical care. Certain studies involving potentially therapeutic benefit via non- or less-invasive procedures where the only clinical alternative would be invasive.

For these types of studies, the special protections addressed in 17.8.2 and 17.8.3 below would need to be adequately addressed as a condition of IRB approval.

For studies that do not qualify as above, investigators should remember that they must always develop eligibility criteria for their studies that consider safety, protection of vulnerable populations, and of course, the purpose of the research. Although not required as a condition of IRB approval (as it is above), all individuals meeting study eligibility criteria should be offered enrollment, regardless of the language they speak. Protections addressed below in 17.8.2 and 17.8.3 can be addressed on an expedited, ‘as needed’, basis, if and when the opportunity presents itself to discuss a study with a non-English speaker.

17.8.2 Consenting a Non-English Speaking Subject

Except as provided in Section 5.9 of these SOPs, informed consent must be obtained, and it must be documented by the use of a written consent form approved by the IRB.

The person obtaining consent from a non-English speaking subject's consent should either be a study investigator who is fluent in English and the language of the subject, or a study investigator who is assisted by either a qualified translator (non-family member) or a recognized translation service.

Informed consent should be documented by the use of either:

A translated version of the IRB approved ‘full’ English consent form that embodies the basic and required additional elements of informed consent. An affidavit of accurate translation from the IRB approved English version must be provided from a qualified translator who is unaffiliated with the study. The translated consent form and affidavit must be submitted and approved by IRB before its use. The document is signed and dated by the subject or the subject's legally authorized representative at the time of consent. A copy of the signed and dated consent form must be given to the person signing the form.

Or

A “short form” written consent document which states that the elements of informed consent have been presented orally to the subject or the subject's legally authorized representative. Both the short form and the oral presentation must be presented in the language of the subject. The IRB must receive and approve all foreign language versions of the short form document (along with translator affidavit) prior to use. Note that English and Spanish versions of an IRB acceptable 'short form' document are available in the forms library of the electronic management system.
When this ‘short form’ method is used:

1. The oral presentation should be conducted by either a study investigator who certifies to the IRB that she/he is fluent in English and the language of the subject, or a study investigator who is assisted by either a qualified translator unrelated to the study, or a recognized translation service, and
2. There must be a witness to the oral presentation who is fluent in both English and the language of the subject. Note:
   o If an unaffiliated, qualified translator or service is used in the oral presentation as above, that individual may serve as the witness,
   o a family member may not serve as the witness, and
3. The IRB must approve a written summary of what is to be read to the subject. Note: the IRB approved English consent form may serve as the summary, and
4. The witness must sign both the short form and a copy of the summary; and
5. The person actually obtaining consent must sign a copy of the summary; and
6. A copy of the summary must be given to the subject or representative, in addition to a copy of the short form.

17.8.3 Handling Visits and Procedures with a Non-English Speaking Subject

Investigators who are not fluent in the language spoken by the subject are expected to have a qualified translator present (or translation service used) for visits/procedures. This person cannot be a family member if the study is deemed greater than minimal risk to the subject.

17.9 SBU Guidance on the Management of Incidental Findings in Human Research


Unless specifically addressed otherwise, where the word subject is used in this document, it is meant to encompass adult subjects, minor subjects who assent for research, parents who give permission for those minor subjects, and legally authorized representatives of adult subjects who cannot consent for themselves.

17.9.1 Definition

Incidental Finding (IF): A finding that:
- Concerns an individual research subject that has potential health or reproductive importance; and
- Is discovered in the course of screening for, conducting, or analyzing results from research; and
- Is beyond the aims of the study, i.e., occurring from variables not directly under study.
17.9.2 Background

Federal regulations [45 CFR 46.111(a)(6)] require that studies have adequate provisions for enrollment screening and data monitoring to ensure the safety of subjects. In the course of carrying out these provisions, information that is secondary to the goals of the research may be identified which may impact the safety and/or wellbeing of the subjects.

These IF’s have risks and benefits associated with them. For example, discovery of a possible abnormality during the course of a research-related fMRI study may lead to anxiety, as well as costs of further evaluation to determine clinical relevance (whether or not it ultimately turns out to be clinically relevant). However, an IF may also save a subject’s life, if, e.g. that abnormality turns out to be an operable brain tumor. It is important, and respectful to the potential subjects, to be clear in the consent process regarding the possibility of IFs, and procedures to be followed if they are uncovered. This information may impact a subject’s willingness to participate in a given research study.

It is not the intent of this guidance to imply that investigators have an obligation to proactively search for IFs in research data/scans. It is important during the consent process to ensure that the subject understands that the goal of research is to collect data to answer the study aims, not to provide health information to individuals. It is also important not to foster a ‘therapeutic misconception’, i.e., that participation in a research activity will yield clinical benefit, or that the absence of IF’s implies a ‘clean bill of health’.

17.9.3 Procedures for IFs that are Reasonably Foreseeable

Certain types of research, e.g., research involving certain genetic/genomic analyses, or experimental scanning (MRI, CT, PET etc.), have a high potential for discovery of IF’s. In developing these, and other types of research studies, Principal Investigators have an ethical obligation to subjects to assess the ‘reasonably foreseeable’ potential for IF’s, identify and assess the types of IF’s possible, and procedures to be followed for disclosure to subject.

The PI has primary, hands on, responsibility in this process. Members of the study team must be knowledgeable of the plan such that suspected IF’s are reported to the PI for implementing the plan from that point forward.

17.9.4 Submission to the IRB

The submission to the IRB should include:

- A summary of the assessment referenced above, i.e., a general description of the IF’s that are possible in the activity, along with incidence of occurrence (based on available literature). As examples, MRI’s could uncover possible tumors or evidence of prior stroke; genetic analyses could uncover questions of paternity.
- Consideration should also be made regarding the need to re-contact the subject, if future analyses of data may uncover IF’s after participation has ended.
The plan, if any, for assessing the significance of IF’s, including involvement of outside consultants/experts to assist in said assessment.

This assessment is not for the purpose of determining whether or not to inform the subject, but for the purpose of gathering information to provide to the subject so that they can weigh for themselves the IF’s associated ‘risks’ (e.g. anxiety, possible costs of follow-up), ‘benefits’ (e.g. discovery of an operable tumor), and need for follow-up.

Any involvement with outside individuals or departments should be in place prior to commencement of the activity (and associated costs, if anticipated, should be built into the budget). If applicable, these arrangements should be addressed in the consent process so that the subject can consent to their information being shared in this manner for IF assessment.

The process to be followed for disclosure to the subject:

- Depending on the types of potential IFs and/or potential clinically meaningful findings, disclosure to the subject may need to be conducted by a licensed physician (or psychologist, genetic counselor, or other professional as appropriate). If nonprofessional study personnel are to be responsible for conveying test results, they may want to consult beforehand with such professionals in order to be able to conduct an informative discussion with the subject. These details should be included in the plan submitted to the IRB.
- The default for IF disclosure should be that such disclosure is made directly to the subject, consistent with respect for the subject, and the subject’s control of his/her own information. However, when the possibility of finding medically significant IFs in a research study is expected to be high, the subjects should be asked during the consent process if they will agree to disclosure by the investigator to their primary care physician. If the subject does not have a physician, the subject may be offered SBU University Hospital’s HealthConnect service, phone # 444-4000, which can provide guidance and appointments with a primary care physician. SBU University Hospital also has a financial assistance/charity care program which can be reached at 444-4331.
- Depending on the specific IF revealed, the investigator may suggest a specialist, such as an oncologist. To ease the subject’s anxiety, the more significant the IF, the more rapidly this step should occur, and the more sensitive the investigator must be in communicating the IF to the subject, using assistance as needed (e.g. notice of possible cancer may require the presence of an oncologist who can immediately address questions and concerns etc.).
- When future analyses are done on study data that has been de-identified, it may be impossible to let subjects know individual results. However, data should not be de-identified for the sole purpose of avoiding a responsibility to report IFs.

The plan for informing subjects in the consent process of the potential for IF’s, including:

- Probabilities of occurrence (based on available literature),
- The foreseeable risks and benefits associated with the types of IF’s that are possible
- How the IF’s may be uncovered, e.g., during screening, procedures performed for research, future analysis of results, etc.
- Statement that payment for any clinical follow-up as a result of being informed of an IF will be the subject’s responsibility. If the subject, or subject population, has no health insurance, the investigator should advise the subject of available avenues for accessing follow-up or should know to whom to refer the subject for information and counseling. SBU University
Hospital also has a financial assistance/charity care program which can be reached at 444-4331.

- Statement that any findings, incidental or not, discovered during the course of the research activity, that indicate that the subject may hurt him/herself or others, or that the safety of a child is at risk, is mandated to be reported to applicable authorities.

17.9.5 Incidental Findings (IF) Consent Form Language

NOTE: Adapt to your specific study, based on the assessment/disclosure plan proposed to the IRB, as above. See below for other suggested insertions, as applicable*):

Incidental Findings

The procedures in this study are being done, and results reviewed, only for research reasons, as explained in the beginning of this consent form. In other words, this study is neither designed nor intended to detect health problems.

Nonetheless, it is possible that during review of results from (list the procedure/s), we may uncover something that may (potentially) have health or reproductive importance to you. Such findings are called ‘incidental findings’. In studies like this, the types of incidental findings include (provide general detail). The possibility of uncovering these types of incidental findings is (common/rare). If this happens, the principal investigator will contact you to discuss what the finding possibly means, if you agree to be told this information. You will then be referred to your medical doctor for follow-up. We can help you secure a medical doctor if you don’t currently have one.

The discovery of an incidental finding may cause you to feel anxious. If you have further tests done by your medical doctor, those results will then become part of your medical record, which may affect current and future health or life insurance. The costs for any care that will be needed to diagnose or treat an incidental finding would not be paid for by this research study. These costs would be your responsibility (financial assistance programs are available, should you need such help).

Do you agree to be informed of any incidental findings discovered during the course of this research study? Choose, and sign below one option:

YES, I want to be informed of incidental findings discovered during the course of this research study

__________________________  _____

NO, I do not want to be informed of incidental findings discovered during the course of this research study

__________________________  _____

*Add/amend the above language as applicable. Here are some examples:
“The (scans/tests etc) that are/is done in this study are/is not of the same quality as those done by a doctor for medical reasons.”

And/or

“The investigators of this study are not medical doctors and are not trained to assess these possible findings. Your consent to be in this study also includes permitting the principal investigator to share your data in a confidential manner with experts outside of the study team so that more information regarding the importance of any uncovered incidental findings can be determined.

And/or

“Because of the possible significance of the IF’s that may result from these procedures, your consent to be in this study also includes permitting the investigators to disclose IF’s not only to you, but directly to your primary care physician, as necessary. If you do not have one, assistance will be provided in securing one”

And/or:

(specifically for MRI studies): “Most incidental findings represent common minor abnormalities that pose no clinical risk and require no medical referral: for example, one study found that 61 out of 151 participants (40%) had such incidental findings that required no referral. Incidental findings that require medical referral are much rarer: for example, a study of children and young adults found that only 1 out of 225 participants required urgent medical referral, and another study found that only 2 out of 2000 people needed a medical referral for an aneurysm and 1 out of 2000 people needed medical referral for a potentially malignant brain tumor.”

17.9.6 Procedures for IF’s that are Not Anticipated

Where an IF occurs that is not anticipated, the event is deemed an unanticipated problem involving risk to subjects, and should be reported immediately to CORIHS using the Unanticipated Problems Reporting Form (in electronic management system) for assessment and determination of course of action.

When the potential need to share study findings with a subject has arisen unexpectedly, the PI should submit to the IRB its review the plan for communicating the results to the subject. Depending on the study, the plan may need to include transmitting (and confirming transmission of) the information to the subject’s primary care physician as well, following subject consent for release of medical information. See above section for variables to consider.

17.9.7 Special IF considerations for Children as Research Subjects:

Parents of minor subjects, and minor subjects for whom the IRB has required that assent (either verbal or documented) be obtained, must be informed of the possibility of IFs, as above. In instances where
the child is in the research (or samples may be retained) and passes the age or majority, the consent process s/he undergoes as an adult should include discussion of IF’s. Note:

- When an IF reveals a potentially grave or life-threatening condition, including substance abuse, that requires clinical evaluation (or intervention, in the case of substance abuse), the parent or guardian has a responsibility to learn of this information and act in a way to preserve the child or adolescent’s health. The parent permission and minor assent documents should clearly address the possibility of this disclosure.
- In accordance with state law, if the IF is a pregnancy in the minor subject (e.g. detected through screening procedures), the minor subject is to be told. Informing the parent can only be done with the minor’s permission to do so. When research studies involving minors test for pregnancy:
  - Assent form should read, “If, as a result of the study tests, we find out that you are pregnant, we will tell you so. We will also strongly urge that you discuss these results with your parent or legal guardian so that appropriate health care can be obtained as soon as possible”
  - Parent permission should read, “If, as a result of the study tests, we find out that your child is pregnant, we will tell her so. We will also strongly urge your child to discuss these results with you so that appropriate health care can be obtained as soon as possible.
- In some cases, an IF may reveal sensitive information, e.g. the child is experiencing physical abuse by the parent. In these instances, contact the IRB through the ORC. A plan of action will be developed, in consultation with legal counsel.

17.10 Community Based Participatory Research (CBPR)

CBPR is a subset of community-based research that has the most significant community involvement, from generating research ideas, to conducting the research, to disseminating results back to the community. It is anticipated that CBPR will become an active aspect of the HRPP upon the Institution’s successful application for a Clinical and Translational Science Award (CTSA).

17.11 Proper Documentation in Human Subjects Research

1. Applicability: This guidance applies to all University research involving human subjects (i.e. that qualified for exempt, expedited, or full review), with the exception of pharmaceutical funded/initiated studies. Such studies through the pharmaceutical industry have very specific documentation requirements promulgated by the sponsor and the FDA which must be followed to the letter to ensure the compliant conduct of the clinical trial.
2. Introduction: Detailed documentation is critical for ensuring, and proving, your compliance with federal regulations and University policies for the conduct of any and all research involving human subjects. This guidance provides details for proper documentation in research involving human subjects. When ORC Staff conduct audit/monitoring visits, it will be expected that appropriate documentation processes are being followed.
3. There should be two types of ‘stories’ that must be clearly documented for each study (A) The Regulatory Binder and (B) The Subject Record.
(A) The Regulatory Binder: The Regulatory History of the Study

Note: Some, but not all, of the documents below may already be available in the IRB electronic system. If the PI decides not to place those documents in the regulatory binder for the study, the PI is responsible for ensuring that all study personnel know how to access them in the electronic system.

The following documents should be in this binder, in sequential order, with most current documents on top:

1. IRB approval, acknowledgement letters.
2. All IRB approved/acknowledged study documents (e.g. protocol, protocol amendments, stamped consent/permission/assent documents, diary forms, translations, advertisements/brochures for recruitment, surveys), package inserts, Investigator brochures, Certificate of Confidentiality, etc.).
3. Protocol deviations/exceptions with report to the IRB (and sponsor as applicable), and resulting determinations and IRB approved corrective action plans, if required.
4. Unanticipated problems involving risk to subjects or others (UP's): with report to IRB, and their determination.
5. Data collection form (sometimes called Case Report Form) templates. A case report form is a data collection tool used to help investigators capture all research-required information for each subject. It is an excellent tool to ensure that the protocol is followed as approved by the IRB. For investigator initiated studies, a case report form/source document collection form can be created by going through the protocol and outlining, step by step, what research procedures will occur, and what data was collected at each study visit. The web has many sites to aid in the construction of case report forms or data collection forms. (for example see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4170533/ or http://www.bumc.bu.edu/irb/files/PDFs/ABB_CaseReportForms_ClinicalResear...)
6. Inclusion/Exclusion Checklist template, with acceptable ranges (i.e. lab values, ages, etc.), and a line for the subject’s value, where applicable. PI should review and sign the completed checklist for each subject, prior to any research procedures being conducted on the subject (including screening, randomization etc.). Although this requirement is currently in place only for more than minimal risk studies, it is strongly suggested that all studies adopt the practice to ensure that only IRB approved, eligible subjects are enrolled in the study.
7. Delegation of Authority Form: With this document, the PI formally delegates authority to specific team members to do specific research-related tasks. The delegation must be consistent with the individuals’ expertise and licensure where applicable (e.g. Ms. S. Coordinator: consent process; Dr. C. Investigator, conducts the neuropsych exams; Mr. G. Student: data input/analysis etc.). This document should also show team members signatures and initials (for audit purposes).
8. Proof of licensure for team members, based on their delegation of authority from the PI, as above.
9. Subject ID code list location
10. **Subject screen log/Subject enrollment log:** this allows you to document the chronological enrollment of subjects

11. **Monitoring visit reports** from within or outside the University, self-audit reports

12. **Relevant communications:** e-mails, telephone call notes relating to the conduct of the study, or subject queries or complaint etc.

And, as applicable:

1. Drug/device dispensing log
2. Reports required by sponsors, if any, and resulting correspondence
3. Decoding procedures (for blinded trials)
4. Certificate of Confidentiality
5. FDA Forms (e.g., 1571), reports to FDA, FDA communications, DSMB reports (if the PI is the sponsor of an IND/IDE)
6. Location of stored/archived research records
7. Membership of the Data Safety Monitoring Board

**(B) The Subject Record:** The Complete “Story” for every Subject

*There should be a record of all activities that have occurred on the study for each subject.*

*The record should be coded, and the key to the code should be retained in a separate locked location in order to protect subject confidentiality.*

1. **Description of method of recruitment** for the subject in question (e.g. “Ms. Patient was encountered in the clinic when she came for a medication check for her thyroid”, or Mr. Grad Student responded to an advertisement in Psych B. etc.)

2. **Completed inclusion/exclusion checklist** with specific values/data entered for the subject. *Although this requirement is currently in place only for just more than minimal risk studies, it is strongly suggested that all studies adopt the practice to ensure that only IRB approved, eligible subjects are enrolled in the study.*

3. **Details of the consent process** with the subject. A form can be used to facilitate this documentation, an example of such, is provided in Appendix I following this SOP.

4. **Signed informed consent/permission/assent documents** (including any consent addenda signed by the subject during the course of the study).

5. **Source documents:** A source document contains data that is initially collected on the subject. It can be a case report form/data collection form or may simply be lab values, etc.

The source documentation details the specific values/data entered for the subject, i.e., inclusion/exclusion data, screening, research procedures conducted/data collected throughout the course of the study. Such information must match what the informed consent documents describe will be conducted/collected. Examples: hard copies of completed surveys, questionnaires, lab/radiology reports, x-rays.
6. **Completed case report forms/data collection forms for each visit.** These should also provide a section where the investigator can put ‘visit notes’ (e.g. subject reported no problems etc.)

7. **A log of all adverse events (AE’s) that the subject experienced** (if it does not constitute an unanticipated problem involving risks to subjects or others, which must be reported to the IRB immediately, these AE’s are reported at the time of continuing review).

### Appendix I Documentation of Consent/Permission/Assent Process

*(To be completed by the Study Team Member who is Obtaining Consent)*

**Study PI:**

**Study Identifier:** ________________  Date: ____________

**Subject Name:** __________________________

**Parent Name(s), if subject is a minor** __________________________

**Circle answer:**

1. Have you been delegated authority by the Principal Investigator to conduct consent processes for this study?  
   - [ ] Y  
   - [ ] N  
   - [ ] N/A (You are the PI)

2. Did you first verify that the consent document being used is the most current IRB approved/stamped version, obtained either from the electronic system, or the study regulatory binder?  
   - [ ] Y  
   - [ ] N

3. Did you discuss with the subject/parent:
   1. The purpose of the study  
   - [ ] Y  
   - [ ] N
   2. Possible risks and benefits  
   - [ ] Y  
   - [ ] N
   3. All research procedures  
   - [ ] Y  
   - [ ] N
   4. Alternatives to being in study  
   - [ ] Y  
   - [ ] N
   5. Participation is voluntary  
   - [ ] Y  
   - [ ] N
   6. Subject can withdraw at any time  
   - [ ] Y  
   - [ ] N

4. Did the subject/parent exhibit an appreciation of:
   1. The purpose of the study  
   - [ ] Y  
   - [ ] N
   2. Possible risks and benefits  
   - [ ] Y  
   - [ ] N
   3. All research procedures  
   - [ ] Y  
   - [ ] N
   4. Alternatives to being in study  
   - [ ] Y  
   - [ ] N
   5. Participation is voluntary  
   - [ ] Y  
   - [ ] N
6. Subject can withdraw at any time  Y   N

5. Was the subject/parent given an opportunity throughout the process to ask questions?  Y   N
6. After consent process, was the subject/parent given time to review the consent form?  Y   N
7. Was the subject given a copy of the IRB approved/stamped, signed consent form?  Y   N

Your signature below confirms the accuracy of the information provided above, and certifies that no study procedures were performed prior to the subject signing the consent document.

_______________________________  ________________________________
Printed Name                       Signature                       Date

17.12 Genomic Data Sharing (GDS) for NIH Grant Submissions

NIH GDS (Genomic Data Sharing) Policy applies to:
1. All NIH-funded research that generates large scale (> than 100 individuals) human or non-human genomic data (e.g., SNP arrays, genome sequencing, RNA sequencing, transcriptomic, metagenomic, epigenomic and gene expression data), as well as the use of these data for subsequent research sharing in NIH-supported repositories; and
2. All research involving genotype/phenotype data that will be submitted to one of the NIH-supported repositories, even if the research itself is not NIH-supported:
   - Database of Genotypes and Phenotypes (dbGaP),
   - Gene Expression Omnibus (GEO),
   - Sequence Read Archive (SRA), or the
   - Cancer Genomics Hub.

When does the Policy NOT apply?
- When the genomic data is generated without NIH funds (unless the researcher voluntarily requests submission to one of NIH-supported repositories)
- When NIH-funded research for projects involve instrument calibration exercises, statistical or technical methods development, or the use of genomic data for control purposes, such as for assay development
- When the following funding is requested: Institutional Training Grants (T32s, T34s, T35s, and TL2s), K12 Career Awards (KL2s), Individual Fellowships (Fs), Resource Grants and Contracts (Ss), Linked awards derived from previously reviewed applications, or Facilities or coordinating centers funded through related initiatives to provide genotyping, sequencing, or other core services in support of GDS.

When NIH funding is requested for a grant proposal, what does the researcher need to do?
- You must provide a basic plan for following the GDS policy, located in the Resource Sharing Plan section of funding applications. (The Genomic Data Sharing Plan template available in the electronic
management system should be reviewed. Complete and upload with the applicable IRB submission.)
• If broad sharing of genomic data is not possible, include an explanation.

**What is required for Just-In-Time awards?**
NIH will require the following documentation at Just-In-Time:
• An IRB approval letter for your human subjects protocol, and
• An Institutional Certification (available through the Office of Research Compliance) to be completed and signed by the researcher, and then submitted to the Office of Research Compliance for an authorizing signature

**What is required when genomic data needs to be submitted to an NIH-supported data repository, but NIH is not the funder and/or a funding request is not involved?**
The IRB will be responsible for the authorizing signature on the Institutional Certification.

**What should be in the consent documents for subjects when genetic data will be deposited in NIH-supported repositories?**
The consent templates in the Forms Library of the electronic management system contain instructions on language to be used when genetic data is to be deposited in NIH-supported repositories.

**Resources**
The Genomic Data Sharing Policy
Implementation of the NIH Genomic Data Sharing Policy for NIH Grant Applications and Awards

17.13 *ResearchMatch as a Recruitment Tool*

The University is a part of ResearchMatch (RM), the national registry that connects researchers with volunteers who wish to get involved in research studies. This national registry provides a secure, web-based approach to address a key barrier to advancing research: participant recruitment.

This new tool allows investigators to conduct targeted searches for potential volunteers based on location and specific demographics.

Investigators may register for feasibility access to assess the functionality of the registry and explore the database to determine how many people registered in ResearchMatch might fit the criteria for a future study or one that is currently ongoing:

1. Go to [https://www.researchmatch.org/](https://www.researchmatch.org/)
2. Click “Researchers” at the top of the page
3. Green button “Register Now” (If you think you’ll need help registering, click on the tutorial link below the green button)
4. Select “Stony Brook University” as the institution
5. Type in your Stony Brook email address
6. Retrieve verification code from your email, cut and paste it into RM
7. Read site instructions
8. Read Researcher Acknowledgement form and “ACCEPT”

To use this recruitment tool, researchers are required to submit individual requests for approval by the IRB. The “ResearchMatch Recruitment Method Instructions”, available in the electronic management system library, provides the details for adding this recruitment method to both new and existing studies. Once you have IRB approval for your study, including an approved RM contact message, one of the RM liaisons can approve your message to be sent to registered RM users (i.e., potential subjects). If a user is interested in volunteering for your study, they accept your invitation and release their information to you for direct contact.

17.14 Conducting Research in a Clinical Setting (e.g., University Hospital): Special Considerations

Hospitals are unique settings in which to conduct research, as the responsibilities and priorities of research teams and clinicians must be carefully balanced when it comes to interacting with patients who may be, or may be approached to become, subjects.

Key points to keep in mind are:

- Clinical management always takes precedence over the requirements of a research protocol. That being said, if a protocol deviation occurs (whether due to competing clinical management or for any other reason), it should be reported to the IRB as soon as possible, per SBU policy.
- Communication between researchers and clinicians is important:
  - Researchers should consult with the patient’s nurse or other health care provider before approaching the patient for recruitment, consent process, or for the conduct of research procedures.
  - A copy of the research consent must be in the EMR.
  - A copy of the current protocol must be on the unit or be readily available for clinical staff to review if necessary. Cerner Powertrials should be in use by Study Coordinators to post the protocol and I/E criteria for their respective studies as well as note when a patient is a participant on a study.
- If issues or questions arise and cannot be readily resolved, contact should be made with the unit supervisor, Assistant Director of Nursing, PI and/or treating MD.
- All research visits must be thoroughly documented in EMR, so all parties are aware of all procedures, clinical or research that have been conducted on the patient/subject.

17.15 Additional Requirements for Studies Funded by the Department of Defense

1. When appropriate, research protocols must be reviewed and approved by the IRB prior to the Department of Defense approval. Consult with the Department of Defense funding component to see whether this is a requirement.
2. Employees of the Department of Defense (including temporary, part-time, and intermittent appointments) may not be able to legally accept payments to participate in research and should check with their supervisor before accepting such payments. Employees of the Department of Defense cannot be paid for conducting research while on active duty.
3. Service members must follow their command policies regarding the requirement to obtain command permission to participate in research involving human subjects while on-duty or off-duty.

4. Components of the Department of Defense might have stricter requirements for research-related injury than the DHHS regulations.

5. There may be specific educational requirements or certification required.

6. When assessing whether to support or collaborate with this institution for research involving human subjects, the Department of Defense may evaluate this institution’s education and training policies to ensure the personnel are qualified to perform the research.

7. When research involves U.S. military personnel, policies and procedures require limitations on dual compensation:
   - Prohibit an individual from receiving pay of compensation for research during duty hours.
   - An individual may be compensated for research if the participant is involved in the research when not on duty.
   - Federal employees while on duty and non-Federal persons may be compensated for blood draws for research up to $50 for each blood draw.
   - Non-Federal persons may be compensated for research participating other than blood draws in a reasonable amount as approved by the IRB according to local prevailing rates and the nature of the research.

8. When conducting multi-site research, a formal agreement between organizations is required to specify the roles and responsibilities of each party.

9. Other specific requirements of the Department of Defense research be found in the “Additional Requirements for Department of Defense (DOD) Research” section in the IRB’s “WORKSHEET: Additional Federal Criteria.”

17.16 IRB Reliance/Single IRB (sIRB) Review

SBU investigators involved in multi-site research are encouraged to discuss with collaborators the possibility of shared IRB review, i.e., having one IRB review on behalf of all sites.

If the research is part of a multicenter grant awarded from NIH, single IRB (sIRB) review is required under most circumstances (https://grants.nih.gov/grants/guide/notice-files/NOT-OD-16-094.html). The reader is referred to Section 17.16.5 for details specific to compliance with the NIH sIRB policy.

Investigators should contact the Reliance Administrator in the Office of Research Compliance early in the multi-site grant/contract process to discuss possible sIRB options as discussed in 17.16.2 (SBU Serving as the Reviewing IRB) and 17.16.3 (SBU Ceding Review to an External IRB) below.

17.16.1 Reliance Agreements

Reliance agreements must be in place for all shared IRB review arrangements. The Reliance Administrator ensures that these agreements are negotiated to reflect study-specific, respective responsibilities of the reviewing IRB and the relying Institutions. The Reliance Agreement:
• Documents the respective authorities, roles, responsibilities, and communication between an organization providing the ethical review and a participating organization relying on a reviewing IRB.

• Describes the responsibilities of all parties and how communication between parties will occur, for example, notifications of the outcome of regulatory review and management of federally-mandated reports such as reports of unanticipated problems, serious or continuing noncompliance, and suspensions or terminations of IRB approval.

• When IRB certification requirements apply (e.g., for NIH Genomic Data Sharing, Certificates of Confidentiality), the agreement or written procedures will indicate who is responsible for meeting the certification requirements.

• Specifies contact information and personnel for both the sIRB and relying institution(s).

• Address whether the relying organization applies its FWA to some or all research, and ensure that the IRB review is consistent with requirements in the relying organization’s FWA.

• Address which organization is responsible for obtaining any additional approvals from DHHS when the research involves Subpart B, C, or D determinations.

The institution that is awarded the funding for the research is responsible for maintaining all agreements and for ensuring that adequate and appropriate communication channels between the sIRB and participating sites are in place. Participating sites are responsible for maintaining copies of the site agreement in accordance with the terms of their FWA.

17.16.2 SBU Serving as the Reviewing IRB

A. Factors Considered by the ORC to have SBU provide IRB Services

The Reliance Administrator evaluates the following factors, and others as appropriate, when considering a request for an SBU IRB to serve as the IRB of record for a particular study or studies:

1. The terms of the external site(s) FWA;
2. The accreditation status of the external site(s)
3. Prior experience with the site(s) and investigators;
4. The compliance history of the site(s) and investigators (e.g., outcomes of prior audits or inspections, corrective actions);
5. The research activities to be conducted at the external site(s);
6. The willingness of the external site(s) to accept SBU’s reliance terms and procedures; and/or
7. The ability the site(s) to collaboratively provide meaningful oversight of the proposed research, taking into account factors such as:
   a. The risks and procedures of the research;
   b. The resources available at each site and ability to accommodate or collaborate with each other in observing the consent process, performing compliance reviews, investigations of potential noncompliance, and similar matters;
   c. The expertise and experience of the SBU IRB with the proposed research, subject population, and applicable regulations;
d. The ability of the SBU IRB to comply with the relevant local context considerations of the external site(s), as provided by that site(s); and/or

e. The willingness or ability of the external site(s) to provide information and respond to questions regarding investigator qualifications, conflicts of interest, organizational requirements, local context, and other matters that may inform the IRB review.

The Reliance Administrator will present relevant factors for consideration by the IO or AVP-RC, who will make the final decision regarding whether or not the SBU IRB will serve as the reviewing IRB. The PI will be notified of the decision.

B. Responsibilities when SBU is the Reviewing IRB

1. Responsibilities of the SBU IRB

- Policies and procedures in the conduct of review for all sites (SBU and external) will mirror those outlined throughout these SOPs, as set forth in Domain II of the AAHRPP accreditation standards. Possible exceptions are noted in 17.16.4 below. Additionally, the following SBU IRB responsibilities are to be applicable for all sites:
  - Have the final authority to decide whether SBU or external researcher or research staff’s COI and its management, if any, allows the research to be approved
  - Have the authority to request an audit of research being reviewed.
  - Make relevant IRB policies readily available to relying external sites, including their HRPP staff, researchers, and research staff, and ensure that changes to those policies are communicated as well.
  - Ensure that an ORC contact person along with contact information is specified for researchers and research staff to obtain answers to questions, express concerns, and convey suggestions regarding the SBU IRB.

- Adding sites to an already approved IRB study will be considered a modification, and will be conducted by the expedited or full board process. In order for the review to be conducted via the expedited process criteria, such a modification is usually considered a “minor change to previously approved research”. Factors that will indicate that a full review is required may include, e.g., involvement of investigators with FCOI, FDA 483 issues that have not been resolved adequately, or any other site-specific issues that are deemed questionable. Additional site amendments (regardless of type of review) do not change the expiration date of the IRB approval for the ‘main’ protocol.

2. Responsibilities of the SBU Principal Investigator

- Coordinate with ORC for the PI’s at collaborating sites to have access via the electronic management system to current status and current protocols, consent documents, etc. regarding the study. (Alternatively, the IRB can review the plan provided by the SBU PI to ensure open communication with the collaborating site(s)).
- Submission to the IRB information pertaining to the particular characteristics of each site’s local research context to be considered either (a) through knowledge of its local research context by the
IRB, (b) through consultants, or (c) through review by appropriate designated institutional officials at external site(s). Additionally, the submission will also include details for the IRB’s evaluation regarding the management plan for information that is relevant to the protection of participants (e.g., unanticipated problems involving risks to participants or others, interim results, protocol modifications). When the Stony Brook researcher is the lead researcher of a multi-site study, this information will also be made known to the IRB of record (e.g., Independent IRB, IRB, etc).

17.16.3 SBU Ceding IRB Review to an External IRB

A. Standing Reliance Agreements

SBU has standing agreements in place to engage the services of external IRBs for the review of specific categories of research including:

- Chesapeake Research Review, Inc. (‘Advarra’) for industry-initiated, industry-funded research
- NCI’s Adult CIRB for NCI research involving adult subjects
- NCI’s Pediatric CIRB for NCI research involving children

SBU is a participating institution in the SMART IRB initiative as well, having signed an overarching agreement indicating willingness to cede to other institutions’ IRBs, pending satisfactory evaluation of factors identified below.

Research that falls within the above parameters must be registered with the University prior to submission to the external IRB following the procedures outlined in Section 17.16.3 (C) below. Post-approval requirements for investigators are also summarized in Section 17.16.3 (C) below.

B. Factors Considered by the ORC in the decision to allow SBU to Cede to an External IRB

SBU may choose to enter into an agreement to rely upon other external IRBs, most commonly when required as a condition of a grant or contract. The Reliance Administrator evaluates the following factors, and others as appropriate, when considering a request to rely upon an external IRB:

1. The accreditation status of the proposed IRB;
2. The compliance history of the IRB (e.g., outcomes of prior audits or inspections, corrective actions);
3. Prior experience with the IRB;
4. The federal IRB registration and organizational FWA, as applicable;
5. The expertise and experience of the proposed IRB (e.g., with reviewing the type of research, research procedures, and subject population(s));
6. The research activities to be conducted at the University
7. The risks and complexities of the proposed research;
8. The proposed reliance terms and procedures, including acceptance of SBU local context issues, as well as the procedures for collaborative management of matters such as conflicts of interest disclosures, investigator training, noncompliance, unanticipated problems, and federal reports;
9. The plan for review and allowance of the incorporation of site-specific consent language; and
10. The plan for incorporation of other relevant local requirements or context information in the review process.

**When reliance on a non-accredited IRB is proposed**, the evaluation will also take into consideration one or more of the following based upon the risks of the research and the University’s familiarity with the IRB:

1. A statement of assurance from the proposed IRB that its review will be consistent with applicable ethical and regulatory standards, and that it will report any regulatory investigations, citations, or actions taken regarding the reviewing IRB, and, when applicable, to the organization’s FWA (Note, this statement of assurance is acceptable to AAHRPP if the risks are minimal);
2. An attestation about, or summary of, any quality assessment of the reviewing IRB such as evaluation by an external consultant or internal evaluation of compliance using the FDA’s self-evaluation checklist or AAHRPP’s self-evaluation instrument;
3. The willingness of the external IRB to accommodate requests for relevant minutes and other records of the proposed study and/or to copy the University’s HRPP office on correspondence such as determination letters and notices of suspensions or terminations of IRB approval;
4. The willingness of the external IRB to accommodate a request for someone from the relying organization to serve as a consultant to the IRB or to observe the review of the proposed study; and/or
5. An assessment of the external IRB’s policies and procedures by the IO or AVP-RC.

The Reliance Administrator will present relevant factors for consideration by the IO or AVP-RC, who will make the final decision regarding whether or not to cede to the requested External IRB. The PI will be notified of the decision.

### C. SBU, External IRB, and SBU Investigator Responsibilities When SBU Cedes Review

1. **The External IRB** has the same authority as the SBU IRB and all determinations and requirements of the external IRBs are equally binding. See section 17.16.4 for possible exceptions to external IRB vs. SBU responsibilities.

2. **SBU** remains responsible for the conduct of the research in which it engages. Research reviewed by external IRBs remains subject to review, approval, oversight, and monitoring by SBU (in cooperation with the reviewing IRB when appropriate) and must adhere to all applicable policies, procedures, and requirements of the University HRPP. As with SBU IRB-reviewed research, officials of SBU may not approve research that is subject to a reliance agreement if it has not been approved by the reviewing IRB. See section 17.16.4 for possible exceptions to external IRB vs. SBU responsibilities. ORC is responsible for notifying the reviewing IRB when SBU policies that may impact IRB review are updated.

3. **Responsibilities of the SBU Investigator When Using an External IRB**

   - **General Compliance Requirement:**
     - The SBU Investigator must be familiar with, and comply with the external IRB’s policies and procedures for initial and continuing review, record keeping, prompt reporting, and any
additional requirements or procedures outlined in the IRB reliance agreement or companion materials (e.g., reliance SOPs). All information requested by the reviewing IRB must be provided in a timely manner. SBU will support investigator compliance with the terms of reliance agreements by providing investigators with a Reliance Arrangement Form that provides information relevant to their responsibilities.

- Expectations of PI compliance, as detailed in these SOPs, remain in place regardless of the reviewing IRB.
- Even though the External IRB may be reviewing the study, it must not commence at SBU until all HSR training, COI disclosure, and required ancillary reviews and certifications (e.g., Chair endorsement, University Hospital sign-offs, IBC, RDRC etc. have been satisfied.

**Institutional Registration Requirement:**
Studies that will be reviewed by external IRBs must be registered with SBU via the IRB electronic management system. Details for this registration requirement are available on the SBU website at [https://research.stonybrook.edu/node/10056](https://research.stonybrook.edu/node/10056)

The Reliance Administrator will review the information and verify that CITI training, COI review, and any other applicable approvals or requirements have been completed, and determine the need for relaying local context information to the external IRB in accordance with the reliance agreement. Where waivers or alterations of HIPAA authorization are requested, and the external IRB will not be responsible for review (e.g., studies reviewed by the NCI CIRB), the Reliance Administrator will forward such requests to an SBU IRB Chair or a designated expedited reviewer for review. The Reliance Administrator will notify the investigators by e-mail or via the electronic management system once the proposed research has been cleared for submission to the external IRB. Once approved by the external IRB, investigators must submit in the electronic management system a copy of the approval letter and any approved consent document(s). If the protocol was modified during the external IRB review process, the approved version of the protocol should be provided as well.

**Post-IRB Approval Requirements:**
- Investigators approved through external IRB review must report local unanticipated problems, complaints, and any noncompliance to the ORC via the IRB electronic management system in addition to reporting to the external IRB. Copies of the report submitted to the external IRB are generally acceptable, but additional information may be requested on an as needed basis.
- Investigators must also submit copies of continuing review reports, updated protocols, updated consent forms, study closures and corresponding IRB approval or acknowledgment.
- Changes in PI and the addition of other research team members must be submitted to the ORC via the IRB management system prior to the new PI or research team member.
assuming any study responsibilities. CITI trainings, COI review, and any other applicable requirements will be verified.

- Notices about, and reports from, DSMB’s, external monitors, auditors, or inspectors must be provided to the ORC via the IRB management system as well.
- In general, Investigators are reminded that all other University reporting requirements, such as to Compliance, Privacy, and Risk Management, remain applicable in addition to HRPP reporting requirements.

17.16.4 Exceptions to IRB vs. Local Site Responsibilities

Certain areas of responsibility can be handled by either the reviewing IRB or the local site, provided they has been agreed to in the reliance agreement or outlined in a companion document. For example, alternative procedures may be used for any of the following:

1. Conducting and documenting scientific review
2. Management and documentation of ancillary reviews and institutional permissions for research;
3. Training requirements and verification of qualifications and credentials for external investigators and staff;
4. For-cause and not-for-cause compliance reviews;
5. Site-specific consent language
6. HIPAA compliance
7. Handling of matters concerning noncompliance, including which institution is responsible for deciding whether each allegation of non-compliance has a basis in fact, whether an incident of noncompliance constitutes serious or continuing noncompliance, and who will handle reporting to federal agencies
8. Handling of unanticipated problems, and responsibility of reporting to federal agencies when required;
10. Review of investigator financial disclosures for COI (note: the reviewing IRB must provide final approval of any management plans generated to mitigate investigator FCOI)
11. Managing organizational conflict of interest relating to the research
12. Procedures for submission and review of interim reports and continuing review materials; and/or
13. The communication of IRB determinations and other information to external investigators and organizations.
14. In the case of the termination of a reliance agreement, identification of the party responsible for continued oversight of active studies until closure or a mutually agreed upon transfer of the study

17.16.5 NIH Single IRB (sIRB) Policy for Multi-site Research

The NIH sIRB policy applies to grant applications proposing non-exempt human research which are received for due dates on or after January 25, 2018. For contracts, the policy applies to all solicitations issued on or after January 25, 2018. The policy does not apply to career development, research
training, or fellowship awards, nor to sites that are not conducting the same protocol as the other sites (e.g., sites providing statistical support or laboratory analysis only) or to foreign sites.

Exceptions to the policy are automatic when local IRB review is required by federal, tribal, or state law/regulation/policy. Such exceptions and the basis should be cited in the proposed sIRB plan (see below) and apply only to the site(s) to which the law/regulation/policy applies. Other exceptions will be considered when there is compelling justification. The site(s) and justification for why the site(s) cannot rely on the single IRB of record should be included in the proposed sIRB plan. NIH will consider the exception request and inform the applicant of the outcome.

**Selection and Designation of a sIRB**

SBU investigators submitting applications for NIH-funded multi-site research must describe the sIRB plan in the funding proposal (grant application or contract proposal), and, if applicable, may request direct cost funding to cover additional costs related to the requirements of the NIH policy.

The Reliance Administrator in the ORC should be contacted as early in the grant writing process as possible to either confirm that SBU can provide IRB services for the study, or to assist the investigator in making alternative arrangements (e.g., use the IRB at one of the participating sites, Chesapeake IRB, etc.). The Reliance Administrator will consult with others within the organization as needed and make a recommendation to the AVP-RC, or the IO, for consideration. If SBU IRB can serve as the sIRB, the Reliance Administrator will assist the investigator in working with the Office of Sponsored Programs to ensure accurate, direct cost, budgeting for the service.

**Reliance Agreements for sIRB Studies**

A Reliance Agreement (or “Authorization Agreement”) between the sIRB and the participating sites is required. See Section 17.16.1 for details.

**sIRB Responsibilities**

1. Per the NIH Policy, the sIRB is responsible for conducting the ethical review of NIH-funded multi-site studies for participating sites and for carrying out the regulatory requirements as specified under the HHS regulations at 45 CFR Part 46.
2. The sIRB must have the necessary infrastructure to support the required activities (e.g., administrative or regulatory staff, policies, procedures, workflows and technology).
3. In reviewing multi-site research protocols, the sIRB may serve as a Privacy Board, as applicable, to fulfill the requirements of the HIPAA Privacy Rule for use or disclosure of protected health information for research purposes.
4. The sIRB can delegate to relying institutions the ability to monitor or observe the conduct of the research and/or the consent process.
5. The sIRB must review and approve proposed management plans for investigators determined to have a financial conflict of interest.
Participating Site Responsibilities

All sites participating in a multi-site study are expected to rely on an sIRB to carry out the functions that are required for institutional compliance with IRB review set forth in the HHS regulations at 45 CFR 46. Participating sites are responsible for meeting other regulatory obligations, such as obtaining informed consent, overseeing the implementation of the approved protocol, and reporting unanticipated problems and study progress to the sIRB. Participating sites must communicate relevant information necessary for the sIRB to consider local context issues and state/local regulatory requirements during its deliberations and must rely on the sIRB to satisfy the regulatory requirements relevant to the ethical review. Although IRB ethical review at a participating site would be counter to the intent and goal of this policy, the policy does not prohibit any participating site from duplicating the sIRB. However, if this approach is taken, NIH funds may not be used to pay for the cost of the duplicate review.

Additional Responsibilities of the Participating Site:

1. Responsibility for reporting incidents of protocol deviations or noncompliance to the sIRB;

2. Monitoring or observing the conduct of the research and/or the consent process, when specified in the Reliance Agreement;

3. Ensuring disclosure and management of conflicts of interest according to the participating sites’ policies and procedures and submit for approval to the sIRB management plans related to investigator FCOI’s in human subject research;

4. Reporting to the sIRB changes to research implemented to eliminate apparent immediate hazards to participants;

5. Ensuring ancillary reviews by University Hospital, IBC, RDRC etc. are conducted prior to commencement of the research (or IRB approval of the research, depending on local policy).

When an external IRB serves as the sIRB for a study in which the University is engaged, investigators must register the study with the University prior to submission to the external IRB following the procedures outlined in Section 17.16.3.C. Post-approval requirements for investigators are also detailed in Section 17.16.3.C. Research reviewed by external IRBs remains subject to review, approval, and oversight by SBU and must adhere to all applicable policies, procedures, and requirements required for the safe and ethical conduct of the study.