

**SUNY Upstate Medical University**  
Institutional Review Board For The Protection Of Human Subjects (IRB)

**GUIDELINES & POLICIES**

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# INTRODUCTION

SUNY Upstate Medical University (Upstate) is guided by the ethical principles regarding all research involving human subjects as set forth in the report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research entitled "Ethical Principles and Guidelines for the Protection of Human Subjects of Research" (**The Belmont Report**).

Furthermore, in compliance with the federal regulations for the protection of human subjects, (**45 CFR 46**) Upstate maintains an Institutional Review Board (IRB) for the Protection of Human Subjects. The IRB is appointed by the Vice President for Research. These Guidelines and Policies will be reviewed and revised as necessary, by the Vice President for Research, the IRB chairperson and IRB Administrator/Compliance officer when appropriate.

All faculty, staff and students, who participate in the conduct of research, involving human subjects, are required to successfully complete the web based education program, CITI (Collaborative Institutional Training Initiative). Certification of completion for the initial CITI training program is valid for three years. Re-certification through the CITI continuing education program is required every three years thereafter. A link to the CITI registration is available on the [IRB web site](#).

## THE IRB

The Institutional Review Board for the Protection of Human Subjects (IRBPHS or IRB) is an administrative body established to protect the rights and welfare of human research subjects recruited to participate in research activities conducted under the auspices of Upstate. The IRB has the authority to approve, require modifications in, or disapprove all research activities that fall within its jurisdiction as specified by both the federal regulations and local institutional policy. The IRB findings and actions taken on protocols are communicated with the Upstate Administration in a variety of ways. The Vice President for Research receives the minutes for each convened meeting. The administrator of the IRB reports to the Vice President for Research or his/her designee on all human subject activity that is approved by the IRB in order that he/she is fully informed.

The minutes for each convened IRB meeting will be distributed to the Vice President for Research and/or his/her designee and the minutes will be available to IRB members (via IRBNet). A limited portion of the IRB minutes (specifically the sections titled, "Re-submissions", "New Proposals", and "Proposals Submitted for Expedited Review") will be distributed to the President and the Executive Director of University Hospital. IRB members are to only share a limited portion of the IRB minutes (specifically the sections titled, "Re-submissions", "New Proposals", and "Proposals Submitted for Expedited Review") with colleagues who require this information to perform their duties. Requests for additional information from the IRB meeting minutes can be made by contacting the Vice President for Research or his designee.

The IRB operates in compliance with the U.S. Code of Federal Regulations, Department of Health and Human Services (DHHS) Title 45 Part 46, entitled "Protection of Human Subjects," as well as the Food and Drug Administration (FDA) regulations on human subjects research. A copy of the [DHHS](#) and [FDA](#) regulations may be obtained at their respective web sites. The Federalwide Assurance Document (FWA) number issued to Upstate by the DHHS is 00005967. The Office for Human Research Protections (OHRP) registration number is 00000391.

IRB members are appointed by the Vice President for Research. The IRB Chairperson and Vice Chairperson(s) are also appointed by the Vice President for Research. While the Federal Regulations require that an IRB have at least five members, the Upstate IRB usually consists of approximately 20 members. This is necessary to ensure that the IRB can appropriately review the wide range of protocols submitted. While most IRB members are faculty members (primary concerns are in scientific areas), the IRB includes at least one member whose primary concerns are in non-scientific areas; and at least one member who is not affiliated with the institution (nor an immediate family member of a person affiliated with the institution). Every effort is made to balance the IRB with respect to gender. Every effort is also made to include a prisoner representative on the IRB. Alternate IRB members may be appointed by the Vice President for Research. Alternate IRB members may possess similar expertise and will have the same primary concern (e.g., non-scientific) as the main IRB member, for whom they are designated to be an alternate. Alternates will be noted on the IRB roster submitted to OHRP.

Investigators who are also IRB members are not permitted to review (new submissions or continuing reviews) or approve (in the case of expedited studies) studies in which they are involved. In addition, an IRB member participating in a study being reviewed by the IRB will be

recused from discussion and voting on any actions, but may provide the IRB with information. For the initial review of a new protocol, requiring full board review, any IRB member participating in the study will absent him/herself from the meeting during the voting.

IRB members not scheduled to attend a meeting have access to all meeting documents.

Upstate policy and federal regulations require that all research involving human subjects, human tissue, surveys of human subjects, or medical records be reviewed and approved by Upstate's IRB prior to initiation of the research. This requirement applies to all human subject research conducted by faculty, on- and off-campus, whatever the funding support for the project.

This process ensures that the rights and welfare of research subjects are protected by minimizing risks, obtaining informed consent, selecting subjects equitably, and ensuring confidentiality. In addition, the IRB must review and approve all projects at least annually if they continue beyond one year. The IRB has the authority to suspend or terminate approval of research when it is determined that the research has been associated with unexpected serious harm to participants, or is not being conducted in compliance with the determinations of the IRB or the federal regulations on human subjects research.

The IRB records specified in 45 CFR 46.115 (and 21 CFR 56.115) shall be retained for at least 3 years, and records relating to research which is conducted shall be retained for at least 3 years after completion of the research (see section 21 for information regarding the retention of informed consent documents and authorization forms).

## DEFINITIONS

**Research** is defined as a systematic investigation, including development, testing, and evaluation, designed to develop or contribute to generalizable knowledge- 45 CFR46.102(d)

**Human subject** means a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual, **or** (2) identifiable private information-45 CFR 46.102(f)(1),(2)

**Identifiable private information** includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonable expect will not be made public (for example, a medical record). - 45 CFR 46.102(f)(2)

**Informed consent** must be sought under circumstances that minimize the possibility of coercion of undue influence and must include the eight basic information elements described in the regulations. Information must be presented in language understandable to the subject or the subject's legally authorized representative. --- 45 CFR 46.116(a),(b)

**Informed consent** must be documented with a written form approved by the IRB and signed by the subject or the subject's legally authorized representative. --- 45 CFR 46.117

## SCOPE OF REVIEW

All applications submitted to the IRB must designate an Upstate faculty member or medical staff physician at University Hospital at Community General as the Principal Investigator (unless the PI is covered under an inter-institutional memorandum of understanding with Upstate). Upstate requires that responsibility for compliance with Institutional Guidelines and Policies rest with the Principal Investigator. Therefore, although fellows, house-staff, staff nurses or students may actively participate in human subjects research activities, the Principal Investigator of record on a research project submitted to the IRB must be a SUNY Upstate Medical University faculty member or medical staff physician at University Hospital at Community General. All individuals who will be assisting the Principal Investigator in the conduct of the study must be listed as study team members.

Individuals with an emeritus rank may be allowed to serve as Principal Investigator on human subject research proposals with the approval of the Dean. The Dean will review requests upon recommendation of the Department Chair.

IRB review and approval is required for any research involving human subjects that is:

- Conducted by or under the direction of any employee or agent of this institution, in connection with his or her institutional responsibilities,
- Performed on the Upstate campus,
- Performed with or involving the use of facilities or equipment belonging to Upstate.

The responsibility for determining whether an activity constitutes human subjects research rests with the investigator. Since the University will hold the investigator 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 IRB Office.

**Research conducted by affiliated faculty** (faculty members who hold voluntary, clinical or adjunct appointments) is subject to these Guidelines and Policies for research on human subjects and must be submitted to the IRB for review.

An *Individual Investigator Agreement* should be executed when studies are being conducted at non-Upstate sites (e.g., a private practice office) by voluntary faculty (not Upstate employees), who are not covered either by another IRB or an inter-institutional memorandum of understanding with Upstate, and the Upstate IRB is responsible for review and oversight of the human subjects research.

An *Individual Investigator Agreement* should be executed when studies are being conducted at Upstate University Hospital at Community General, by Upstate University Hospital at Community General medical staff physicians (not Upstate employees).

This agreement assures the Upstate IRB that the investigator, named in the agreement, understands and accepts the responsibility to comply with the standards and requirements stipulated in the documents referenced in the *Individual Investigator Agreement* and to protect the rights and welfare of human subjects involved in research conducted under the *Individual Investigator Agreement*. In addition, this agreement authorizes Upstate to audit records related to

the research conducted under this agreement as may be required to assure compliance or to comply with Upstate's Federal Wide Assurance.

**Research Conducted by Upstate faculty at Another Institution** needs to be reviewed by the Upstate IRB as well as the other institution's IRB. For example, an Upstate researcher engaged in research at Crouse Hospital or the Veterans Administration Medical Center should secure approval from the IRBs at Upstate and the host institution (unless the researcher is not using any Upstate facilities, patients, or equipment and will not use his/her Upstate title in any grant or funding application or publication).

Changes in protocols or consent forms required by the other IRBs should be brought to the attention of the Upstate IRB.

## **REVIEW CATEGORIES**

An application for human subject research submitted to the IRB will fall into one of two review categories: a) full board review or b) expedited review. These review categories are defined by regulation (45 CFR 46.110). Please note that the term "expedited review" does not refer to the Webster's Dictionary definition of expedited. Only certain research projects, which meet the regulatory definition of minimal risk, qualify for the expedited review process.

# **IRB REVIEW PROCESS FOR NEW PROTOCOLS**

(Full Board & Expedited)

It is the policy of the SUNY Upstate Medical University Institutional Review Board (IRB) to delay IRB review until Foundation/Agency peer review and notification of priority score, which indicates the study is likely to be funded, has been completed. This policy, consistent with the May 1, 2000 NIH policy, is intended to reduce the workload burdens on IRB's.

Once a study is given a fundable score or has received funding, we will accept an IRB application for review.

**Upstate Medical University uses IRBNet for the electronic administration and management of its IRB. All projects must be submitted via IRBNet. Please refer to the "Read Me First~IRBNet for Upstate Researchers" document on IRBNet for specific instructions on how to submit a New Project to the IRB for review. In addition, all reviews (scientific and board reviews), IRB decisions and actions are communicated to the PI on IRBNet.**

When a new project is submitted to the IRB, it is assigned a unique study number. The submitted materials are reviewed by the IRB staff for clarity of presentation, completeness and accuracy. If there is a need for major revisions, the Principal Investigator will be notified with recommendations for change or request for required materials. Once changes have been made and/or materials submitted, the review process will continue. The project will then be assigned to scientific reviewers, who are not involved with the conduct of the study, as described below. Scientific reviewers are generally Upstate Faculty members, but may also include SU faculty members or outside consultants.

NIH sponsored cooperative group studies do not require scientific review prior to review by the IRB (or prior to review by the Chairman/Vice Chairman or designated IRB member for expedited review studies). One IRB member will be assigned as the primary reviewer.

Studies which are sponsored by pharma or funded through a vigorous peer review process (i.e., NIH, NSF, American Heart) require one scientific review prior to review by the IRB (or prior to review by the Chairman/Vice Chairman or designated IRB member for expedited review studies). Other studies require one or two scientific reviews prior to IRB review (or prior to review by the Chairman/Vice Chairman or designated IRB member for expedited studies), depending on the risk to subjects. This determination will be made by the IRB Chair or Vice Chair in consultation with the IRB administrator.

An IRB Staff member will review each application for compliance with federal and state regulations and institutional policies. The IRB administrator or Coordinator, in consultation with the IRB Chairman or Vice Chairman, will determine if the protocol is eligible for expedited review, based on the federal regulations.

The (pre-IRB) scientific review is undertaken to determine that the proposed research procedures are consistent with sound research design and to ensure that human subjects will not be exposed to unnecessary risk by being asked to participate in a poorly designed study.

Comments and questions raised by the reviewer(s) and/or IRB administrator/Coordinator will be provided to the Principal Investigator, for response. All comments and questions need to be

addressed either with a change in protocol/application/consent document or with a written explanation from the Principal Investigator.

Applications requiring full board review, will be added to the next open IRB meeting agenda upon receipt of changes or responses to reviews, as applicable.

Deadlines are posted on the [IRB Web Site](#). The Principal Investigator will be notified of the Board's decision.

Applications that qualify for expedited review are reviewed by the chair, vice-chair or a designated member of the IRB upon receipt of the above materials. If the chairman, vice-chairman or designated member of the IRB feels that additional changes are needed, this will be communicated to the Principal Investigator. The chairman/vice-chairman/designated IRB member does not have the authority to disapprove a research proposal. A research proposal may only be disapproved by the full board. Therefore, if the IRB chairman, vice-chairman or designated IRB member is unable to approve a research proposal after communication with the Principal Investigator, the proposal will be added to the next open IRB meeting agenda for full board review and the Principal Investigator will be notified of the Board's decision.

The board meets on the second Monday of every month (except if otherwise noted). To have a new protocol reviewed at a particular meeting, the complete initial submission must be submitted to the IRB office (via IRBNet) by the deadline prior to that meeting. The specific IRB meeting dates and deadlines are available on the [IRB Web Site](#).

NOTE: If special circumstances exist and approval is needed more quickly, contact the IRB office by phone (464-4317) to coordinate the review.

## **ACTIONS ON PROTOCOLS REVIEWED BY THE IRB**

By regulation, action on protocols that require full IRB review may be taken only at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas. In order for the research to be approved, it must receive the approval of a majority of those members present.

The full Board may act on a protocol in one of four ways:

- 1) The protocol may be ‘Approved. In this case, an approval letter and stamped consent(s), if applicable, will be posted on IRBNet .
- 2) The protocol may be approved pending modifications (“Modifications Required”). In this case, an approval letter and stamped consent **will not be** posted on IRBNet until the requested modifications have been made, as stipulated in the IRB minutes (this may or may not need to be re-reviewed by the full IRB);
- 3) The protocol may be ‘Tabled Without Action’, needing substantial revisions or clarifications (such protocols will always need to be re-reviewed by the full IRB);
- 4) The protocol may be ‘Not Approved’

IN CASES WHERE A STUDY IS ‘NOT APPROVED’, the IRB will provide its rationale for the action taken. The investigator may request an appearance before the Board to present arguments for reversal of the decision or propose a change in the protocol based on the advice and counsel of the Committee.

Actions taken at the IRB meeting are posted on IRBNet after each meeting.

**Once a project is approved, no protocol or consent form changes, amendments, or addenda may be made without prior IRB review and approval.**

The IRB approved version of the consent and /or assent form(s) with the IRB approval and expiration date listed in the header of each page will be posted as a pdf document in IRBNet. The IRB approved, stamped consent may be printed for use from IRBNet. The consent form is valid until the expiration date. If a consent or assent form is revised and approved by the IRB, during this period, it is stamped with the new approval date, the expiration date remains the same.

A study approved by the IRB may be subject to further review and requirements by University Hospital, if hospital facilities and/or staff are to be utilized. Please refer to Policy R-08, *Guidelines for Obtaining Research Support from University Hospital*

**HOWEVER, IF THE IRB DOES NOT APPROVE A PROJECT, THERE IS NO POSSIBILITY OF REVERSING THE IRB ACTION BY A HIGHER UNIVERSITY, HOSPITAL, OR FEDERAL OFFICIAL.**

## CLINICAL PRACTICE VS. CLINICAL INVESTIGATION

The IRB is aware that research conducted in an academic setting can often result in an overlap between clinical practice, designed to take care of a specific patient's medical needs and clinical investigation, designed to collect generalizable knowledge to advance standards of care. This distinction can be particularly confusing in clinic-based research where contact with patients and clinical-investigators may extend over long periods of time.

In cases where one may be unsure about whether an activity is clinical practice or research, we encourage faculty to contact the IRB for an opinion. This will avoid any future confusion should the question arise in the course of an application for funding or review of a submitted manuscript for publication. In cases where the distinction remains unclear, the IRB will consult with the Department Chairman before a decision is made as to which category the activity belongs.

The **Belmont Report** includes a section entitled "A. Boundaries Between Practice and Research" which makes these distinctions between practice and investigation clear. We urge all faculty to review this document carefully.

# EXEMPTION FROM IRB REVIEW

All requests for exemption are to be submitted via IRBNet. **Review ‘Read Me First- IRBNet for Upstate Researches’ for step by step instructions.**

## EXEMPTION FROM IRB REVIEW

The federal regulations provide for exemption from IRB review for certain kinds of research (e.g., review of existing data and specimens, surveys) if certain conditions are met. The Upstate Medical University IRB retains the right to decide if a project is exempt or requires IRB review, based on the investigator’s request and the federal regulations. All studies involving review of medical records for research purposes must be submitted to the IRB for a decision regarding exemption.

### MEDICAL RECORD AND SPECIMEN RESEARCH:

**In order to be eligible for Exemption from IRB review, the research must be retrospective and no identifying information can be recorded.**

“**Retrospective**” means that all the information needed for the project is in the medical record on the date the request is made to the IRB or for specimen research, all specimens are “on the shelf” on the date of the request to the IRB.

1. **Provide a brief description** of the project (in the IRBNet Registration Form or in a letter) including the following information:
  - a. The dates of records/specimens to be reviewed (to establish that the study is retrospective)
  - b. Whether other institutions/organizations are involved, i.e. are charts being reviewed at another institution or private practice?
2. **Attach** (Upload) **a completed De-identification Form** (in the IRBNet library) to establish that the study is anonymous.
3. **Attach** (Upload) your **Data Form** (a form which details all the types of information you will record from the medical record or that will be associated with the specimens- i.e., age, dx, etc.)

### NOTE:

**No Dates** (including, but not limited to: birth date, admission date, discharge date, date of death, date of dx, etc.) **may be used or recorded.** You may record a year (i.e., ‘2008’)

**Specific Ages** may be used & recorded **only** for subjects 89 years of age or less. Subjects > 89 yrs of age must be grouped as follows: “> 89 years old”.

*If the proposal is judged to be exempt, the IRB Office will issue an exemption letter. If the decision is otherwise, the investigator will be asked to submit a completed application for IRB review.*

### OTHER CATEGORIES OF RESEARCH:

**1. Provide a brief description** of the project (in the IRBNet Registration Form or in a letter) which notes the applicable category of research, which may be exempt from IRB Review (see below) and includes appropriate information to meet the requirements of the designated category.

**Categories of research, which may be exempt from IRB Review:**

**1.** Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

**2.** Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subject's responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation. **Note: underlined sections only apply to adult subjects; however, research involving observation of public behavior when the investigator(s) do not participate in the activities being observed, is applicable to children.**

**3.** 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: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

**4.** 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.

**5.** Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

**6.** Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) 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.

## CONTINUING REVIEW PROCESS FOR APPROVED RESEARCH PROTOCOLS

Continuing review is a federally mandated requirement. All research studies approved by the IRB must be reviewed at least annually. The expiration date is noted on each page of the consent document. The IRB of SUNY Upstate Medical University has set a limit of 4 continuing reviews. After the fourth regular continuing review, if the study is to continue, it is necessary to re-submit the complete study (5-Year Continuing Review) for IRB review (similar to a “new Project” submission).

It is the responsibility of the Principal Investigator to complete the continuing review report form and submit all requested items at least 4 weeks prior to the expiration date in order to ensure that the review process is completed on time.

Once your project is approved by the IRB, IRBNet will send those with full project access an e-mail notification 60 and 30 days prior to the expiration of the approval period. You should respond to the first notice as soon as possible, to ensure that there is no lapse in your study approval. If your approval **does** lapse before you have been re-approved (even if you submitted the continuing review materials), the research activity (including data analysis) must be halted immediately. If there are concerns for the well being of enrolled subjects, please contact the IRB Chair to discuss.

In certain circumstances, determined at the time of initial or continuing review, the Board may stipulate that continuing review should take place more frequently than once a year (for example, high risk protocols or protocols with a high risk: potential benefit ratio). If special reporting requirements are set as a condition of approval, the investigator must submit the required information in a timely manner that will permit determination of whether changes have occurred in the risk: benefit ratio.

In addition, the IRB may request additional information from sources other than the principal investigator in order to assess the completeness and accuracy of information submitted and to verify that no material changes have occurred since the last IRB review. These situations may include the following: complex projects involving unusual levels or types of risks to subjects; projects conducted by investigators who previously have failed to comply with requirements of the federal regulations or the requirements of the Upstate IRB; and projects where concern about possible material changes occurring without IRB approval have been raised, based upon information provided in continuing review reports or from other sources.

As part of the continuing review process, the IRB requires an investigator to report the experience to date in implementing the protocol (progress report). If this information is not provided, the review will be delayed until the information is provided.

If the trial has a *Data/Safety Monitoring Board (DSMB)*, any reports received during the year should be submitted. It is the PI's obligation to continuously monitor the overall risk-benefit ratio associated with participation in the study, thus promoting the safety and interest of the subjects in the study. The Committee reviews DSMB reports as part of its process of continuing review.

One board member is assigned to conduct an in depth review of each research study and makes a recommendation regarding continuation. Re-approval is only granted at a convened meeting of the full Board, unless the project is eligible for expedited continuing review. IRB members have access to all study information on IRBNet.

**NO GRACE PERIOD OR EXTENSIONS ARE ALLOWED [45CFR 46.10]**

If a study does not receive approval by the expiration date, no subjects may be enrolled nor may any study-related activities continue, until the continuing review process is complete. If there are concerns for the well being of enrolled subjects, please contact the IRB Chair to discuss.

If the study expires because the materials required for continuing review have not been submitted to the IRB, the study will be permanently closed unless the required materials are submitted within two months of the expiration date. If the study is permanently closed, the PI will be required to submit a new application for IRB review in order to continue the study.

**DO NOT INCLUDE REQUESTS FOR CHANGES AS PART OF THE CONTINUING REVIEW REPORT. REQUESTED CHANGES MUST BE SUBMITTED AS AMENDMENTS (see “Making Changes/Amendments To Approved Research Proposals”)**

## **FIFTH-YEAR RENEWAL PROCEDURES**

After the fourth regular continuing review, if the study is to continue, it is necessary to re-submit the study (see, “Instructions-Continuing Review” on IRBNet) for IRB review. Studies which require scientific review prior to IRB review will be assigned to one scientific reviewer. **Under no circumstances may the study proceed without the completion of the review process and approval granted.**

**To figure out when you need to submit your 5-year continuing review,** look at the **Local Board Reference #**, which will tell you the year the study was originally approved and how many regular continuing reviews the study has undergone.

**For example, study #2008-3 was originally approved in 2008 and has undergone 3 regular continuing reviews. This study will require a 5- year renewal in 2013.**

**It is your responsibility to track when your 5 year continuing reviews are due.**

## **MAKING CHANGES/AMENDMENTS TO APPROVED RESEARCH PROTOCOLS**

Once the IRB has approved a project, it must be carried out exactly as planned. Any changes, including (but not limited to) subject population, recruitment plans, research procedures, study design, study instruments, study sites, or research personnel, must be approved by the IRB **prior to implementation**.

Researchers planning a change should submit proposed changes to the IRB on IRBNet (see *Instructions-Amendments*”).

**Minor** protocol/consent changes may be approved by expedited review. These would be changes that do not adversely alter the overall risk:benefit profile of the study; would not affect the willingness of current subjects to remain in the study; and do not alter the scientific validity of the study design. Changes to study design, which may increase risk to subjects, may require full board review. Changes that are perceived to significantly affect the risk:benefit ratio for subjects must be reviewed by the full Board.

**Implementation of any change must **not occur** prior to IRB approval unless the change is required to eliminate an immediate hazard to the subjects. In this case, the IRB should be notified as soon as possible of the change.**

Changing the Principal Investigator:

If a Principal Investigator is on sabbatical leave from the University, an interim PI must be appointed. The IRB should be informed of this person's qualifications. If a researcher leaves the University permanently, the IRB should be notified of any interim investigators and of the final replacement. Such changes require prior review and approval by the IRB.

# REQUIREMENTS FOR NOTIFYING THE IRB OF UNANTICIPATED PROBLEMS AND ADVERSE EVENTS

This policy applies to all non-exempt human subjects research conducted by Upstate Medical University faculty. The purpose of this policy is to ensure the prompt reporting of unanticipated problems and adverse events to the IRB, so that human subjects can be better protected from avoidable harms. It should be noted that only a small subset of adverse events occurring in research subjects are unanticipated problems that must be reported to the IRB.

**I. Unanticipated Problems** includes any incident, experience, or outcome that meets **all** of the following criteria:

- A. unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied;
- B. related or possibly related to participation in the research (*possibly related* means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research); and
- C. suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

## **II. Adverse Events:**

**An adverse event** is any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject's participation in the research, whether or not considered related to the subject's participation in the research.

Includes both physical & psychological harms

**A serious adverse event** *is* any untoward medical occurrence that:

- results in death;
- is life-threatening (places the subject at immediate risk of death from the event as it occurred);
- results in inpatient hospitalization or prolongation of existing hospitalization;
- results in a persistent or significant disability/incapacity;
- results in a congenital anomaly/birth defect; or

- based upon appropriate medical judgment, may jeopardize the subject's health and may require medical or surgical intervention to prevent one of the other outcomes listed in this definition

### **III. Reporting Internal Adverse Events by Investigators to the Upstate IRB:**

- **Internal adverse events** are those adverse events experienced by subjects enrolled by investigators at Upstate or enrolled by affiliated investigators at other institutions for which the Upstate IRB is responsible.

Upon becoming aware of an adverse event, the investigator must first determine whether or not the adverse event meets the criteria for an unanticipated problem (as described in section I). If the adverse event is determined to be an unanticipated problem, it must be promptly reported to the Upstate IRB.

**Please Note:** when making the determination as to whether the adverse event meets the 1<sup>st</sup> criterion “unexpected”, consider the known or foreseeable risks (that are described in the protocol, IB, product labeling, package inserts, and consent form) **AND** the expected natural progression of any underlying disease, disorder or condition of the subject and the subject’s predisposing risk factor profile for the adverse event.

If the adverse event is not consistent with either the known or foreseeable risks or subject profile (as described above), then it would be consider “unexpected”.

### **IV. Reporting External Adverse Events by Investigators to the Upstate IRB:**

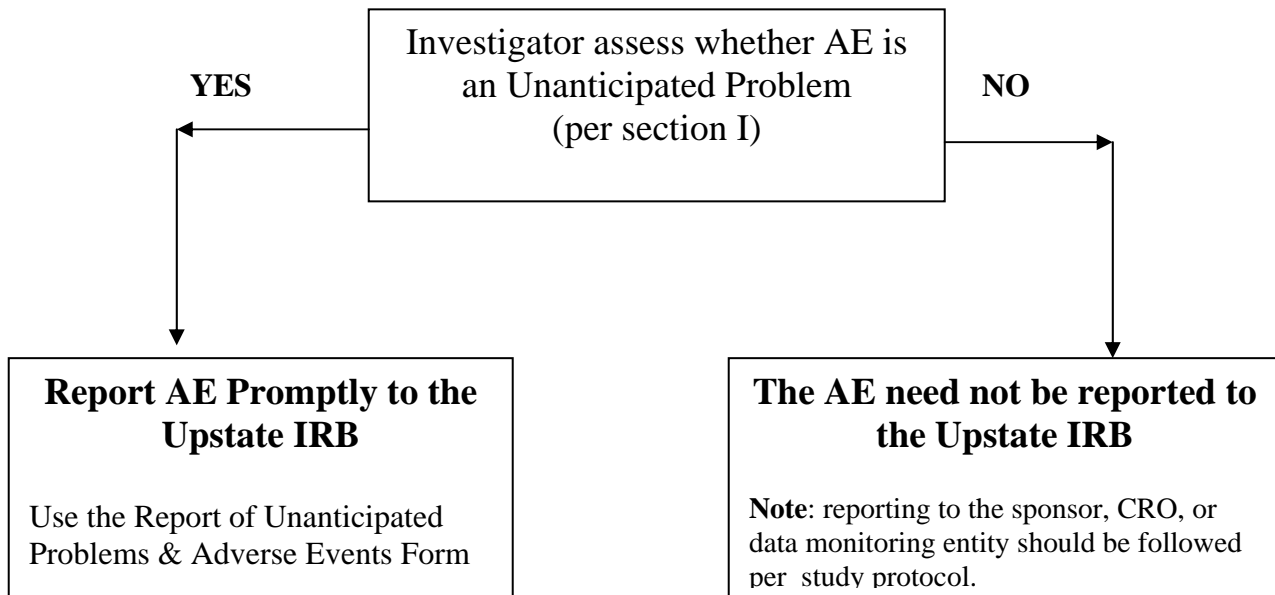
- **External Events** are those adverse events experienced by subjects enrolled by investigators at other institutions engaged in the research.

In multicenter trials neither the investigator nor the IRB will be able to appropriately assess the significance of the external adverse event.

**Per OHRP guidance:** Individual adverse events should only be reported to all the investigators and IRBs at all institutions when a determination has been made that the events meet the criteria for an unanticipated problem.

Therefore only adverse events which have been determined to meet the criteria for an Unanticipated Problem need to be reported to the Upstate IRB. The investigator may need additional information from the monitoring entity (i.e., sponsor, DSMB, statistical center) to make this determination.

**Determining when an internal or external adverse event requires reporting to the IRB:**



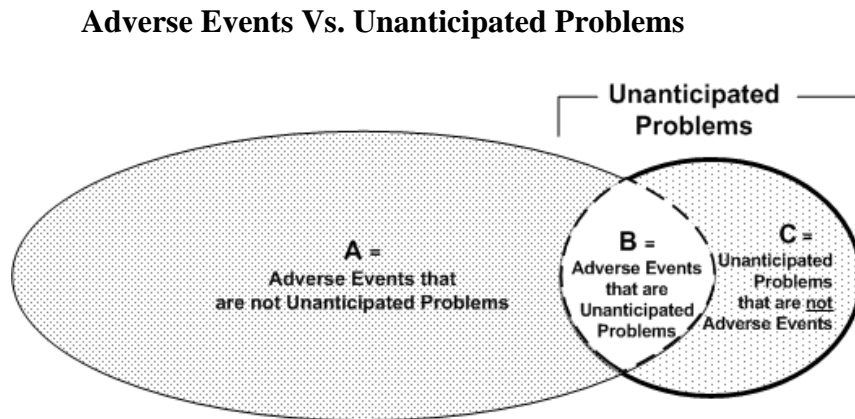
*\***Note:** if the investigator initially determines that an adverse event is NOT an unanticipated problem, but the monitoring entity subsequently determines that the adverse event does in fact represent an **unanticipated problem**, then the investigator should report this to the IRB.*

OHRP considers adverse events that are unexpected, related or possibly related to participation in research, and *serious* to be the most important subset of adverse events representing unanticipated problems because such events always suggest that the research places subjects or others at a greater risk of physical or psychological harm than was previously known or recognized and routinely warrant consideration of substantive changes in the research protocol or informed consent process/document or other corrective actions in order to protect the safety, welfare, or rights of subjects.

However, other adverse events that are unexpected and related or possibly related to participation in the research, but *not* serious, would also be unanticipated problems if they suggest that the research places subjects or others at a greater risk of physical or psychological harm than was previously known or recognized. Again, such events routinely warrant consideration of substantive changes in the research protocol or informed consent process/document or other corrective actions in order to protect the safety, welfare, or rights of subjects or others.

## V. Reporting Unanticipated Problems (not related to Adverse Events) to the Upstate IRB:

Upon becoming aware of any other incident, experience or outcome, the investigator must first determine whether or not the incident, experience or outcome represents an unanticipated problem (as described in section I). If the incident, experience or outcome is determined to be an unanticipated problem, it must be promptly reported to the Upstate IRB.



\* Under 45 CFR part 46: Do not report A; Report B and C.

### Note:

- The vast majority of adverse events occurring in human subjects are not unanticipated problems (area A).
- A small proportion of adverse events are unanticipated problems (area B).
- Unanticipated problems include other incidents, experiences, and outcomes that are not adverse events (area C).

## VI. Time-Frame for investigators to report ALL Unanticipated Problems (including unanticipated adverse events) to the IRB

In order to ensure that appropriate steps are taken in a timely manner to protect other subjects from avoidable harm, the IRB expects investigators to promptly report Unanticipated Problems to the IRB, as follows:

1. **Unanticipated Problems that are serious adverse events should be reported to the IRB within 1 week of the investigator becoming aware of the event.**
2. **Any other Unanticipated Problem should be reported to the IRB within 2 weeks of the investigator becoming aware of the problem.**

## **VII. IRB Review of Unanticipated Problems Reported by Investigators**

Reports of *internal unanticipated problems* will be initially screened by the IRB Chair, Vice Chair or IRB administrator to determine if any immediate action is required to protect the safety, welfare, or rights of subjects or others. All internal reports of unanticipated problems submitted by investigators to the IRB will be added to the next open IRB meeting agenda to be reviewed during a convened meeting of the IRB.

Reports of *external unanticipated problems* will be reviewed by the IRB Chair, Vice Chair or other experienced IRB member to determine if any additional action is required.

It is expected that reports of unanticipated problems may warrant consideration of substantive changes in the research protocol or informed consent process or document. The following are examples of corrective actions or changes the IRB or designated IRB member may consider in response to an unanticipated problem:

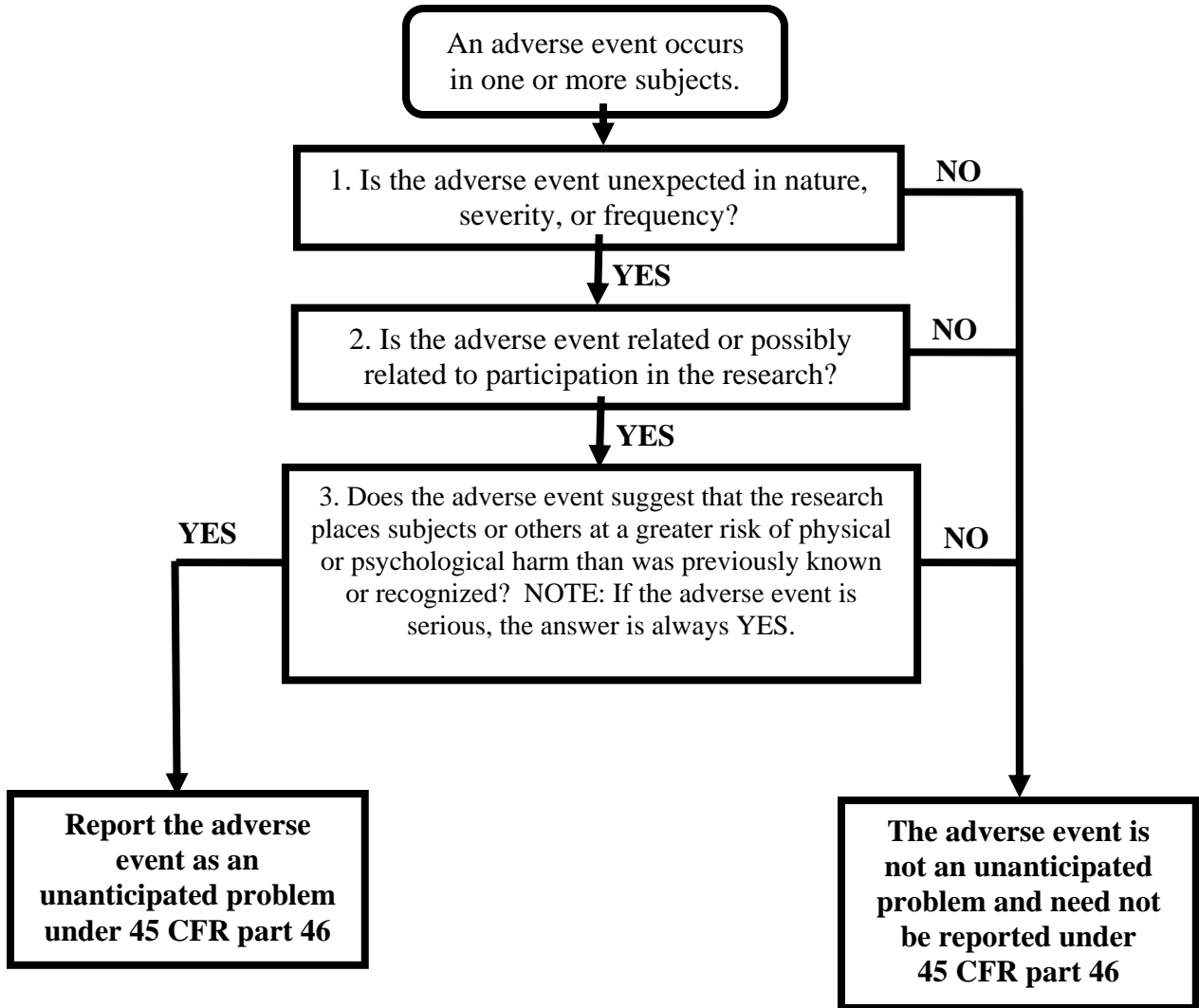
- Modification of the eligibility criteria;
- Implementation of additional monitoring procedures;
- Modification of informed consent documents;
- Provision of additional information to previously enrolled subjects;
- Suspension of enrollment of new subjects;
- Suspension of research procedure in currently enrolled subjects;
- Termination of approval of research

## **VIII. IRB Reporting to Institutional Official, HHS supporting agency head, OHRP and FDA**

OHRP and FDA regulations require that Upstate notify institutional officials, supporting HHS agency heads, OHRP and FDA (if applicable) of all *internal unanticipated problems*. These reports do not indicate any deviation or wrong doing on the part of the investigators; but, instead, are made to inform federal agencies of potential changes in risk in previously-approved research due to *unanticipated problems*.

The IRB administrator or IRB coordinator will report all **internal unanticipated problems** to the Upstate Vice President for Research, HHS supporting agency head (if applicable), OHRP and FDA (if applicable) within one month of the IRB's receipt of the report of the problem from the investigator. The IRB provides copies of these reports to the PI.

**Algorithm for Determining Whether an Adverse Event  
is an Unanticipated Problem**



OHRP 1/15/2007 Guidance  
<http://www.hhs.gov/ohrp/policy/AdvEvt/Guid.htm>

## **RECRUITMENT OF RESEARCH SUBJECTS**

Many investigators will play the role of both physician and investigator when enrolling from their own patient population. In this situation the investigator may be faced with a conflict between what is best for the subject and what is best for the research study. Both the American Medical Association and the American College of Physicians recommend that physician-investigators handle their dual role by always placing the health and welfare of their patients first, before their value as study subjects.

In order to recruit other clinicians' patients, the investigator should enlist the assistance of the potential subjects' own physician/clinician. Investigators should not initiate direct contact with potential subjects with whom the investigator does not have a clinician-patient relationship. This could be viewed as an invasion of privacy or a breach in doctor-patient confidentiality.

It is usually not appropriate to seek consent at the time of a procedure, diagnosis or other stressful moment. A subject may require time to decide whether or not to participate, to ask questions and to confer with family or other personal advisors.

### **Recruitment Incentives for Enrolling Research Subjects:**

Recruitment incentives may be offered by study sponsors to investigators or other persons on the research team for enrolling or accelerating the enrollment of subjects. Referral fees are given to doctors or other practitioners for referring their patients to another investigator's study. The practice of accepting or offering financial incentives (bonuses) for subject enrollment and referrals, (sometimes referred to as "finder's fees") may compromise the integrity of the study and may generate an unethical conflict of interest. Therefore, Upstate does not allow investigators or their staff or their departments to accept or to offer recruitment incentives, including finder's fees.

If subject recruitment incurs additional costs, such as advertising expenses, it is appropriate to accept additional monies from the sponsor to cover these specific additional expenses.

### **Requirements for Recruiting Research Subjects through Advertisements:**

Advertisement is a common method used for recruiting research subjects. There are many types of advertising including posted notices, newspaper and magazine ads, radio announcements and Internet websites. **All advertising requires IRB approval.** The IRB is charged with reviewing the information contained in the advertisement, as well as the mode of its communication, to determine whether the procedure for recruiting subjects affords adequate protection. IRB review is necessary to ensure that the information is not misleading to potential research subjects.

Advertisements to recruit subjects may include: (1) the name and address of the clinical investigator, (2) the title of the study, (3) the purpose of the research (may include a

summary of the eligibility criteria used to admit subjects to the study), (4) a summary of potential risks/discomforts and time commitment, (5) description of incentives for participation (such as payments or free treatment), and (6) location of the study site and the person to contact for further information.

Advertisements are generally eligible to be reviewed by the expedited review process.

## **RESEARCH MISCONDUCT**

Scientific research must be conducted in accordance with the highest regard for standards of honesty. Misconduct of any nature in research is an anathema to the intrinsic goals of all scientific inquiry and dissemination of knowledge. The academic community cannot tolerate plagiarism, fraud, lying, or other types of malfeasance in the conduct of scientific research. Such activities undermine the foundations of our institutions, the fundamental concepts underlying scientific research, and the public's trust in the personal integrity of biomedical scientists. The faculty and administration of Upstate are committed to preserving and encouraging an environment of creativity commensurate with the highest ethical standards of scientific research. To that end, a research misconduct policy and guidelines have been promulgated by Upstate and annual assurances are filed with the Office of Research Integrity of the Department of Health and Human Services.

**[SUNY Upstate Medical University Research Misconduct](#)**

## **NONCOMPLIANCE BY RESEARCHERS OR RESEARCH PERSONNEL WITH PROTOCOL REQUIREMENTS AND/OR IRB GUIDELINES & POLICIES**

Noncompliance will be reviewed by the IRB Chair and/or board and may be referred to the Vice President for Research, or his/her designee, and/or the Dean of the appropriate college for further action, including disciplinary action.

### **Serious Non-compliance is defined as:**

Non-compliance that creates an increase in risks to subjects, adversely affects the rights, welfare and safety of the research subjects or adversely affects the scientific integrity of the study. Willful violation of policies and/or federal regulations may also constitute serious noncompliance.

Serious non-compliance will be reported to appropriate institutional officials, the head of any supporting Federal Department or Agency (if applicable), the Office of Human Research Protections at DHHS, the corporate study sponsor (if applicable), and the FDA (if applicable).

### **Suspensions or Terminations of Approved Research Studies:**

If the IRB determines that a research project should be suspended or terminated for cause, the action will be reported to appropriate institutional officials, the head of any supporting Federal Department or Agency (if applicable), the Office of Human Research Protections at DHHS, and the corporate study sponsor (if applicable). If the project that is suspended or terminated involves a drug, device, or biologic regulated by the Food and Drug Administration, the FDA shall also be notified of the suspension/termination.

### **Reporting protocol deviations/violations to the Upstate IRB:**

Only Protocol Deviations that meet the definition of an unanticipated problem should be submitted to the IRB. An Unanticipated Problem includes an incident, experience, or outcome that meets all of the following criteria:

- D. unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied;
- E. related or possibly related to participation in the research (*possibly related* means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research); and

- F. suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

If a protocol deviation meets the above definition then it must be reported to the IRB promptly using the *Report of Unanticipated Problems & Adverse Events*.

## MEDICAL DEVICES

Studies that propose to evaluate a *significant risk device* must be conducted under an Investigational Device Exemption (IDE) granted by the FDA. The determination that an IDE is necessary is generally made by the sponsor of the study. *Non-significant risk devices* may be studied without the need for an IDE. Whenever the IRB reviews an application for a study involving a medical device for which the sponsor/investigator has not obtained an IDE, the IRB will carefully evaluate the claim that the device is a non-significant risk device. The application should include a description of the device, a picture of the device and a report of prior investigations with the device. In addition, the IRB will evaluate the potential harm that may arise in the context of the actual use of the device, taking account of the risks associated with any surgical procedures that may need to be performed. The IRB will conduct its review in compliance with published guidance from the FDA concerning the evaluation of experimental medical devices. Guidance regarding device regulations can be found at:

<http://www.fda.gov/oc/ohrt/irbs/default.htm>

# RESEARCH USING HUMAN BIOLOGICAL MATERIALS

Research involving human biological material constitutes research that is subject to federal regulations.

In this context a sample refers to any human biological material. This includes, but is not limited to, molecular material such as DNA, cells, tissues (blood, bone, muscle, etc.), organs (liver, bladder, heart, etc.), gametes, embryos, fetal tissue, waste (hair, nail clippings, urine, feces, etc.), and other materials of human origin.

Four levels of identification of research samples are recognized. These are differentiated by the amount of information that is available about the subject from whom the sample was obtained.

The levels include:

1. **Unidentified Samples (Anonymous):** These samples are/were obtained and stored without any identification that may link the specimen to a specific patient.
2. **Unlinked Samples (Anonymized):** Unlinked samples are those that may have been acquired from identified human sources, but all identifiers or codes have been removed and destroyed such that the ability to identify particular individuals, via clinical or demographic information, would be extremely difficult for the investigator, the repository or a third party.
3. **Coded Samples:** Coded samples are those from which the source of the specimen can be identified by reference to a code rather than a name or other personal identifier. When such samples are obtained from a tissue repository, the repository retains information linking the code to a particular human specimen. Information is sufficient such that the investigator, repository or third party could link the biological sample or information derived from the research using the sample with a particular person or small group of identifiable individuals.
4. **Identified Samples:** These samples are collected or supplied to investigators with personal identifiers sufficient to allow identification of the donor of the material.

**Identifiers** are information that can be used to link a sample or scientific result with a specific person or group of people. Examples of identifiers include name, social security number, hospital number or other unique identifier. It should also be noted that using current information technology, a combination of descriptive data may be sufficient to allow identification of the donor and thereby collectively may be considered identifiers (e.g. zip code, birth date or profession may be sufficient to identify a specific individual).

### **Exemption from IRB Review:**

Some research using existing (already on the shelf) pathological specimens, or diagnostic specimens, may be eligible for an exemption from IRB review 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.

### **Consent Requirements:**

The necessity of obtaining informed consent from the subject applies to research involving human biological material. As a general rule, the Committee expects the investigator to obtain such consent from the sample source. In the case of research involving existent identified or coded samples, the Committee recognizes that it may not be feasible to obtain such consent.

However, federal regulations in 45 CFR 46.116(d) provide for the waiver of this requirement when the following conditions are met:

- 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 will be provided with additional pertinent information after participation.

You may request a waiver of consent based on the above conditions in the application for IRB review.

**NOTE:** There are specific consent document guidelines for studies in which samples will be collected and stored for future research and there are specific consent document guidelines for studies in which genetic testing is included (see **template for banking specimens** and **template for genetic research**).

### **Research using "waste" and "extra" material:**

Research that is conducted on "waste" or "extra" human tissue or fluids must be submitted for review by the IRB.

**"Waste material"** is material that is collected originally for clinical or diagnostic purposes only but is no longer needed.

**"Extra material"** is material that is collected above and beyond what is needed for a clinical or diagnostic procedure. It is collected during the same procedure, but solely for investigational purposes.

The IRB may determine that research on waste or extra material qualifies for expedited review; however, the requirement for informed consent still applies.

## **Expanded Access to Investigational Drugs, Biologics, Devices (such a treatment INDs)**

FDA regulations and/or guidance allow certain individuals not enrolled in clinical trials to obtain non-emergency access to investigational drugs, biologics, or devices. See the FDA guidance document: [Treatment Use of Investigational Drugs - Information Sheet](#) and [Frequently Asked Questions About Medical Devices](#)

**IRB Requirements in Expanded Access uses:** Depending upon the specific case (*e.g.*, expanded access method, health status of the patient, IRB meeting schedule, etc.), either full IRB or IRB chair/Vice Chair approval will be required before a patient/subject can be treated or enrolled into one of these access programs. Determination of type of IRB review will be made by IRB Staff in consultation with the Chair. Finally, prior approval from the sponsor and FDA is required before submitting to the IRB.

See “Read Me First~ IRBNet Instructions for Upstate Researchers” for specific submission instructions.

## **INCLUSION OF WOMEN & MINORITIES IN STUDY POPULATIONS**

NIH policy requires the inclusion of women and minorities in research study populations so that research findings can be of benefit to **all** persons at risk of the disease, disorder, or condition under study. Principal Investigators of NIH funded grants and cooperative agreements falling under the scope of the NIH policy must report annually on the number of subjects planned and enrolled to date by ethnic origin and gender.

It is the policy of Upstate to extend these requirements to all studies involving human subjects. It is expected that investigators will use all available resources to ensure the diversity of research populations.

## **SPECIAL CLASSES OF SUBJECTS**

Special consideration must be given by all researchers to protect the welfare of particularly vulnerable subjects, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons [45 CFR 46.111]. The U.S. Department of Health and Human Services regulations set forth specific provisions on research involving pregnant women, human fetuses and neonates (of uncertain viability or nonviable neonates), prisoners and children. Some of the requirements are described below.

1) Pregnant women or fetuses may be involved in research if all of the following conditions are met:

- (a) Where scientifically appropriate, preclinical 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;
- (b) 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;
- (c) Any risk is the least possible for achieving the objectives of the research;
- (d) 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, her consent is obtained in accord with the informed consent provisions of subpart A of this part;
- (e) 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 informed consent provisions of subpart A of this part, 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;
- (f) Each individual providing consent under paragraph (d) or (e) of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;

(g) For children as defined in Sec. 46.402(a) who are pregnant, assent and permission are obtained in accord with the provisions of subpart D of this part;

(h) No inducements, monetary or otherwise, will be offered to terminate a pregnancy;

(i) 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

(j) Individuals engaged in the research will have no part in determining the viability of a neonate.

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

(a) Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates.

(b) Each individual providing consent under paragraph (b)(2) or (c)(5) of this section is fully informed regarding the reasonably foreseeable impact of the research on the neonate.

(c) Individuals engaged in the research will have no part in determining the viability of a neonate.

(d) The requirements of paragraph (b) or (c) of this section have been met as applicable.

3) 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 are met:

(a) The IRB determines that:

(i) 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

(ii) 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

(iii) 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 subpart A of this part, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

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

- (i) Vital functions of the neonate will not be artificially maintained;
- (ii) The research will not terminate the heartbeat or respiration of the neonate;
- (iii) There will be no added risk to the neonate resulting from the research;
- (iv) The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- (v) The legally effective informed consent of both parents of the neonate is obtained in accord with subpart A of this part, except that the waiver and alteration provisions of Sec. 46.116(c) and (d) 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 (c)(5), 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 (c)(5).

(c) 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 subparts A (the common rule) and D (protections for children).

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

If information associated with material described in the above paragraph 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 subparts of this part are applicable.

**Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant women, fetuses, or neonates.**

The Secretary will conduct or fund research that the IRB does not believe meets the requirements of the above sections if:

(a) 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

(b) The Secretary, after consultation with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law) and following opportunity for public review and comment, including a public meeting announced in the Federal Register, has determined either:

1. That the research in fact satisfies the conditions of Sec. 46.204, as applicable; or (2) The following:

(i) 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;

(ii) The research will be conducted in accord with sound ethical principles; and

(iii) Informed consent will be obtained in accord with the informed consent provisions of subpart A and other applicable subparts of this part.

**Research Involving Children (less than 18 years of age):**

Subpart D of the HHS regulations requires additional protections for research involving children:

- **Children** are persons who have **not attained the legal age** for consent **in the jurisdiction in which the research will be conducted**
- The IRB must find that **the activity represents one of four permissible categories** of research, and that adequate provisions are made for soliciting **the assent of the children and the permission of each child's parents or guardian. ---**
- Children who are **wards of the State** or any other agency, institution, or entity can be included in research only under certain conditions.

The four research categories involving children that may be approved by the IRB, based on degree of risk and benefit to individual subjects, are as follows:

1. **(45 CFR 46.404 & 21 CFR 50.51) Research not involving greater than minimal risk.** Research in this category may be approved provided: Adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians.

2. **(45 CFR 46.405 & 21 CFR 50.52) Research involving greater than minimal risk, but presenting the prospect of direct benefit to an individual subject.** Research in this category may be approved provided: (a) the risk is justified by the anticipated benefit to the subject; (b) the relationship of risk to benefit is at least as favorable as any available alternative approach; and (c) Adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians.

3. **(45 CFR 46.406 & 21 CFR 50.53) Research involving greater than minimal risk with no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition.** Research in this category may be approved provided: (a) the risk represents a minor increase over minimal risk; (b) 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; (c) the intervention or procedure is likely to yield generalizable knowledge about the subject's disorder or condition that is of vital importance for the understanding or amelioration of the subject's disorder or condition; and (d) Adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians.

4. **(45 CFR 46.407 & 21 CFR 50.54) Research that is not otherwise approvable, but which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children.** Research in this category may be approved provided: (a) 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 children; and (b) The secretary of the Department of Health And Human Services, after consultation with a panel of experts in pertinent disciplines and following opportunity for public review and comment, has determined that the research may be conducted.

**Requirements for permission by parents or guardians and for assent by children (46.408):**

In addition to the determinations required under other applicable sections of this subpart, the IRB shall determine that adequate provisions are made for soliciting the assent of the children, when in the judgment of the IRB the children are capable of providing assent. In determining whether children are capable of assenting, the IRB shall take into account the ages, maturity, and psychological state of the children involved. This judgment may be made for all children to be involved in research under a particular protocol, or for each

child, as the IRB deems appropriate. 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 where the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances in which consent may be waived in accord with §46.116 of Subpart A.

In addition to the determinations required under other applicable sections of this subpart, the IRB shall determine, in accordance with and to the extent that consent is required by §46.116 of Subpart A, that adequate provisions are made for soliciting the permission of each child's parents or guardian.

Where parental permission is to be obtained, the IRB may find that the permission of one parent is sufficient for research to be conducted under §46.404 or §46.405. Where research is covered by §46.406 and §46.407 and permission is to be obtained from parents, both parents must give their permission unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child.

In addition to the provisions for waiver contained in §46.116 of Subpart A, if the IRB determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children), it may waive the consent requirements, provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further 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 by parents or guardians shall be documented in accordance with and to the extent required by §46.117 of Subpart A.

When the IRB determines that assent is required, it shall also determine whether and how assent must be documented.

#### **Additional Guidance regarding Parental Permission and Subject Assent:**

When children or minors (under the age of 18) are involved in research, the regulations require that **assent** (a child's affirmative agreement to participate in research) of the child or minor be obtained and the **permission** (the agreement of parent(s) or guardian(s) to the participation of their child or ward in research) of the parent(s) be obtained, in place of the consent of the subjects.

Given that children have not reached their full intellectual and emotional capacities and are legally unable to give valid consent, involving children in research requires the permission of their parents or legally authorized representatives.

While children may be legally incapable of giving informed consent, they nevertheless may possess the ability to **assent** to or dissent from participation. Out of respect for children as developing persons, children should be asked whether or not they wish to participate in the research, particularly if the research: (1) does not involve interventions likely to be of benefit to the subjects; and (2) the children can comprehend and appreciate what it means to be a volunteer for the benefit of others.

**NOTE: The lack of active objection shall not be considered to be either consent or assent; both require a positive action by the potential subject and when appropriate the parent/guardian.**

### **Research Involving Prisoners**

Subpart C of the HHS regulations requires additional protections for research involving prisoners as subjects:

- **Prisoner** means any individual **involuntarily confined or detained** in a penal institution, including individuals detained in other facilities which provide alternatives to criminal prosecution or incarceration, and individuals detained pending arraignment, trial, or sentencing. --- 45 CFR 46.303(c)
- At least **one** member of the Institutional Review Board (IRB) must be a **prisoner or a prisoner representative** with appropriate background and experience. --- 45 CFR 46.304(b)
- The IRB must find and certify to OPRR that **six additional protections** specific to prisoners have been satisfied. --- 45 CFR 46.305
- The IRB must find, and OPRR must determine, that **the research represents one of four permissible categories of research**. Certain research may go forward only after OPRR has consulted with appropriate experts in penology, medicine, and ethics. --- 45 CFR 46.306

The Upstate IRB has an appointed prisoner representative who is required to review all research proposals involving prisoners. The review by the prisoner representative is in addition to the primary scientific review. The prisoner representative may write an opinion but this is not required. If approval is given verbally, it will be noted in writing by the IRB office staff and in the IRB meeting minutes.

**When the IRB is reviewing a protocol in which prisoners are or may be subjects, the IRB is required to meet the following specific requirements:**

- (a) A majority of the Board (exclusive of prisoner members) shall have no association with the prison(s) involved, apart from their membership on the Board.

(b) At least one member of the Board shall be a prisoner, or a prison representative with appropriate background and experience to serve in that capacity. When a particular research project is reviewed by more than one Board, only one Board need satisfy this requirement.

**In addition, the IRB must make seven additional findings under 45 CFR 46.305 as follows:**

(1) The research under review represents one of the following categories of research permissible under Section 46.306(a)(2);

(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, vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere; and research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults) provided that the study may proceed only after the Secretary of Health and Human Services has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of his intent to approve such research; 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. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the research, the study may proceed only after the Secretary of Health and Human Services has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of the intent to approve such research.

Except as provided in paragraph (A) of this section, biomedical or behavioral research conducted or supported by DHHS shall not involve prisoners as subjects.

(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 Board 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 boards 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 Board finds there may be a need for follow-up examination or care of participants after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoner sentences, and for informing participants of this fact.

# **INFORMED CONSENT**

Informed consent is one of the primary ethical requirements underpinning research with human subjects; it reflects the basic principle of respect for persons. Since the central requirement for human subject research is that people participate voluntarily, the consent process is one of the most important parts of planning a research proposal. Informed consent assures that prospective human subjects will understand the nature of the research and can knowledgeably and voluntarily decide whether or not to participate.

## **Obtaining Informed Consent:**

The consent process must assure that the potential subject understands the study and its risks and benefits and can certify his or her willingness to participate. This obligation is the responsibility of the Principal Investigator. Consent is an ongoing process, it starts before the consent form is signed and continues until the subject's participation is complete. The informed consent process involves meeting with a potential subject, finding out whether he or she is capable of giving consent, and discussing the purpose, risks, and benefits of participation.

A subject may require time to decide whether or not to participate, to ask questions and to confer with family or other personal advisors. It is generally not appropriate to seek consent in a rush or at the time of a procedure, diagnosis or other stressful moment. Information given to potential subjects or their representatives must be in language that is understandable to the subject or representative.

## **Retaining Informed Consent Documents:**

For Studies not subject to the HIPAA Privacy Rule (no authorization included in consent document):

Documentation of the informed consent of the subjects - either the signed informed consent form or the short form and the written research summary - are records related to conducted research that are typically held by the PI and must be retained for at least three years after completion of the research, unless the IRB waived the requirement for informed consent or the requirement for documentation of informed consent (45 CFR 46.117).

In addition, other regulations may apply and require retention of these records for a longer period of time.

For Studies that are subject to the HIPAA Privacy Rule (authorization is included in consent document):

Documentation of the informed consent and authorization to use and share personal health information of the subjects - the signed informed consent and authorization form -

are records related to conducted research that are typically held by the PI and must be retained for at least six years from the date signed by the subject (or subject's representative) or from the date when last in effect, whichever is later.

Because there may be no specific expiration date on the consent/authorization form, the current guidance is that the consent/authorization form should be kept indefinitely.

Such records may be preserved in hardcopy, electronic or other media form and must be accessible for inspection and copying by authorized representatives of the institution and federal agencies at reasonable times and in a reasonable manner.

If the PI leaves Upstate, arrangements must be made to leave the consent/authorization forms with the Department. These arrangements should be communicated to the IRB office.

### **Documentation of Informed Consent:**

Informed consent must be documented by the use of a written consent form (except as noted below) reviewed and approved by the IRB (signified by the presence of an IRB approval stamp and expiration date) and signed and dated by the subject or subject's legally authorized representative. A signed\* copy of the consent form must be given to the subject or subject's legally authorized representative.

\*If the study is subject to HIPAA (i.e., includes identifiable health information and the consent document includes the HIPAA authorization section), the subject is required to receive a signed copy of the consent form.

The consent process may not involve the use of exculpatory language through which the subject or representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, sponsor, institution, or agents from liability for negligence [45 CFR 46.116].

It is assumed that the consent form is only part of the total consent process in which the investigator, perhaps using the written consent form as an outline, describes all facets of the study and answers the subject's questions. **The investigator is responsible for insuring that research subjects understand the research procedures and risks. Failure of the subjects to ask questions should not be construed as understanding on the part of the subject.**

**The Federal regulations require that certain information be provided to each subject [45 CFR 46.116(a)] in the consent form:**

- (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,

- (2) A description of any reasonably foreseeable risks or discomforts to the subject,
- (3) A description of any benefits to the subject or to others which may be reasonably expected from the research,
- (4) A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject,
- (5) A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained,
- (6) For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained,
- (7) An explanation of whom to contact for answers to pertinent questions about the research and research subjects rights, and whom to contact in the event of a research related injury to the subject,
- (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.

**The regulations further provide that the following additional information be provided to subjects, where appropriate [45 CFR 46.116(b)]**

- (1) A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable,
- (2) Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent,
- (3) Any additional costs to the subject that may result from participation in the research,
- (4) The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject,
- (5) A statement that significant new findings developed during the course of the research which may be related to the subject's willingness to continue participation will be provided to the subject,

(6) The approximate number of subjects involved in the study.

**The Upstate IRB expects that all consent documents be drafted using the format of the relevant consent document template as outlined and available in IRBNet. Sample consent documents from study sponsors should be modified accordingly. In addition, the consent document must:**

- Be written in the second person (“You are”).
- Font size must be at least 12 pt.
- Include a version date at the bottom of the 1<sup>st</sup> page (updated each time a change is submitted).
- Include a page number on each page
- Be simply written at an 8<sup>th</sup> grade or lower reading level (no technical jargon, all abbreviations must be defined at least once)
- Refer to research subjects as “subjects” not “patients”.

#### **Requirements when a Study Sponsor Includes Compensation for Research-Related Injury Statements:**

Some sponsors offer subjects compensation for research-related injuries. In these cases, both the University section regarding injuries (“**In Case of Injury**”) and the sponsor section regarding compensation (“**Compensation for Research-Related Injuries**”) must be included. In addition, the following disclaimer must follow the sponsor’s statement.

“Neither the researchers nor SUNY Upstate Medical University make any representation, warranties or guarantees with respect to the above policy, including either its continued existence or its applicability to yourself should any adverse side effects occur.”

**IF** the sponsor’s statement will only compensate subjects for research-related injuries, which are a **direct result** of the study drug/procedures, then the following two disclaimers must follow the sponsor’s statement.

“The above paragraph states the policy of (*corporate sponsor*). (*Corporate sponsor*) will make the final determination as to whether any injury suffered during this study is a “direct result” of the study drug/procedures. Your physician will provide supporting information to (*corporate sponsor*), but cannot guarantee reimbursement.”

“Neither the researchers nor SUNY Upstate Medical University make any representation, warranties or guarantees with respect to the above policy, including either its continued existence or its applicability to yourself should any adverse side effects occur.”

\* **NOTE:** The IRB requires written verification, from the study sponsor, of the accuracy of the statement included in the consent document regarding compensation for research-related injuries. A letter from the study sponsor, which references the consent form or the paragraph(s) in the consent form, with their approval will satisfy this requirement.

### **Payments to Research Subjects for Participation:**

The practice of paying research subjects to participate in research is not prohibited. However, the IRB will review the specific procedures and amount of payment for each research study in order to minimize the possibility of coercion or undue influence and to determine whether the payments offered for participation constitute undue inducement.

The consent document should include the details of the payment plan, including when the payment(s) will be received and the conditions under which a subject would receive partial payment (for example, if the subject withdrew before the end of the study). Free parking, travel expenses, childcare expenses or meal allowances should also be detailed. This should be included in the “Costs/Payments” section of the consent document and **NOT** in the “Benefits” section.

### **Waiver of Documentation of Informed Consent - 45 CFR 46.117(c)**

Documentation of informed consent is required in **most** cases; however, the IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds that:

- The only record linking the subject to the research would be the consent document, and the principal risk would be potential harm resulting from a breach of confidentiality. The IRB may determine that each subject be asked whether s/he wants documentation linking the subject with the research, and the subject's wishes will govern;
- OR**
- 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.

In cases where the requirement of documentation is waived, the IRB may require that an information document or a letter be given to study participants.

**NOTE: A waiver of documentation of informed consent is not a waiver for obtaining informed consent, it only allows for the waiver of the subject’s signature on the consent form .**

## **WAIVER OF INFORMED CONSENT - 45 CFR 46.116(d)**

The IRB may waive the requirements for obtaining informed consent or approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent listed above, provided 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 will be provided with additional pertinent information after participation.

## RESEARCH SUBJECTS' RIGHT TO PRIVACY

The privacy regulations (The Privacy Rule) that have been promulgated by the federal Office of Civil Rights under the Health Insurance Portability and Accountability Act (HIPAA) impact research involving human subjects. These regulations define conditions where certain health information may be used or disclosed in research activities. Further, the regulations define conditions where 'authorization' must be obtained from the patient. The full text of these regulations is available at [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa).

**Questions concerning HIPAA regulations can be directed to the Institutional Privacy Officer, Cindy Nappa.**

### DEFINITIONS PERTAINING TO PRIVACY IN RESEARCH:

**Health Information**: any information, whether oral or recorded in any form or medium, that is created or received by an Upstate investigator, and relates to the past, present, or future physical or mental health or condition of an individual. To assist you in making the determination of what constitutes 'health information', this definition includes physical or mental information regarding the diagnosis, treatment and/or prevention of physical or mental conditions of the type that is now (or could be in the future) covered by health insurance.

**Individually identifiable health information (IIHI)**: is a subset of health information, including demographic information collected from an individual that identifies the individual (either directly, or through codes/identifiers).

**De-identified Health Information**: health information can be considered de-identified if, EITHER:

1. The investigator provides the Upstate IRB a written attestation by an expert in de-identification methods, that there is a very small risk that the information could be used by others to identify the subject.

[The preamble to the Privacy Rule provides guidance (see, e.g., <http://www.fcs.m.gov/working-papers/wp22.html> and [http://www.fcs.m.gov/docs/checklist\\_\\_799.doc](http://www.fcs.m.gov/docs/checklist__799.doc)) for what would be required in this regard, e.g., removing all direct identifiers, for reducing the number of variables on which a match might be made, and for limiting the distribution of records, etc.].

OR

2. The investigator certifies to the IRB (via the HIPAA De-identification Certification Form) that all of the following 18 identifiers are removed, and the investigator has no actual knowledge that the remaining information could be used, alone or in combination, to identify a specific subject. This is referred to as

the Safe Harbor method. The 18 identifiers are 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 #'s, fax #'s, electronic mail addresses, social security #'s, medical record numbers, health plan beneficiary #'s, account #'s, certificate/license #'s, vehicle identifiers and serial #'s, license plate #'s, medical device identifiers and serial #'s, Web Universal Resource Locators (URL's), Internet Protocol (IP) address #'s, Biometric identifiers (including finger and voice prints), full face photographic images and any comparable images, and any other unique identifying #, characteristic, or code.

**Use And Disclosure:**

**Use** - sharing within the entity. For example, when members of the covered entity's workforce share IIHI.

**Disclosure** - sharing outside the entity. For example, sharing IIHI with someone who is not a member of the covered entity's workforce.

**POLICY:**

All Upstate investigators who conduct research where individually identifiable health information is used, generated, or disclosed are required to protect their research subjects' right to privacy of their health information, using procedures as outlined in this document. This policy, and these procedures, are *in addition to* provisions already in place under the Common Rule at 45 CFR 46.

**PROCEDURES:**

**The procedures below must be followed in addition to the above IRB policies and Guidelines**

**(A) Notice of Privacy Practice (NOPP):**

Effective April 14, 2003, all subjects must be given a copy of the Upstate Notice of Privacy Practices (NOPP) at the time the consent/authorization form is signed. Their signing of the research consent form will acknowledge receipt of the NOPP.

**(B) Research involving De-identified data:**

One of the methods described must be detailed for assuring that the data are de-identified. The HIPAA De-identification form, available in IRBNet must be completed if the 18 listed identifiers are to be removed to satisfy HIPAA standards.

**The Privacy Rule does not apply to:**

1. De-identified information.
2. Coded information (all 18 identifiers must be either be coded or not used).

3. The code (link) that allows identification of coded information.

**Note:**

1. The code must not use any information from the 18 identifiers, such as initials, re-arranged letters and/or numbers from name, birth date, etc.).

2. Even though the Privacy Rule does not apply to such coded information, the common rule considers some coded information to be indirectly identifiable. Therefore, even if a researcher de-identifies information via coding, a protocol may be required to be submitted to the IRB. The IRB will determine whether or not the research is covered by the common rule and/or the Privacy Rule.

**(C) Research Databases & Registries:**

**Creating a Database/Registry that includes IIHI** – Databases and Registries created for future (unspecified) research are allowed under HIPAA. Depending on the circumstances, an authorization, a waiver of authorization or a data use agreement (if the information is in the form of a limited data set) will be required to assemble the data.

**Permissible uses for the Database/Registry** – Databases/registries may have multiple purposes. For research, the uses are regulated by the activities specified in the authorization, waiver of authorization, or data use agreement. Changes to the goals require new/amended authorizations, waivers, or data use agreements.

**Researcher access to the Database/Registry** – The researcher will need to obtain approval from the IRB to access the information for research purposes. Depending on the circumstances, an authorization, a waiver of authorization or a data use agreement (if the information is in the form of a limited data set) will be required to access the data.

**(D) Research Use Or Disclosure of IIHI Without Subject Authorization:**

1. The IRB can waive the requirement to obtain authorization for use or disclosure of IIHI if one of the following conditions applies:

**(a) The IRB finds and documents that all of the following criteria are addressed and met in the application submission (PI completes a waiver of authorization form):**

- i) The use or disclosure of IIHI for the research involves no more than minimal risk to the privacy of individuals, based on:
  - a. an adequate plan to protect identifiers from improper use
  - b. an adequate plan to destroy identifiers at the earliest opportunity, and
  - c. adequate written assurances that health information will be protected (e.g., not re-used/disclosed to any other person)

or entity except as required by law, for authorized oversight, etc.)

- ii) The research could not practicably be conducted without the waiver or alteration; and
- iii) The research could not be practicably be conducted without access to and use of the health information.

**(b) The proposed use of health information is via a 'limited data set' (PI completes a limited data set form):**

A limited data set (LDS) contains information that is not completely de-identified. A LDS can contain dates of admission and discharge, dates of birth and death, dates of procedures, city, state, zip codes. A LDS must exclude the following direct identifiers: name, street address, telephone/fax numbers, e-mail address, social security number, certificate/license numbers, vehicle identifiers and serial numbers, uniform resource locators and internet protocol addresses, full face photographs and other comparable images, medical record numbers, account numbers, and health plan numbers, device identifiers and serial numbers, biometric identifiers, including finger and voice print.

To use a Limited Data Set, a Data Use Agreement (DUA) must first be in place with the recipient of the information. The Data Use Agreement defines the permissible uses/disclosures of the LDS by the recipient, defines who can use or receive the data, and require the recipient to assure that data will not be re-identified and that individuals will not be contacted. The limited data set and data use agreement will be reviewed and executed by the Upstate Privacy Administrator. The PI should submit a limited data set (LDS) form to the IRB.

**2. Minimum Necessary Requirement**

The amount of information used, disclosed or requested must be limited to the minimum necessary to achieve the stated purpose. This requirement applies when authorization is not obtained.

**3. Accounting for Disclosures Requirement**

With the exception of limited data sets obtained under a data use agreement, disclosures of IIHI without authorization (i.e., a waiver of authorization was granted), made after April 14, 2003 require that:

**All disclosures must be tracked.**

When a subject requests an accounting of disclosures, s/he must be provided with, a list of all individuals or entities to which their IIHI was disclosed without their authorization. The PI must keep track of each instance where s/he has provided an entity outside of Upstate Medical University with a subjects' IIHI without that

subject's authorization on an *Accounting Form or Modified Accounting Form (if 50 or more subjects to be enrolled)*.

The research record must contain an *Accounting Form* for each subject and the researcher(s) must document any disclosures made for which authorization has not been obtained. The *Accounting Form* must be faxed to Clinical Data Services at 464-7781, after each entry.

**In consideration of this accounting requirement, and the associated workload, it is strongly urged that the investigator either obtain an authorization, or utilize a limited data set prior to disclosure of his/her subjects' IHI.**

**(E) Research Use of Health Information with Subject Authorization:**

Under the HIPAA regulations, a patient coming into a doctor's office or hospital for clinical treatment will sign consent, allowing the physician's office (or hospital, etc.) to use or disclose his or her health information for treatment, payment and health care operations purposes.

In the research setting, it is clear that health information could be generated and used or disclosed during the course of a research study. It is also clear that health information could be derived from research activities where the procedure involves a simple blood draw from which genetic information can be obtained. It is thus important to assess the proposed research protocol for the need to access health information, and the potential for producing health information. If either is possible, then the HIPAA regulations will likely apply.

It is important to remember, that subjects can revoke their authorization for use of their health information at any time during the research. However, health information that was obtained prior to when authorization was revoked can continue to be used and disclosed if its inclusion is important to maintain the integrity of the research study. For example, health information could be reported to account for a subject's withdrawal from the study, to be used as part of a marketing application to the FDA, to conduct investigations of scientific misconduct, or to report adverse events.

All research consent documents must include a section titled “**Confidentiality of Records and Authorization to Use/Share Protected Health Information for Research**”. This section should be inserted as the last section in the consent, just prior to the signature section (see **sample consent documents on IRBNet**)

Template language can be found in each sample consent on IRBNet. Follow the instructions (in italics) to make the language study specific. **Subjects must be given a signed copy of the consent/authorization form.**

For studies which include banking or saving specimens for future research; consent language may include requesting permission to bank the specimens only, unless the future use can be specifically stated. **The authorization for banking specimens cannot also serve as the authorization for future unknown uses of the specimens.**

**NOTE:** If, during the course of the research, a disclosure of IIHI is made for which authorization was not obtained, the researcher must record the disclosure on an *Accounting Form*.. The form should be faxed to Clinical Data and filed in the research record.

**(F) Policy Violations:**

Upstate Medical University faculty, staff and students are obligated to report violations of this policy. Such reports will be brought before the privacy board at a convened meeting. The privacy board will make a determination, in consultation with applicable University Officials, to assess whether additional information and/or further investigation is required. The affected departmental Chair and Dean will be copied on all correspondence between the committee and the involved parties. Where violations are apparent, the Privacy officer, in consultation with applicable University Officials, may take immediate corrective action as deemed appropriate, prior to review by the full committee. In addition, other applicable University offices and/or external agencies (e.g., Office of Civil Rights) will be notified as required. **Note that health care providers who violate HIPAA may also be subject to significant criminal and civil penalties.**

**Questions concerning HIPAA regulations can be directed to the Institutional Privacy Officer, Cindy Nappa.**