

**UT Southwestern Medical Center
Human Research Protection Program
Policy, Procedure and Guidance Documents**

Updated November 18, 2019

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE MANUAL

0.0 ABOUT THE HUMAN RESEARCH PROTECTION PROGRAM OFFICE

EFFECTIVE DATE: MAY 30, 2019

I. Overview

- a. The University of Texas Southwestern Medical Center has assured the US Department of Health and Human Services (DHHS) of compliance with DHHS regulations (45 CFR § 46.103) for the protection of human subjects, through an Office of Human Research Protection (OHRP) approved Federalwide Assurance (FWA00005087).
- b. The Director of Human Research Protection Programs serves as the Human Protection Administrator (HPA) and is responsible for maintaining the FWA records and documentation.
- c. The HRPP Office maintains the Federalwide Assurance and IRB membership roster with OHRP.

II. HRPP Office

a. Policy Development

The Director of Human Research Protection Program develops and implements written HRPP policies and procedures under applicable regulations for the protection of human subjects in consultation with the HRPP Steering Committee.

b. Knowledge, Skills and Abilities of HRPPO staff

The Director of the Human Research Protection Program (HRPP) and staff must be familiar with the ethical principles guiding human research; the requirements of federal regulations, applicable state law, the institution's FWA; and, institutional policies and procedures established for the protection of human subjects.

c. HRPPO Responsibilities

- i. Managing IRB operations. This includes all activities necessary to maintain an IRB such as:
 1. Pre-review all submissions to ensure consistency and completeness. The pre-review will also ensure the IRB has enough information to make the required regulatory decisions.
 2. Managing IRB meetings,
 - a. Creating agendas and assigning IRB reviewers
 - b. Assembling and sending IRB materials
 - c. Ensuring quorum will be present and maintained
 - d. Tracking IRB member attendance

3. Manage membership rosters,
 - a. Manage updates to rosters with Institutional Official (IO)
 - b. Send membership letters to members
 - c. Maintain current OHRP membership rosters
 4. Preparation and finalization of IRB minutes
 5. Recording and reporting IRB decisions
 6. Maintaining IRB records
- ii. Managing reviews of research involving reliance on non-UTSW IRBs. This includes responsibilities necessary to ensure research maintains compliance with institutional policies and the UTSW Federalwide Assurance (FWA) responsibilities such as:
1. Establishing and managing all signed IAAs/MOUs and ensuring compliance with the requirements agreed upon by the external IRB and UTSW.
 2. Assuring and warranting that all investigators participating in the approved research are and will remain members of the Institution's staff in good standing and are credentialed and privileged to perform the procedures outlined in the studies.
 3. Assuring that all UTSW investigators comply with the UTSW investigator ethics education requirements and other human research related training/education requirements and policies.
 4. Following the external IRB approval, conducting additional administrative reviews as determined by the UTSW Institutional Official and UTSW policy to include the following:
 - a. Ensuring all other institutional committee reviews and approvals are secured (Subcommittee for Human Use Radiation, Institutional Biosafety Committee, Protocol Review and Monitoring Committee, Laser Committee, etc.)
 - b. Ensuring funding, billing plans, and payments to participants are in place and Medicare coverage analysis are completed, if applicable
 - c. Ensuring the research site is adequate for procedures purposed in the protocol and assessing the potential impact on clinical services
 - d. Ensuring all HIPAA and data security requirements are being met
 - e. Assessing potential Conflict of Interest (COI) disclosures and development of management plans by the COI Committee, if applicable

4. To observe, or have a third party observe, the conduct of the research.
 - ii. In addition, the IRB will review noncompliance and unanticipated problems, In cases where corrective actions is needed, the IRB may take appropriate actions, to include, but not limited to, requiring modifications, determining data collected cannot be used for publication, suspending or terminating approval, requiring additional education, disqualifying investigators from conducting research.
- b. Managing Inappropriate Influence of IRB, IRB Members and HRPP staff

The UT Southwestern Medical Center grants the IRBs the authority to act independently to bind all activities falling under the authority listed above (see Institutional Policy RES-151). All UTSW personnel who become aware of attempts to inappropriately influence the IRB, IRB Members or HRPP Staff are to report such incidents to the Director of Human Research Protection Programs (HRPP), who notifies the Institutional Official (if allegations involve the Director or IO, then the Provost will be notified). The IO in consultation with the Director of Human Research Protection Program and other appropriate institutional officials will evaluate the allegation. If the allegation is validated they will determine the appropriate response and any action required will be taken by at least a department level supervisor. Responses may range from an oral or written reprimand up to and including suspension of the individual from some or all current or future research activities under the review of the UTSW IRBs. The IO may refer the issue for additional institutional action.
- c. Knowledge, Skills and Abilities of IRB Members

The IRB Chairs and members (primary, alternate, and ex officio) must be familiar with the ethical principles guiding human research; the requirements of federal regulations, applicable state law, the institution's FWA; and, institutional policies and procedures established for the protection of human subjects. The IRB as a whole must also have effective knowledge of subject populations and other factors which can potentially contribute to a determination of risks and benefits to subjects and which can impact participants' informed consent.
- d. Removal of IRB Members

Members may be disqualified from the IRB for scientific misconduct, unethical behavior, conflict of interest, or non-compliance with the rules governing the IRB or failure to actively participate. Such concerns are forwarded to the Institutional Official for review and action, as appropriate.
- e. IRB Meetings

IRBs meet regularly to review and act on initial and continuing review, as well as review of requests for modification of approved research, reports on non-compliance or unanticipated problems for all non-exempt human research. The Director of Human Research Protection Program (HRPP) establishes the schedule for meetings. The Director of HRPP, IRB Chair, or Institutional Official may direct or convene additional meetings at any time.
- f. Appeal of IRB Decisions

- i. If a Principal Investigator or other individual/entity has concerns regarding a Designated Reviewer or IRB decision or recommendations for changes in a study, then he/she/they may submit these concerns to the HRPP Office in writing, including a justification for changing the decision. The request may be sent to the reviewer and/or the HRPP Director for final resolution.
- ii. If any individual/entity believes the IRB did not have all necessary documentation or information during the original review, he/she/they may request a review of the appeal by the full IRB. The appeal request must include a memo containing the justification for changing the decision and any supporting documentation or information the IRB did not have during the original review.
- iii. The IRB determination following a review of an appeal is considered final and the individual/entity may not submit an additional appeal.

IV. Affiliated Institution Responsibilities

The UT Southwestern Medical Center IRBs may provide review and continuing oversight of some or all research conducted at affiliated institutions through a valid signed IRB Authorization Agreement Form. Institutions relying on the UTSW IRBs remain responsible for ensuring compliance with the IRB’s determinations and the terms of its OHRP approved FWA, as applicable.

I. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
RES 151- HUMAN RESEARCH PROTECTION PROGRAM

II. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
May 2019	HRPP	New Development

III. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

0.1 POLICY AND PROCEDURE ADDENDUM FOR THE 2018 REQUIREMENTS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

IV. POLICY STATEMENT

- A. This Policy and Procedure addendum to the UT Southwestern Human Research Protection Program Policy, Procedure and Guidance Documents describes the variations in requirements and procedures that the UT Southwestern HRPPO will adhere to for research subject to the revised Common Rule (hereafter referred to as the 2018 Requirements [45 CFR §46]) that is IRB-approved, or determined exempt, on or after January 21, 2019. This also applies to any studies subject to the pre-2018 version of the Common Rule that the UT Southwestern HRPP decides to transition to comply with the new rule. When the research invokes multiple regulatory frameworks (e.g., Common Rule, FDA, HIPAA), all applicable regulations will be applied.
- B. Unless required by the Federal department or agency conducting or supporting the research, or by foreign, state, or local laws or regulations (including tribal law), the UT Southwestern IRB will no longer require submission of, or conduct review of, Federal grant applications or proposals when research is subject to the revised Common Rule.
- C. In accordance with federal and institutional regulations and prior to project implementation, the IRB must approve any undertaking in which a UT Southwestern faculty, staff, or student (i.e., an employee or agent) conducts non-exempt human research. This policy provides information related to determining whether an activity is research involving human subjects and covered by the Federal Regulations, in particular the revised DHHS definitions of “research” and “human subjects.”
- D. Definitions
 - a. The definitions in [10.0 GLOSSARY OF HUMAN RESEARCH TERMS](#) will be applied to research, to exemption determinations, and to evaluations regarding whether a proposed activity is human subjects research approved or evaluated on or after January 21, 2019. In cases where multiple definitions exist, including “*Pre-2018 Common Rule Definition*” and “*2018 Common Rule Definition*,” the “*Pre-2018 Common Rule Definition*” will be applied to all research, to exempt determinations, and to evaluations regarding whether a proposed activity is human subjects research approved or evaluated before January 21, 2019; the “*2018 Common Rule Definition*” will be applied to all research, to exempt determinations, and to evaluations regarding whether a proposed activity is human subjects research approved or evaluated on or after January 21, 2019.
- E. Exemptions
 - a. Research that meets the categories set forth by the federal regulations [45 CFR §46.104(d)] may qualify for exemption. Requests for exemption may be reviewed by a Designated Reviewer (an experienced HRPPO staff member designated by the HRPP Director) or by a member of the IRB designated by the IRB Chair. Exemption determinations may not be made by researchers. Research is exempt from the human

research protection regulations. The principles of respect of persons, beneficence and justice are applied to all research conducted at the UTSW including human research that has been determined to be exempt.

- b. Exemption #2(i) and (ii) for research involving survey or interview procedures or observations of public behavior does not apply to research in children, except for research involving observations of public behavior when the investigator does not participate in the activities being observed. Exemption #2(iii), where identifiable information is obtained and the IRB conducts a limited IRB review, is NOT applicable to research in children. Exemption #3 does NOT apply to research involving children.
- c. Exemptions do not apply to research with prisoners EXCEPT for research aimed at involving a broader subject population that only incidentally includes prisoners.

F. Expedited Review

- a. In order to approve research, the IRB (Expedited Reviewer) shall determine that all required determinations of approval (45 CFR §46.111) are satisfied. For certain exempt categories (2iii, 3i, 7, and 8), limited IRB review will ensure that 45 CFR §46.111(a)(7) has been met.

G. Continuing Review

- a. Unless the UT Southwestern IRB determines otherwise, continuing review of research is not required for research approved on or after January 21, 2019 which meet the following criteria:
 - i. Research eligible for expedited review in accordance with 45 CFR §46.110;
 - ii. Research reviewed by the IRB in accordance with the limited IRB review described in 45 CFR §46.104(d)(2)(iii), (d)(3)(i)(C), or (d)(7) or (8);
 - iii. Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:
 - a. Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
 - b. Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care
- b. The UT Southwestern HRPP will require a status report when continuing review is not required for studies approved via expedited or convened board review and may close studies if the status report is not submitted in a timely manner.

H. Informed Consent Requirements

- a. In addition to the requirements for obtaining informed consent and the consent process described in [3.1 INFORMED CONSENT REQUIREMENTS](#), the following specific requirements for consent, whether written or oral, apply to research subject to the revised Common Rule:
 - i. An investigator shall seek informed consent only under circumstances that provide the prospective subject or the LAR sufficient opportunity to discuss and consider whether or not to participate and that minimize the possibility of coercion or undue influence

- ii. The prospective subject or the LAR must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information
- iii. Informed consent must be appropriately documents in accordance with 45 CFR §46.117
- iv. Except for broad consent:
 - a. Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension
 - b. Informed consent as a whole must present information in sufficient detail relating to the research, and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's or legally authorized representative's understanding of the reasons why one might or might not want to participate.
- b. Broad Consent [45 CFR §46.116(d)]
 - i. Broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens (collected for either research studies other than the proposed research or nonresearch purposes) is permitted under the revised Common Rule. Broad consent is not currently recognized in FDA regulation or guidance.
 - ii. The UT Southwestern IRB may limit or constrain the use of broad consent as appropriate. Any determination where broad consent is not allowed or limited will be communicated as per [8.2 REPORTING POLICY AND PROCEDURE](#).
 - iii. When obtaining broad consent, the general requirements for informed consent described in Section 8.1 apply except as noted.
- c. The UT Southwestern IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject's legally authorized representative, if either of the following conditions are met [45 CFR §46.116(g)]:
 - i. The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or
 - ii. The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.
- d. Unless the requirement for documentation of consent is waived by the IRB, informed consent must be documented by the use of written informed consent form (ICF) approved by the IRB and signed (including in an electronic format) by the subject or the subject's LAR. A written copy must be given to the person signing the ICF.
- e. When UT Southwestern is the prime awardee for a study conducted or supported by a Federal department or agency, one IRB-approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal website after the clinical

trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

- I. Informed Consent Waivers and Alterations
 - a. The IRB may approve an investigator's request to waive or alter the requirement to obtain informed consent if the investigator demonstrates with specificity that the criteria under 45 CFR 46.116(e) and 46.116(f) are met for all studies approved on or after January 21, 2019.
 - b. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.
 - c. An IRB may not approve a request to alter or omit any of the general requirements for informed consent [45 CFR §46.116(a)]
 - d. If a broad consent procedure is used, an IRB may not alter or omit any of the elements described in 45 CFR §46.116(d)
 - e. The revised Common Rule adds a third condition under which an IRB may waive the requirement to obtain a signed informed consent form [45 CFR 46.117(c)(iii)].

V. SCOPE

- A. This policy and procedure applies to:
 - a. all Investigators, the Human Research Protection Program Office and IRB.
 - b. all non-FDA regulated exempt or non-exempt human subjects' research initially approved by the IRB on or after January 21, 2019.
 - c. all non-FDA regulated exempt or non-exempt human subjects' research initially approved by the IRB **prior to** January 21, 2019 and subsequently transitioned fully by the IRB to the Revised Common Rule.

VI. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Determining whether an activity is Human Subjects Research
 - a. The investigator is responsible for making a preliminary decision regarding whether his/her activities meet either (a) the Department of Health and Human Services (DHHS) definitions of both "research" and "human subjects"
 - b. The investigator may contact the HRPPO staff, HRPP Director, or IRB Chair for advice on the application of the federal regulations and UT Southwestern policy.
 - c. The following sequential assessment is used when evaluating a particular activity to determine whether the activity is human research:
 - i. Step 1: Is the activity "Research" according to DHHS regulations?
 - (1) If the activity is part of a systematic investigation (including research development, testing and evaluation); and, is designed to (e.g., the primary purpose) contribute to generalizable knowledge the activity is research. Proceed to step 2.

- (2) If it is either (1) not a systematic investigation, or (2) not contributing to generalizable knowledge, the activity is not “Research” according to DHHS regulations. Go to Step 3 to determine whether the activity is “Human Research” according to FDA regulations in [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#).
- ii. Step 2. The research involves human subjects because:
 - (1) the investigator will obtain information or biospecimens about living individuals; and
 - (2) the investigator will obtain this information or biospecimens through intervention or interaction with those subjects and uses, studies, or analyzes the information or biospecimens; or
 - (3) the information or biospecimens obtained, used, studied, analyzed, or generated by the investigator is both private AND identifiable
 - (4) If the statements 1 AND 2 or 3 are true, the research involves human subjects according to DHHS regulations and requires IRB approval. Go to Step 3 to determine whether the study is human research according to the FDA regulations [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#).
 - (5) If the statements 1, 2 or 3 are false, the research does not involve human subjects according to DHHS regulations. Go to Step 3 to determine whether the study is human research according to the FDA regulations [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#).
 - ii. Summary of “Human Research” determinations (DHHS)
 - (1) If the activity is research and involves human subjects (Step 2, (4)), it is considered human research according to the DHHS and requires IRB approval. (See section F in [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#) for activities considered human research).
 - (2) If the activity is not research (Step 1, (4)), it is considered non-research and does not require IRB approval according to DHHS. (See section G in [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#) for activities considered nonresearch).
 - (3) If the activity is research (Step 1, (1)) and does not involve human subjects (Step 2, (5)), the activity is considered non-human research and does not require IRB approval according to DHHS. (See section H in [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#) for activities considered non-human research)

- b. Investigators will be informed of the HRPPO's determination of whether the proposed activity constitutes research involving human subjects, is non-regulated research or is non-human subjects' research (See [8.2 REPORTING POLICY AND PROCEDURE](#)).

B. Exemptions

- a. Exempt Categories (**Note:** Other than exempt category 6, these categories do not apply to research that is also FDA-regulated):
 - i. (1) Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
 - ii. (2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
 - a. (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
 - b. (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; **or**
 - c. (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an **IRB conducts a limited IRB review** to make the determination required by 45 CFR §46.111(a)(7): *"When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data."*
 - iii. (3) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:
 - a. (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

- b. (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; **or**
- c. (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an **IRB conducts a limited IRB** review to make the determination required by 45 CFR §46.111(a)(7): *"When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data."*

For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that he or she will be unaware of or misled regarding the nature or purposes of the research.

- iv. (4) Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:
 - a. (i) The identifiable private information or identifiable biospecimens are publicly available;
 - b. (ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;
 - c. (iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164 ['HIPAA'], subparts A and E, for the purposes of "health care operations" or "research" as those terms are defined at 45 CFR 164.501 or for "public health activities and purposes" as described under 45 CFR 164.512(b); **or**

- d. (iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for nonresearch activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 et seq.
- v. (5) Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended. (i) Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal website or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.
- vi. (6) Taste and food quality evaluation and consumer acceptance studies:
 - a. (i) If wholesome foods without additives are consumed, **or**
 - b. (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.

Note: Exempt categories 7 & 8 always require limited IRB review and are only available when broad consent will be (or has been) obtained. The UT

Southwestern IRB may limit or constrain the use of broad consent as appropriate. Any determination where broad consent is not allowed or limited will be communicated as per [8.2 REPORTING POLICY AND PROCEDURE](#).

- vii. (7) Storage or maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required by 45 CFR §46.111(a)(8):
 - a. (i) Broad consent for storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens is obtained in accordance with the requirements of 45 CFR §46.116(a)(1) – (4), (a)(6), and (d) (See Sections 8.1 and 8.3);
 - b. (ii) Broad consent is appropriately documented or waiver of documentation is appropriate, in accordance with 45 CFR §46.117 (See Sections 8.6 and 8.7); **and**
 - c. (iii) If there is a change made for research purposes in the way the identifiable private information or identifiable biospecimens are stored or maintained, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
- viii. (8) Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met:
 - a. (i) Broad consent for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with 45 CFR §46.116(a)(1) through (4), (a)(6), and (d) (See Sections 8.1 and 8.3);
 - b. (ii) Documentation of informed consent or waiver of documentation of consent was obtained in accordance with 45 CFR §46.117 (See Sections 8.6 and 8.7);
 - c. (iii) An IRB conducts a limited IRB review and makes the determination required by 45 CFR §46.111(a)(7): *“When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data”* and makes the determination that the research to be conducted is within the scope of the broad consent referenced in 8.i above; **and**
 - d. (iv) The investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

- b. For exempt research subject to limited IRB review, the following criteria for IRB approval shall be applied:
 - i. For exempt categories 2 and 3, the IRB may approve the research when it determines that there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data [45 CFR §46.104(2)(iii) and (3)(iii)]
 - ii. For exempt category 7, the IRB may approve the research when it determines that the following criteria are satisfied:
 - a. Broad consent for storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens is obtained [45 CFR §46.116(a)(1) - (4), (a)(6), and (d)]
 - b. Broad consent is appropriately documented or waiver of documentation is appropriate [45 CFR §46.117]; and
 - c. If there is a change made for research purposes in the way the identifiable private information or identifiable biospecimens are stored or maintained, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
 - iii. For exempt category 8, the IRB may approve the research when it determines that the following criteria are satisfied:
 - a. There are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data; and
 - b. The research to be conducted is within the scope of the broad consent obtained from subjects.

C. Expedited Review

- a. Expedited review of research subject to the 2018 Requirements will be conducted using the procedures listed in [2.1 INITIAL REVIEW OF RESEARCH](#) with the following change:
 - i. The limited IRB review that is required for certain exempt research approved under certain exempt categories [45 CFR §46.104(d)(2)(iii), (d)(3)(i)(C), and (d)(7) and (8)]
 - ii. Continuing review of research which qualified for expedited review but for which the IRB determines and documents that continuing review is required
- b. When an determination is made on a study eligible for expedited review under 45 CFR §46.110(b)(1)(i) that the study is more than minimal risk, this rationale will be documented.

D. Continuing Review

- a. The UT Southwestern IRB may determine and document that continuing review is required for any research protocol that falls within the above criteria. For example, the IRB may determine and document that continuing review is required when:
 - i. Required by other applicable regulations (e.g., FDA);

- ii. The research involves topics, procedures, or data that may be considered sensitive or controversial;
 - iii. The research involves particularly vulnerable subjects or circumstances that increase subjects' vulnerability;
 - iv. An investigator has minimal experience in research or the research type, topic, or procedures; and/or
 - v. An investigator has a history of noncompliance
- b. The UT Southwestern IRB will require a status report when continuing review is not required for studies approved via expedited or convened board review and may close studies if the status report is not submitted in a timely manner.
- c. Reminders for the status report are generated by eIRB and automatically sent to the PI (and a coordinator, if designated) before the IRB approval period expires (e.g., approximately eight weeks, six weeks and four weeks prior to expiration). The PI is responsible for responding to those requests in a timely manner.
- d. The PI is responsible for completing the application for the status report according to the instructions in eIRB.
- e. The PI must submit status reports (approximately one month prior to expiration) for studies where continuing review is not required as long as the research:
 - i. Remains open to enroll new subjects; or
 - ii. Continues to carry out research procedures or interventions; or
 - iii. Remains active for long-term follow-up (even when the research is permanently closed to enrollment and all subjects have completed all research-related interventions); and/or
 - iv. Requires analysis of data with identifiers; or
 - v. For research externally supported, the project is still being funded locally.
- f. See [1.4. STUDY CLOSURE AND INACTIVATION](#) for details on circumstances in which a PI may close a study.
- g. Upon receipt of the CR materials, the HRPPO staff screen the application to determine whether the study is eligible for expedited review and to determine whether the submission is complete.
- h. If the CR submission includes information to indicate changes were made without IRB approval the HRPPO staff flag the study for further analysis and consult the HRPP Director (HRPPD), or IRB Chair, for guidance. The HRPPO staff may contact the investigator to clarify the statement, request submission of a report of non-compliance or other appropriate actions. If the information indicates possible noncompliance, the HRPPO staff requests submission of a reportable event and follows guidance provided in [9.3 NONCOMPLIANCE REVIEW](#).
- i. The HRPPO staff screen for Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and/or Family Educational Rights to Privacy Act (FERPA) concerns.
- j. The IRB may only use the status report review process for studies which meet the requirements where continuing review is not required as above
- k. The HRPPD, IRB Chair, or designee serves as the Designated Reviewer for status reports.
- l. Review Outcomes of status reports
 - i. Accepted – Acceptance indicates that the status report has no issues and that the research can continue for another year. Designated Reviewer has concluded that the research (including the research plan and consent forms)

continues to meet the federal criteria for approval. Designated Reviewer acceptance verifies that the Designated Reviewer agrees with the information/materials submitted for continuation of the protocol and/or specific findings described in the CR report by the PI.

- ii. Conditional Acceptance – Conditional acceptance indicates that the status report has been accepted. The investigator must submit minor revisions or clarifications to the status report, consent, or any other applicable documents identified during the review. The submission of revisions required must be provided within the time period specified (usually about 30 days).
 - a. The HRPPO staff track the status of response to conditions. If a response is not received within a reasonable time period (with the exception of extenuating circumstances), the HRPPO staff forwards the status report to the Designated Reviewer for consideration of closure of the study.
 - b. The PI responds to each of the conditions and sends the response to the HRPPO. The Designated Reviewer may forward the responses to the IRB for additional review, request additional information from the investigator, or accept the response.
 - iii. Defer to IRB – If significant concerns are identified during the review of a status report, the Designated Reviewer may defer review of the status report to the IRB (expedited or convened). The Designated Reviewer will provide the IRB with the reasons for deferring to the IRB.
- m. Duration of approval
- i. The Designated Reviewer determines the length of approval, as appropriate to the degree of risk but not longer than one year from the date the study status report was accepted or conditionally accepted (unless anniversary date is used, see below).
 - ii. The Designated Reviewer may set a shorter approval period for:
 - a. high risk protocols or protocols with unanticipated problems (UPIRSOs);
 - b. protocols with high risk/low potential benefit ratios;
 - c. research with a history of noncompliance issues; or
 - iii. Use of anniversary dates when a status report is determined to occur annually – status reports accepted or conditionally accepted for one year may retain the current status report due date (day and month) as the date by which the next status report must be reviewed (status report due date), if the acceptance/conditional acceptance occurs within 30 days of the status report due date.
- n. The Designated Reviewer may close any study where a status report has not been submitted after the status report due date has passed. The Designated Reviewer notifies the PI in writing of that determination.

E. Informed Consent Requirements

- a. In addition to the elements of informed consent described in [3.1 INFORMED CONSENT REQUIREMENTS](#), the following elements are required for research subject to the revised Common Rule:
 - i. Basic Elements
 - a. Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject

or legally authorized representative in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension

- b. One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens [45 CFR §46.116(b)(9)]:
 - a. A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or
 - b. A statement that the subject's information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.
- ii. Additional Elements
 - a. A statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit
 - b. A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions
 - c. For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen)
- b. Elements of Broad Consent
 - i. The following elements of broad consent [45 CFR §46.116(d)] shall be provided to each subject or the subject's LAR:
 - a. A description of any reasonably foreseeable risks or discomforts to the subject;
 - b. A description of any benefits to the subject or to others which may reasonably be expected from the research;
 - c. A statement describing the extent, if any, to which confidentiality of records identifying the subject must be maintained;
 - d. 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;
 - e. For research involving biospecimens, a statement that the subject's biospecimens (even if identifiers are removed) may be used for

- commercial profit and whether the subject will or will not share in this commercial profit;
- f. For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen);
 - g. A general description of the types of research that may be conducted with the identifiable private information or identifiable biospecimens. This description must include sufficient information such that a reasonable person would expect that the broad consent would permit the types of research conducted;
 - h. A description of the identifiable private information or identifiable biospecimens that might be used in research, whether sharing of identifiable private information or identifiable biospecimens might occur, and the types of institutions or researchers that might conduct research with the identifiable private information or identifiable biospecimens;
 - i. A description of the period of time that the identifiable private information or identifiable biospecimens may be stored and maintained (which period of time could be indefinite), and a description of the period of time that the identifiable private information or identifiable biospecimens may be used for research purposes (which period of time could be indefinite);
 - j. Unless the subject or legally authorized representative will be provided details about specific research studies, a statement that they will not be informed of the details of any specific research studies that might be conducted using the subject's identifiable private information or identifiable biospecimens, including the purposes of the research, and that they might have chosen not to consent to some of those specific research studies;
 - k. Unless it is known that clinically relevant research results, including individual research results, will be disclosed to the subject in all circumstances, a statement that such results may not be disclosed to the subject; and
 - l. An explanation of whom to contact for answers to questions about the subject's rights and about storage and use of the subject's identifiable private information or identifiable biospecimens, and whom to contact in the event of a research-related harm.
- ii. Investigators must include information regarding the circumstances under which broad consent will be obtained, the proposal for tracking of responses, and the proposed consent form(s) (or oral script if a waiver of documentation of consent is sought) and any other consent materials (e.g., information sheet, audiovisual materials, etc.) in their submission to the IRB. The UT Southwestern IRB will review the information provided with the aid of a checklist to ensure that all requirements are satisfied. The outcome of the IRB's review will be

communicated to the investigator in writing following the procedures described in [8.2 REPORTING POLICY AND PROCEDURE](#).

- iii. When investigators propose research involving the use of identifiable private information and/or identifiable biospecimens research for which broad consent was obtained, the investigators must include documentation of the IRB approval for the storage or maintenance of the information or specimens and a copy of the consent form and/or other materials. The UT Southwestern IRB will review the information provided with the aid of a checklist to ensure that all requirements are satisfied. The outcome of the IRB's review will be communicated to the investigator in writing following the procedures described in [8.2 REPORTING POLICY AND PROCEDURE](#).

F. Informed Consent Waivers and Alterations

a. Waiver Criteria

- i. Waiver or Alteration of Informed Consent for Non-FDA Regulated Studies determined to be public benefit or service programs

- a. The IRB may also waive the requirement to obtain informed consent or alter some of the elements if the IRB finds and documents (under 45 CFR §46.116(e)) that the research or demonstration project is to be conducted by or is subject to approval of state or local government officials and is designed to study, evaluate or examine:

- a. public benefit or service programs; or
- b. procedures for obtaining benefits or services under those programs; or
- c. possible changes in or alternatives to those programs or procedures; or
- d. possible changes in methods or levels of payment for benefits or services under those programs; AND
- e. The research could not practicably be carried out without the waiver or alteration.

- ii. Waiver or Alteration of Informed Consent for Non-FDA Regulated Studies

- a. The IRB may also waive the requirement to obtain informed consent or alter some of the elements if the IRB finds and documents (under 45 CFR §46.116(f))

- a. The research involves no more than minimal risk to the subjects;
- b. The research could not practicably be carried out without the requested waiver or alteration;
- c. If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format;
- d. The waiver or alteration will not adversely affect the rights and welfare of the subjects; and
- e. Whenever appropriate, the subjects or LARs will be provided with additional pertinent information after participation.

- iii. Waiver of Documentation of Informed Consent - Federal regulations permit an IRB to waive the documentation requirements for obtaining informed consent under special circumstances. Waiver of documentation of informed consent is not necessary when informed consent has been waived by the IRB.
 - a. The IRB may waive the documentation requirements to obtain a signed consent if:
 - a. The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject must be asked whether the subject wants documentation regarding the research and the participant’s wishes will govern; or
 - b. The research presents no more than minimal risk of harm to participants and involves no procedures for which written consent is normally required outside of the research context
 - c. The subjects or LARs are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects, and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

VII. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

VIII. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

IX. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
December 2018	HRPP	New Policy Development

X. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

1.1 RECEIVING, ROUTING, AND ADMINISTRATIVE REVIEW OF IRB SUBMISSIONS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: July 1, 2018

XI. POLICY STATEMENT

- G. All exempt and non-exempt research submissions are submitted in the electronic IRB application system (eIRB).
- H. Submissions are routed to appropriate HRPPO staff, and processed by HRPPO staff in preparation for administrative review, expedited review, or convened IRB review.
- I. UT Southwestern IRBs maintain a system of HRPPO pre-review and scientific & ethical pre-review (as applicable) prior to the review by the expedited reviewer or convened IRB (see [2.1. INITIAL REVIEW OF RESEARCH](#))

XII. SCOPE

- B. This policy and procedures applies to the Human Research Protection Program Office (HRPPO) and UT Southwestern convened IRB's.

XIII. PROCEDURES FOR POLICY IMPLEMENTATION

- A. This procedure starts when a submission to the IRB (new application, modification, continuing review, reportable event or notice of study closure) is submitted to eIRB.
- B. This procedure ends when any of the following are true:
 - The submission is determined to not require IRB review and accepted by the administrative reviewer
 - The submission is presented to the Expedited Reviewer
 - The submission is presented to the Convened IRB
- a. A daily list of all new/unattended submission items in eIRB are reviewed and assigned to the appropriate teams (administrative, expedited or convened) in an equitable fashion
- b. HRPPO pre-review
 - i. The HRPPO Staff will conduct a pre-review using the appropriate checklist for the submission.
 - ii. The HRPPO Staff determines whether the submission includes all information required and requests additional information, if needed, from the investigator, to assist the Reviewer or IRB in making a determination
 - iii. The HRPPO staff screen the IRB application to ensure coordination with other university committees or to ensure compliance with pertinent federal requirements. The communication is outlined in the [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#). Examples of screening include, but are not limited to, the items listed below

1. If PI indicates the research is exempt from IND in the application, the appropriate sections of the eIRB application must be completed. If the investigator omits this information, the HRPPO staff may still continue the pre-review process but request the investigator to send the missing information. In general, the HRPPO staff will not forward the study to a convened meeting without this information.
2. If the research involves radiation for research purposes, or the investigator otherwise indicates that Radiation Safety Office (RSO) approval is necessary, the information about the radiation must be included appropriate sections of the eIRB application. The HRPPO staff checks to ensure that the PI has submitted the materials. HRPPO staff will not schedule the application for review and may return the application to the PI if these materials are missing. The investigator may not have obtained RSO approval however, HRPPO staff may check with the Radiation Safety Office (RSO) for advice.
3. For applications indicating one or more of the investigators, employees who are responsible for the design, conduct, or reporting of activities, or their immediate family members have declared a possible conflict of interest, the HRPPO staff will follow the COI review checklist. If a conflict of interest management plan is present, the HRPPO staff ensure all requirements are met such as screening the consent form for recommended conflict of interest disclosure language.
4. The HRPPO staff screen the application to determine whether the study includes off-site research issues and refers to the procedures outlined in the [2.8 COLLABORATIVE RESEARCH INVOLVING EXTERNAL INVESTIGATORS/INSTITUTIONS REVIEWED BY UTSW IRB](#).
5. If the application indicates the research involves prisoners, the HRPPO staff ensures the application contains information about the prisoner population and assigns a prisoner representative as an additional reviewer.
6. The HRPPO staff screen the application to see whether the study involves one of the institutional affiliate hospitals. If so, the appropriate institutional research offices may be contacted and included in the HRPPO pre-review process. The institutional research offices staff review is focused on institutional issues (e.g., personnel credentialing, privacy, and institutional policies).
7. If the investigator indicates that the research involves an investigational new drug (IND) or investigational device exemption (IDE), the HRPPO staff confirm the validity of the IND or IDE number by ensuring that a copy (containing the number) of the detailed protocol from the sponsor (may not use the investigator brochure) are part of the protocol materials. Official FDA documents containing the number are also acceptable.

8. HRPPO staff screen the application to determine whether research involves vulnerable subjects and/or sensitive types of research/procedures (e.g., HIV screening). If so, the HRPPO staff notifies the IRB Chair, Expedited Reviewer or Regulatory Specialist who determines whether a consultant needs to be included in the review.
 9. The HRPPO staff also screen the application for Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and Family Educational Rights and Privacy Act (FERPA) issues. If the PI includes a HIPAA authorization form or waiver or if there are any HIPAA or FERPA concerns, the HRPPO staff annotates this for the reviewer in the eIRB system for expedited reviews or on the IRB Reviewer Worksheet for convened IRB reviews.
- iv. The HRPPO staff ensure the submitted forms are on current IRB templates or on the appropriate previously approved forms.
 - v. HRPPO staff screen the informed consent documents to confirm the required elements of consent are included. The HRPPO staff will work with the PI/Study Coordinator (SC) to obtain corrected consent form changes(s).
 - vi. The HRPPO staff screen for HIPAA issues and follow the HIPAA privacy rule and UT Southwestern Privacy Policies (as appropriate).
 - vii. Verify information in the eIRB system is correct and update information as necessary.
 - viii. If requested by the IRB Chair, Regulatory Specialist or an IRB reviewer, the HRPPO Staff will send the protocol for a Scientific and Ethical Review or Review by Chair.
 1. Scientific/Ethical pre-reviewers complete their reviews and communicate to the HRPPO by a designated deadline
 - ix. The HRPPO office attempts to make all corrections on the electronic documents; however, the PI/SC may be asked to make substantive changes/additions. If items are missing or require clarification, HRPPO staff will correspond with PI/SC.
 - x. If the PI submits a minor modification with a continuing review (CR) application, the HRPPO staff and the IRB follow procedures outlined in the Continuation Review policy, and the HRPPO staff process the modification as part of the CR (See [2.2. CONTINUING REVIEW OF RESEARCH](#)).
 - xi. The HRPPO staff alert the IRB if changes in the consent form(s) or other pending actions are necessary and HRPPO was unable to obtain the corrected document prior to the IRB review. The IRB may then make a stipulation that the changes be made.
 - xii. After the pre-review is complete, HRPPO staff will modify eIRB to route the submission for review as appropriate.
- c. Routing for Review (i.e., Administrative, Expedited, or Convened IRB Review)
- i. For Initial Review and Modifications, the PI requests the type of review by submitting the appropriate application and, as applicable, checking the

appropriate section of the eIRB Smart Form (e.g., Modification Smart Form, Study application, etc.). The HRPPO staff will confirm or modify the type of review.

- ii. For Continuing review, the HRPPO staff will route to either Expedited or Convened IRB review according to the risk level, use of investigational test articles, and any remaining activities on the research study (See [2.2. CONTINUING REVIEW OF RESEARCH](#))
- iii. If the submission qualifies for administrative review (non-human/non-regulated research, Exempt new protocols), the HRPPO will review the submission and make the final acceptance determination.
- iv. Administrative modifications may be reviewed and accepted by the HRPPO staff.
- v. If determined to be eligible for expedited review after the administrative pre-review, the submission is routed through the eIRB system to the Expedited Reviewer
 1. HRPPO staff will document unresolved issues and notes to be forwarded to the Expedited Reviewer in eIRB
 2. Initial Exempt or Expedited Studies may receive an appointment with an appropriate reviewer if determined necessary by the HRPPO pre-reviewer or Expedited Reviewer
- vi. If determined to require review by a convened meeting of the IRB (full board review) after the administrative review, the submission is routed through eIRB for the next available IRB meeting.
 1. HRPPO staff will document unresolved issues and notes to be forwarded to the Primary Reviewer
 2. The HRPPO staff develops, maintains, and revises the IRB meeting schedule, as appropriate. The schedule of meetings is available on the IRB website or by request.
 3. The HRPPO staff creates an agenda, compiles review materials, and notifies the IRB Members and other appropriate individuals scheduled to attend the convened meeting (including alternate members as appropriate) that the materials are available on in eIRB. If special circumstances require adding a protocol to the agenda, the HRPPO staff modifies the agenda in eIRB and distributes the applicable application documents (via eIRB) to IRB members and appropriate individuals prior to the meeting. In addition, the member assigned as the primary reviewer of the study receives the additional materials.
 4. For each meeting, the HRPPO staff generates the agenda in eIRB. The HRPPO staff review the agenda for accuracy and completeness before distributing it to the IRB
 5. IRB members receive access to all appropriate study materials, agendas and reviewer assignments with sufficient time for their review at least 5

days prior to scheduled IRB meetings to be prepared to participate in deliberations and voting.

- C. After receiving, processing, reviewing and routing for review, the following polices are followed: [2.1. INITIAL REVIEW OF RESEARCH](#), [6.2 IRB APPROVAL OF RESEARCH](#), [6.3 CONDUCT OF FULL BOARD MEETINGS](#), [8.2 REPORTING POLICY AND PROCEDURE](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
July 2018	HRPP	Revision to RSO (dissolved SHUR)
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

1.2 DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. In accordance with federal and institutional regulations and prior to project implementation, the IRB must approve any undertaking in which a UT Southwestern faculty, staff, or student (i.e., an employee or agent) conducts non-exempt human research. This policy provides information related to determining whether an activity is research involving human subjects and covered by the Federal Regulations. In general, any activity that meets either (a) the Department of Health and Human Services (DHHS) definition of both “research” and “human subjects” or (b) the Food and Drug Administration (FDA) definitions of both “clinical investigation” and “human subjects” is considered human research and requires review and approval by the UTSW IRB.
- B. Newborn Screening Blood Spots. The exception to the DHHS and FDA definitions of human subjects’ research as described above are Newborn Screening Blood Spots being requested for research
 - 1. [Texas Health & Safety Code Sec. 33.018](#)
 - a) a) The use of de-identified blood spots requires review by Texas Department of State Health Services (DSHS) Commissioner designees and by the DSHS IRB (regardless of funding).
 - 2. [H.R. 1281 \(113th\): Newborn Screening Saves Lives Reauthorization Act of 2014](#)
 - a) Federally funded research using newborn dried spots is considered human subjects’ research regardless of whether the specimens are identifiable.
 - b) The IRB may not approve alterations or waivers of informed consent under 45 CFR 46.116(c) and 116(d) for federally funded research involving newborn dried blood spots.

II. SCOPE

- A. This procedure applies to all Investigators, The Human Research Protection Program Office (HRPPO) and IRB. Summary of responsibilities include:
- B. It is the responsibility of each investigator to seek IRB approval prior to initiation of any non-exempt research involving human subjects or before conducting any clinical investigation.
- C. The investigator is responsible for making a preliminary decision regarding whether his/her activities meet either (a) the Department of Health and Human Services (DHHS) definitions of both “research” and “human subjects” or (b) the FDA definitions of both “clinical investigations” and “human subjects”. The “Non-Human Research” and “Non-Regulated Research” worksheets are available to guide the investigator in making this decision.
- D. The investigator may contact the HRPPO staff, HRPP Director, or IRB Chair for advice on the application of the federal regulations and UT Southwestern policy.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Any non-exempt research involving human subjects that is being conducted without IRB approval may be considered serious non-compliance in accordance with [9.3 NONCOMPLIANCE REVIEW](#) and may jeopardize an investigator's ability to receive IRB approval to conduct research involving human subjects in the future.
- B. The following sequential assessment is used when evaluating a particular activity to determine whether the activity is human research:
1. **Step 1:** Is the activity "Research" according to DHHS regulations?
 - (1) If the activity is part of a systematic investigation (including research development, testing and evaluation); and, is designed to (e.g., the primary purpose) contribute to generalizable knowledge the activity is research. Proceed to step 2.
 - (2) If it is either (1) not a systematic investigation, or (2) not contributing to generalizable knowledge, the activity is not "Research" according to DHHS regulations. Go to Step 3 to determine whether the activity is "Human Research" according to FDA regulations.
 2. **Step 2.** The research involves human subjects because:
 - (1) the investigator will obtain data about living individuals; and
 - (2) the investigator will obtain this data through intervention or interaction with those subjects; or
 - (3) the information obtained by the investigator is both private AND identifiable
 - (4) If the statements 1 AND 2 or 3 are true, the research involves human subjects according to DHHS regulations and requires IRB approval. Go to Step 3 to determine whether the study is human research according to the FDA regulations.
 - (5) If the statements 1, 2 or 3 are false, the research does not involve human subjects according to DHHS regulations. Go to Step 3 to determine whether the study is human research according to the FDA regulations.
 3. **Step 3:** Is the activity "Human Research" according to FDA regulations?
 - a) Criterion 1. The activity involves an FDA regulated test article because at least one of the statements below is true:
 - (1) the activity involves the use of a drug, other than the use of a marketed drug in the course of medical practice; or
 - (2) the activity involves the use of a device to evaluate safety or effectiveness of that device; or
 - (3) data from the activity will be submitted to, or held for inspection by, the FDA in support of a marketing or research application for an FDA-regulated product.
 - (4) If any of the above are true the activity involves an FDA regulated test article. Proceed to criterion 2.
 - (5) If none of the above are true the activity does not involve an FDA regulated test article. The activity is not human research according to FDA regulations (See section G below for activities not considered research)
 - b) Criterion 2. The activity involving an FDA-regulated test article involves human subjects because at least one of the statements below is true:

- (1) the test article will be used on one or more humans; or
 - (2) the data obtained from controls will be submitted to, or held for inspection by the FDA in support of a marketing or research application for an FDA-regulated product; or
 - (3) the data obtained from use of a device on tissue specimens will be submitted to, or held for inspection by, the FDA in support of a marketing application or research application for an FDA regulated product.
 - (4) If any of the above are true, the activity involves human subjects according to FDA regulations and requires IRB approval.
 - (5) If all of the above are false, then the activity does not involve human subjects according to FDA regulations.
4. Step 4: Summary of “Human Research” determinations (DHHS & FDA)
- a) DHHS
 - (1) If the activity is research and involves human subjects (Step 2, (4)), it is considered human research according to the DHHS and requires IRB approval. (See section F below for activities considered human research).
 - (2) If the activity is not research (Step 1, (4)), it is considered non-research and does not require IRB approval according to DHHS. (See section G below for activities considered nonresearch).
 - (3) If the activity is research (Step 1, (3)) and does not involve human subjects (Step 2, (5)), the activity is considered non-human research and does not require IRB approval according to DHHS. (See section H below for activities considered non-human research)
 - b) FDA
 - (1) If the activity involves an FDA regulated test article (Step 3, criterion 1(4)) and involves human subjects (Step 3, criterion 2(4)), it is considered human research according to the FDA and requires IRB approval. (See section F below for activities considered human research).
 - (2) If the activity does not involve an FDA regulated test article (Step 3, Criterion 1 (5)), it is not considered human research according to the FDA and may be considered either non-research or non-human research (refer to Step 4(a) for determination) and does not require IRB approval. (See section G and section H below for activities which do not require IRB approval)
5. Step 4: Funding – if UT Southwestern or an affiliated institution receive a direct federal (DHHS) award to conduct human subjects’ research it is considered human research according to DHHS and requires IRB approval.
- a. This is true even where all activities involving human subjects are carried out by a non-UTSW entity (e.g., subcontractor or collaborator)
 - b. Examples of research funding from the Department of Health and Human Services (DHHS):
 - (1) Agency for Healthcare Research and Quality (AHRQ);
 - (2) Centers for Disease Control and Prevention (CDC);
 - (3) National Institutes of Health (NIH)
6. Investigators will be informed of the HRPPO’s determination of whether the proposed activity constitutes research involving human subjects, is non-regulated research or is non-human subjects’ research (See [8.2 REPORTING POLICY AND PROCEDURE](#)).

- F. The following are examples of human subject research studies that must be reviewed and approved by the UTSW IRB.
1. Masters thesis/Doctoral dissertation: graduate work which involves research on human subjects or a clinical investigation and results in a thesis or dissertation.
 2. Pilot studies: pilot studies involving human subjects are considered human subject research and require IRB review.
 3. Clinical research: involves research to increase scientific understanding about normal or abnormal physiology, disease states or development and research to evaluate the safety, effectiveness or usefulness of a medical product, procedure, or intervention. Vaccine trials, medical device or drug studies and cancer research are all types of clinical research.
 4. Behavioral and Social Sciences Research: focuses on individual and group behavior, mental processes, or social constructs and usually generates data by means of surveys, interviews, observations, studies of existing records, and experimental designs involving exposure to some type of stimulus or environmental intervention.
 5. Epidemiological Research: focuses on health outcomes, interventions, disease states and conclusions about cost-effectiveness, efficacy, efficiency, interventions, or delivery of services to affected populations. This research may be conducted through surveillance, observation monitoring, and reporting programs. Other methods are retrospective review of medical, public health and/or other records.
 6. Human Genetic Research: includes studies such as pedigree studies, positional cloning studies, gene transfer research, longitudinal studies to associate genetic conditions with health, health care or social outcomes and gene frequency studies.
 7. Repository or Bank: includes collecting or storing human specimens or data for future use in research.
- G. The following activities are generally not considered “research” and do not need IRB approval:
1. Health surveillance. Health surveillance is an ongoing part of the medical care and public health care functions closely integrated with timely dissemination of these data to those responsible for preventing and controlling disease or injury (may include emergent or urgently identified or suspected imminent health threats to the population to document the existence and magnitude).
 2. Routine Quality Improvement (QI) means systematic, data-guided activities designed to bring about immediate, positive changes in the delivery of health care in particular settings. QI involves deliberate actions to improve care, guided by data reflecting the effects of local care (e.g., types of practical problem solving; an evidence-based management style; the application of science of how to bring about system change; review of aggregate data at the patient/provider/unit/ organizational level to identify a clinical or management change that can be expected to improve care).
 3. Medical quality assurance This refers to activities particular to an institution’s Quality Assurance (QA) program, such as those activities protected from disclosure as part of its confidential medical quality-assurance program or other equivalent programs.
 4. Program evaluation This refers to assessments of the success of established programs in achieving objectives when the assessments are for the use of program managers, for example, a survey to determine if program beneficiaries are aware of the availability of program services or benefits. [Note: Non-research evaluation is generally designed to assess or improve the program or service rather than to generate knowledge about a disease or condition.]

5. Customer satisfaction surveys: This refers to surveys of program users to obtain feedback for use by program managers. This is similar to program evaluation. The purpose of these surveys is to improve a specific service or program or develop new services or programs under the control of the individual/organization obtaining the information and not to conduct research.
 6. Class Projects: academic projects or student assignments involving collection of data from human subjects when the data is used solely for the purpose of teaching course content (e.g., to teach proficiency in performing certain tasks or using specific tools or methods) and not intended to be used to develop or contribute to generalizable knowledge using the information collected as part of the class project.
 7. Case Reports: use of medical information collected from a clinical activity rather than a research activity and presented on no more than three (3) patients. Case reports are generally done by retrospective review of the medical record and highlights a unique treatment, case or outcome. The examination of the case is usually not systematic and there is usually no data analysis or testing of a hypothesis. Investigators must ensure that the HIPAA privacy rules are followed with respect to using or accessing PHI (a HIPAA Authorization or waiver may be required).
 8. Community Outreach: The primary intent of research is to generate or contribute to generalizable knowledge. The primary intent of non-research community outreach activity is to prevent or control disease or injury and improve health, or to improve an ongoing community outreach program or service. Knowledge may be gained in any community outreach endeavor designed to prevent disease or injury or improve a program or service. In some cases, that knowledge may be generalizable, but the primary intention of the endeavor is to benefit patients participating in an outreach health program or a population by controlling a health problem in the population from which the information is gathered.
 9. Biography or oral history of a single individual: research involving a single individual is not generalizable knowledge. (see precautions in case reports)
 10. Publicly Available Data: research involving publicly available information (e.g., census data, labor statistics) does not constitute human research.
- H. The following research is generally considered “non-human research” and do not need approval:
1. Repository Research, Tissue Banking, and Databases: research limited to obtaining stored data or specimens from a repository only if the investigator cannot readily ascertain the identity of the subject from whom the data or materials originated.
 2. Anonymous pre-existing Data Sets or Specimens: anonymous pre-existing data or specimens (anonymous materials are those with no personally identifiable information contained in either the original data or attached to the original specimen).
 3. Coded pre-existing or coded prospective data or specimens: if
 - 1 the private information/specimens were not/will not be collected specifically for the currently proposed research through an interaction or intervention with living individuals, or
 - 2 the investigator(s) never obtains identifiable data/specimens because:
 - a the holder of the key to decipher the code, destroys the key before the data is provided to the investigator, or
 - b the investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, or until the individuals are deceased; or

- c there are laws or IRB-approved written policies for a repository/data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Statement regarding addendum to comply with revised Common Rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM POLICY AND PROCEDURE

1.3 EXEMPT REVIEW OF RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. Research that meets the categories set forth by the federal regulations [45 CFR 46.101(b); 21 CFR 56.104(d); 32 CFR 219.101(b)] may qualify for exemption. This procedure documents the requirements for determining an exemption from Human Subjects research regulations
- B. Exempt research is exempt from IRB review; therefore, requests for exemption may be reviewed by a Designated Reviewer (an experienced HRPPO staff member designated by the HRPP Director) or by a member of the IRB designated by the IRB Chair.
- C. Exemption determinations may not be made by researchers
- D. Research is exempt from the human research protection regulations
- E. Ethical Principles Relevant to Exempt Research. The principles of respect of persons, beneficence and justice are applied to all research conducted at the UTSW including human research that has been determined to be exempt.

II. SCOPE

- A. This policy and procedure applies to all Investigators, the Human Research Protection Program Office and IRB.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Submission and Screening
 - 1. The PI makes a preliminary determination to submit a study for exempt review based on an assessment of the protocol establishing that it falls into one or more of the categories specified in the federal regulations.
 - 2. The PI submits a completed Exemption Application to the HRPPO via eIRB. Instructions for preparing the application are available on the IRB website. The investigator may call the HRPPO with questions.

3. Upon receipt of the application, the study is in-processed and reviewed for completeness and accuracy per the Receiving, Routing and Administrative Review of Submission Policy and Procedure.
4. The HRPPO staff will route the application to an experienced member of the HRPPO staff or a designated member of the IRB
5. If it is clear to the HRPPO staff that the application does not meet the criteria for exempt review, the HRPPO staff contacts the PI and recommends resubmitting either a non-research, non-human research, expedited or full board application. An IRB Expedited Reviewer is generally consulted.

B. HRPPO Exempt Review

1. The Designated Reviewer receives the exempt application materials.
2. The Reviewer is responsible for reviewing the application to determine that all of the research procedures fit one or more of the exemption categories specified in the federal regulations. The reviewer may request additional information from the PI to aid in providing clarifications where necessary. The reviewer ensures that the research meets ethical principles and standards for protecting research subjects. The Reviewer uses eIRB to note the results of the review.
3. To be determined exempt, all of the following must be true. The research must:
 - a. Present no more than minimal risk, and
 - b. For research funded by HHS or DoD, it must not involve prisoners as participants, and
 - c. Not be subject to FDA regulations (“FDA regulated research”) – category 1 – 5 only, and
 - d. For research funded by HHS, DoD or ED, it must not involve children under category 2(b) unless the research involves observations of public behavior and the investigators do not participate in the activities being observed.
4. The research must also fall within one or more of the categories below:
 - a. **Category 1** - Research conducted in established or commonly accepted educational settings, involving normal education practices, such as:
 - i. Research on regular or special educational instructional strategies, or
 - ii. Research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
 - b. **Category 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 subjects' 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, insurability or reputation.

- c. **Category 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 category D.2. above, 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.
- d. **Category 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. To be eligible for Category 4, the data, records, and/or specimens must be both existing and recorded deidentified (unless publicly available) according to the following definitions:
 - i. **Existing** – research data or specimens are on the shelf/in the records when the research is under IRB review. For example:
 - a. IRB approval is received on June 1, 2017. The data will be gathered from medical records for treatment visits from January 1, 2010 through May 1, 2017. This is existing.
 - b. IRB approval is received on June 1, 2017. The data will be gathered from medical records for diagnosis between January 1, 2010 through May 1, 2017. Laboratory values to determine outcomes will be collected through December 31, 2017. This is both prospective and existing. This is not eligible for exempt review.
 - ii. **Recorded deidentified** – recording data without direct identifiers (i.e., name, MRN, etc.). Subject codes may not be assigned if a separate key will be kept maintaining the link between the code and the identity of the subjects. Cases may be assigned numbers/codes as long as there is **no possibility** for the investigator to reasonably ascertain the identity of the subjects.
- e. **Category 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. The projects conducted pursuant to specific federal statutory authority such as programs under the Social Security Act, or other federal statutory public benefit or services 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.
 - v. Projects for which there is no statutory requirement for IRB review;

- vi. Projects that do not involve significant physical invasions or intrusions upon the privacy interests of subjects;
 - vii. Authorization or concurrence by funding agencies that exemption from IRB review is acceptable.
 - f. **Category 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 FDA or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.
- 5. Criteria used to determine that participants are protected in Exempt Research
 - a. **Criteria 1:** All of the proposed research procedures fit one or more of the exemption categories above
 - b. **Criteria 2:** Selection of participants is equitable (as applicable).
 - c. **Criteria 3:** If there is recording of non-sensitive, identifiable information, there are adequate provisions to maintain the confidentiality of the data.
 - d. **Criteria 4:** If there are interactions with participants, there will be a consent process that will disclose the following information (as applicable):
 - 1) That the activity involves research.
 - 2) A description of the procedures.
 - 3) Risks and benefits.
 - 4) That participation is voluntary.
 - 5) How information will be protected to maintain confidentiality.
 - 6) Name and contact information for the investigator.
 - e. **Criteria 5:** There are adequate provisions to maintain the privacy interest of participants.
- 6. The Designated Reviewer or HRPPO staff contacts the PI for any revisions needed to qualify the study for exempt status.
- 7. The PI is responsible for responding to the Designated Reviewer's issues in a timely manner. Once received, the reviewer determines whether the revisions are sufficient for determination of exempt status.
- 8. The reviewer makes the final determination and notes the appropriate category(ies) in eIRB.

C. Review Outcome(s)

- 1. The Designated Reviewer makes one of the following decisions:

- a. Determination that the research does not qualify for exempt status.
 - 1) The rationale for the determination and recommendations for submission of non-research, non-human research, expedited or full review application will be communicated to the PI where applicable;
 - 2) If the Designated Reviewer determines the research does not qualify for exempt status, the PI may request that the proposal be reviewed by Expedited Review or the Convened IRB who may determine the exemption applies. Alternately, the PI may submit the research proposal as an expedited study if the study meets the criteria for an expedited review. If the study does not meet the criteria for an expedited review, the PI submits a full board review application and requests that the HRPPO schedule a full board review.
 - b. Changes Requested: Indicates that the exempt reviewer has approved the project pending submission of minor revisions and that the Designated Reviewer has given the HRPPO the authority to approve the minor revisions which do not involve substantive issues. The HRPPO staff sends the investigator a summary of the requested changes via eIRB. The PI responds to revisions requested via eIRB. The HRPPO may forward the responses to the Designated Reviewer for additional review, request additional information from the investigator, or acknowledge the response to issue an exempt determination.
 - c. Exempt determination and ready for implementation (general comments or suggestions may be included but not required for approval). If ready for implementation, the HRPPO staff notifies the PI of the decision per the [Reporting Policy and Procedure](#).
2. Appeals - If the PI has concerns regarding the Designated Reviewer or IRB decision/recommendations for changes in the study, he/she may submit the concerns to the IRB in writing, including a justification for changing the IRB decision. The PI may send the request to the reviewer and/or the HRPP Director or IRB Chair for final resolution. If the investigator is still dissatisfied with decision, he/she may send the study to the full IRB for review.
 3. IRB records for all exempt determinations include the citation of the specific category justifying the exempt status.
 4. When a research study has been determined to be exempt, continuing reviews are not required. The HRPP office will periodically request status updates to determine whether the study should be closed in the eIRB system.

D. Changes in ongoing Exempt research

1. Any changes to the research activities must be reviewed by a Designated Reviewer prior to implementing (except where necessary to eliminate apparent immediate hazards to the subject).

2. The PI must submit the proposed changes, and any revised documents to the HRPPO via eIRB.
3. The designated reviewer will determine whether the change alters the exemption determination.
4. If the changes do not affect the exempt determination and are acceptable, the reviewer documents the determination in the eIRB record and updates the expiration date. The PI is then notified.
5. If the changes do affect the exempt determination such that the study will no longer be eligible for exempt status, the reviewer contacts the PI and develops a plan to modify the study via eIRB.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Updated for Revised Common Rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

1.4 STUDY CLOSURE AND INACTIVATION

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. All studies that were previously approved by the UT Southwestern IRB or an external IRB should be inactivated upon completion of the study. Inactivation is appropriate when enrollment is closed, data is no longer being collected, and analysis is complete or involves only de-identified data.
 - a. Note that if the study is federally funded or if you are the lead site on a multi-center trial with active sites, you must keep the protocol open and submit continuing reviews at least annually per your approval letter.
- B. The Principal Investigator (PI), the Institutional Review Board (IRB) or the Human Research Protection Program Office (HRPPO) may initiate inactivation of active approved studies in certain circumstances.
- C. Voluntary study inactivation may be initiated by the PI when human subjects' research activities are complete. Alternatively, the HRPPO may administratively inactivate studies due to non-response of a PI after study expiration. Finally, the IRB may terminate IRB approval. See [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#).

II. SCOPE

- A. This policy and procedures applies to all non-exempt human subjects' research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. PI Initiated Notice of Study Closure for all research reviewed by UTSW IRB or any external IRB
 - a. The Notice of Study Closure should be completed and submitted via the eIRB system when all of the following apply:
 - i. All subject recruitment and enrollment is complete (i.e., no new subject recruitment or enrollment are ongoing),
 - ii. All subject specimens, records, data have been obtained (i.e., no further collection of data/information from or about living individuals will be obtained),
 - iii. No further contact with subject is necessary (i.e., all interactions or interventions are complete and no further contact with enrolled subjects is necessary),
 - iv. Analysis of subject identifiable data is no longer necessary (i.e., subjects' records will no longer be required or all data/specimens have been de-identified). This includes review of source documents by study sponsors, and
 - v. If the study is industry-sponsored, the sponsor or sponsor's representative has agreed the study may be closed at this site.

- b. The format of the Notice of Study Closure is similar to that of the Continuing Review with respect to reviewing the status of participants since the last IRB approval (see [2.2. CONTINUING REVIEW OF RESEARCH](#)).
- c. All requests to inactivate (notice of study closure in eIRB) receive an administrative pre-review by the designated HRPPO staff.
- d. The final report is reviewed via administrative HRPPO staff review.
- e. Administrative HRPPO inactivation— Administrative review allows the HRPPO to quickly inactivate research that is not likely to have significant issues related to the rights, welfare or safety of the participants.
 - 1. Criteria used to determine that a final report is acceptable
 - a. Criteria 1: the proposed research is eligible for inactivation
 - b. Criteria 2: if the report is received after the current approval period has expired, no research occurred during the lapse period (confirmation from the PI is needed if research occurred during the lapse). See [9.3 NONCOMPLIANCE REVIEW](#)
 - c. Criteria 3: there are no unresolved issues related to UPIRSOs, reports of noncompliance or other issues related to rights, welfare or safety of participants
 - d. Criteria 4: no new information needs to be communicated to participants
 - 2. If there is any new information associated with an unanticipated problem or other problems that may adversely affect subject rights, safety or welfare since the last IRB review, the HRPPO staff will consult with management and resolve prior to closure.
 - a. Notice of study closures may be referred to the convened IRB if the reviewer determines the circumstances surrounding the request for closure or information provided in the final report indicate that review by the convened IRB is warranted (e.g., previously unreported UPIRSOs, new reports of serious or continuing non-compliance).
 - 3. Outcomes: the HRPPO staff complete the review of the report. Review outcomes for administrative review of a final report may include:
 - a. Request revisions and/or additional information;
 - b. Acceptance of the Notice of Study Closure in eIRB.
- f. The record is stored according to institutional policy on [8.3 RECORDKEEPING](#).

- B. Administrative Closure Due to Non-Response may be completed for studies reviewed by the UTSW IRB as follows:
1. If the study has not expired
 - a) If the PI fails to respond to the HRPPOs request for submission of a Continuing Review or additional information/revisions to a submitted Continuing Review within a specified period of time (e.g., approximately one month), the HRPPO staff remind the PI of the incomplete status of the submission and request an immediate response.
 - b) HRPPO continues to contact the PI by telephone and email. When the study expiration is within 14 days, the PI's Department Chair may also be contacted requesting immediate submission of the progress report or inactivation report.
 2. If the study has reached the expiration date
 - a) If the PI fails to submit a Continuing Review (CR) or Notice of Study Closure (NSC) or fails to submit required additional information/clarifications to an already submitted CR/NSC, the HRPPO staff notifies the PI of the expired status of IRB approval and that **all research activity must cease**. (For safety exceptions where subjects are enrolled, see [2.2. CONTINUING REVIEW OF RESEARCH](#)).
 - b) If the PI fails to respond to the notice of expiration within one month, the IRB will administratively close the study and the HRPPO staff notify the PI that the IRB has inactivated the study and all research activity must cease (for safety exceptions where subjects are enrolled, see [2.2. CONTINUING REVIEW OF RESEARCH](#)). Future research may require a new protocol submission if the PI still desires consideration for IRB approval.
- C. Inactivation Due to Inactivity/Non-Enrollment
1. If, during Continuation Review, the PI reports that very few or no subjects have been enrolled and the study has been open for a period of three or more years, the IRB may consider inactivating the study, request addition information to justify continuation, or request that the PI submit a Notice of Study Closure.
 2. If there are extenuating circumstances for keeping a study open, the PI files a response to the IRB to justify that the study be kept open along with the Continuing Review. If the IRB agrees that there are extenuating circumstances, the HRPPO staff sends the PI a notification letter of continued IRB approval. (See [2.2. CONTINUING REVIEW OF RESEARCH](#))
 3. If the IRB determines that the extenuating circumstances do not justify leaving the study open, the HRPPO staff process the materials submitted for closure. The HRPPO staff prepares an inactivation notification and sends it to the PI.
- D. Change in PI in lieu of Inactivation
1. When a PI leaves the institution, the protocol should be inactivated. The current PI may request a modification to assign a new PI (with the Continuing or via separate modification to the HRPPO) as an alternative to inactivating the study.
 2. If applicable, when a PI transfers a protocol, the new PI submits appropriate changes to consent forms, advertisements, etc. as part of the modification request to the IRB.

E. Reactivating IRB Approval

1. A PI may request the IRB consider re-initiating research previously inactivated by the HRPPO or IRB following the procedures for [2.1. INITIAL REVIEW OF RESEARCH](#) (i.e., submit the study for a new initial review of research).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

1.5 COMMUNICATION WITH OTHER COMMITTEES AND OFFICES

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: MAY 30, 2019

I. POLICY STATEMENT

- A. The Human Research Protection Program Office (HRPPO) and other organizational components integral to the Human Research Protection Program (HRPPO) will establish working relations to coordinate research protection related activities within UT Southwestern.
- B. The Human Research Protection Program Office (HRPPO) and the Human Research Offices of other affiliated institutions will establish working relations to coordinate research protection related activities between applicable institutions

II. SCOPE

- A. This policy and procedure applies to the Human Research Protection Program Office (HRPPO), affiliated institutions, and other Committees and Offices at UT Southwestern which are integral to the review and oversight of human subjects' research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Coordination procedures common to all research related committees and offices
 - 1. Complaints, Concerns, Comments or Questions and Possible UPIRSO or Alleged Noncompliance
 - a) If the coordinating committees or offices (CCOs) of the UT Southwestern HRPPO or that of an affiliated institution receive a complaint, concern, comment, or question that may indicate possible noncompliance or other issues related to the responsibilities of the HRPPO (e.g., the safety, rights or welfare of research participants), the CCO POC (point of contact) will promptly notify the HRPPO Director or HRPPO Associate Director. The CCO POC may confer with the HRPPO Director or HRPPO Associate Director to assess whether the complaint/alleged noncompliance falls under the purview of the HRPPO, CCO or both.
 - b) If the HRPPO receives a complaint, concern, comment, or question that may indicate possible noncompliance or other issues pertinent to the responsibilities of the CCOs listed above, the HRPPO Director, HRPPO Associate Director or designee will promptly notify the CCO POC. The HRPPO Director, HRPPO Associate Director or designee may confer with the CCO POC to assess whether the complaint issue falls under the purview of the HRPPO, CCO or both.
 - c) If an issue overlaps with the HRPPO, the appropriate CCO will provide the HRPPO Director or HRPPO Associate Director pertinent information from the review. If the issue is determined to be reportable to a federal regulatory agency, the CCO POC will provide a copy of the federal report to the HRPPO Director or HRPPO Associate Director.

- d) See [9.1 COMPLAINTS](#), [9.2 UPIRSO and UADE](#), [9.3 NONCOMPLIANCE REVIEW](#) AND [8.2 REPORTING POLICY AND PROCEDURE](#) for further details.
- 2. Quality Assurance/Improvement Findings
 - a) If the HRPPO Quality Improvement Program, identifies issues pertinent to the responsibilities of the CCOs listed above, the HRPPO Director, HRPPO Associate Director, or designee will promptly notify the appropriate CCO POC.
 - b) If the CCOs listed above receive audit or inspection reports that indicate issues pertinent to the HRPPO's responsibility for the protection of human subjects, the CCO POC is responsible for providing the HRPPO Director, HRPPO Associate Director, or designee with a summary of the issues. The HRPPO Director or HRPPO Associate Director will determine the appropriate process for review of the issue.
 - 3. Joint Policy/Procedures Development and Improvement
 - a) The HRPPO Director in consultation with the HRPP Steering Committee, when appropriate, is responsible for initiating efforts to establish joint policy, procedures and submission forms with the CCOs listed above. Suggestions or recommendations for the joint policy/procedure/form initiatives may be submitted to HRPPO Director.
- B. Institutional Affiliates: Parkland Health & Hospital System (PHHS), Children's Health, Texas Scottish Rite Hospital for Children (TSRHC), The Retina Foundation of the Southwest (RFS) – Research Offices - CCO Point of Contact (POC) with HRPPO: Vice President for Research Administration (PHHS); Vice President for Research Administration (Children's Health), Administrator (TSRHC); Research Administration (RFS)
- 1. Protocol Review Procedures
 - a) Upon submission of a new protocol, the PI prepares and submits a Performance Site Review form in Velos (prior to eIRB submission) which notifies the applicable sites of the new submission.
 - b) The affiliate research staff have access to the eIRB electronic files and are able to screen the submission documents. Screening by the affiliate research staff may streamline the review process by identifying significant issues as early as possible.
 - c) If the affiliate research staff identifies any issues, he/she may contact the PI or HRPPO staff to ensure that required changes are made.
 - d) For affiliate studies, the affiliate Research Department staff have access to the electronic copies of the following:
 - i. All IRB applications;
 - ii. Findings of initial and continuing review approvals;

- iii. Reportable events on affiliate protocols as included in the report to the IRB and initial notifications reported by HRPPO staff (AE UPIRSOs, non-AE UPIRSOs, possible serious or continuing noncompliance; suspension or termination);
 - iv. Other pertinent correspondence, as appropriate.
 2. The HRPPO or Office of Compliance may request assistance with audits of research records for affiliate studies. The IRB/HRPPO, through the POC, may request the affiliate Compliance Office(s) perform a review of ongoing human research. In addition to the reviews requested by the IRB/HRPPO, the affiliate Compliance offices conduct regular audits of research.
 - a) The affiliate Compliance Office will promptly notify the HRPPO Director and Affiliate POC of any audit findings that may indicate possible serious or continuing noncompliance.
 - b) The HRPPO Director or designee are available to attend the compliance auditor's exit conference with the Principal Investigator to improve communication and identify issues of possible noncompliance.
 3. The Affiliate POC or designee will provide updated information on affiliate requirements, policies, and procedures related to human research protection to the HRPPO Director and Chairs. Assurances and the Memorandum of Understanding/Research Services Agreement are updated, as appropriate.
 - a) The Affiliate POC or designee disseminates information to researchers and the HRPPO about affiliate requirements and policy. The HRPPO/HRPPO provides assistance upon request.
 - b) See [8.2 REPORTING POLICY AND PROCEDURE](#) for specifics on reporting between IRB and Affiliates.
 4. Investigator and Study Personnel Education
 - a) The affiliate Research Departments ensures that the PI and all others engaged in the proposed research activity have met current affiliate education requirements for the protection of human subjects, when the PI or engaged personnel are employed by the affiliate. The eIRB Parent Smart Form lists all study staff engaged in research.
- C. Conflict of Interest Committee (COIC) - CCO Point of Contact (POC) with HRPPO: COI Manager
 1. Disclosure of Investigator and study staff Conflict of Interest for Research
 - a) All UT Southwestern IRB members, faculty, as well as any staff or students conducting research must complete a statement of outside activities in accordance with ETH-104 Conflicts of Interest, Conflicts of Commitment, and Outside Activities.
 - b) The COI Office will review and process all statements of outside activities according to [RES-401 FINANCIAL CONFLICTS OF INTEREST IN RESEARCH: DISCLOSURE, MANAGEMENT, AND REPORTING](#)

- c) The COI disclosure form is designed to determine whether a conflict of interest or commitment exists related to the research.
- 2. Disclosure of Financial Conflict of Interest to the IRB
 - a) The IRB Application Smart Form prompts the investigator to declare whether a Financial Interests exists for any personnel on the research proposal.
 - b) The eIRB Continuing Review Smart Form includes a question for the Investigator to declare any changes to Financial Conflicts of Interest for any personnel on the research proposal.
 - c) If a Financial Conflict of Interest exists, the HRPPO staff follows the HRPP Policy [5.3 FINANCIAL CONFLICT OF INTEREST MANAGEMENT](#)
- 3. IRB Review and Oversight of Research with a Conflict of Interest
 - a) In reviewing research protocols in which an investigator has disclosed a COI, the IRB relies on recommendations from the Conflict of Interest Committee (if applicable), applicable regulatory guidance, and federal and state law and the UTSW policy on COI to ensure the protection of human subjects.
 - b) The IRB determines whether the recommendations from the COIC and the COI Management Plan (if applicable) adequately protect the rights and welfare of human subjects or whether other actions are necessary.
 - c) The IRB determines the kind, amount, and level of detail of information to be provided to subjects in the informed consent process regarding source of funding, funding arrangements, financial interests of parties involved in research, and any techniques applied to manage financial COI.
 - d) If the IRB has additional requirement to add to the COI management plan, the HRPPO informs the PI in writing of any additional IRB requirements or recommendations. The COI Office is provided a copy of the IRBs determination.
 - e) The IRB has the final authority to determine if the COI Management Plan is sufficient or if any further action is needed to adequately protect the rights and welfare of human subjects.
 - f) The investigator or other key research personnel and/or the COI Office provides the HRPPO/IRB updated disclosures relating to ongoing research any time a relevant significant financial interest, not originally disclosed, develops or is acquired.
- D. Radiation Safety Committee (RSC)/ Radioactive Drug Research Committee (RDRC) - CCO Point of Contact (POC) with HRPPO: Radiation Safety Officer (RSO) or Chair
 - 1. Protocol Review Procedures
 - a) All new protocols involving the use of investigational procedures involving radiation or radioactive drugs are submitted to the RSC/RDRC for review, preferably prior to protocol

submission to the HRPPPO. The IRB reviews new studies involving research-only radiation concurrently with the RSO/RDRC. The HRPPPO and/or RSO will determine whether additional RSC/RDRC approval is required.

- b) Final approval to implement the study is not granted until the PI provides documentation indicating the RSC and, if applicable, the RDRC has reviewed and approved the protocol.
 - c) For research approved by the IRB that has not yet received final approval from RSC/RDRC, the HRPPPO is responsible for ensuring the final approval is received and is not based on a different radiation exposure than was originally reviewed by the IRB. If the radiation exposure provided on the RSC/RDRC approval is higher than originally approved by the IRB, the protocol must be re-reviewed by the IRB.
 - d) Any requests to modify an already approved study (IRB modification) that adds investigational radiation exposure is reviewed in a similar manner.
 - e) The Smart Form questions on Radiation Exposure provide a framework for quantifying research-related and standard of care radiation exposure. The questions on the Smart Form provides a method to quantify the number of radiation-related procedures and calculates the grand total effective dose of radiation. The RSO has also provided suggested wording for use in the risks section of the consent form.
 - f) RSC/RDRC may make initial decisions that procedures are/are not medically indicated. The IRB will have the final authority on this decision. The IRB may review the draft or final coverage analysis for additional information regarding research-only versus standard of care procedures.
 - g) The RSO may act as a consultant to the IRB in the area of radiation safety, the adequacy of the information in the informed consent form pertaining to radiation risks, and may advise the IRB regarding whether Radiation Safety review is needed. The RSO may attend the IRB meeting or send comments in writing.
 - h) If the RSC/RDRC requires other IRB documents for its review of radiation safety applications, the RSC/RDRC has access to the eIRB electronic files.
 - i) The IRB has membership including Radiologists and Medical Physicists (with dosimetry expertise) to facilitate reviews of research involving radiation.
- E. Institutional Biosafety Committee - CCO Point of Contact (POC) with HRPPPO: Assistant Director, Office of Safety and Business Continuity
- 1. Protocol Review
 - a) When a PI proposes research which falls under the purview of the IBC (Recombinant DNA/Human Gene Transfer into human research participants), the PI must obtain approval from IBC before receiving final IRB approval. IBC is typically a "blocking review," which means that the study is reviewed by the IBC prior to submission to the eIRB system.

However, when studies are not routed to IBC prior to IBC submission, the reviews may occur simultaneously. The IRB will not issue final approval for new protocols falling under IBC purview unless the PI has obtained IBC review first and has received the required IBC review documentation.

- b) If HRPP staff receive an IRB application, which in their judgment may require IBC approval and the PI has not included the required IBC documentation in the submission, HRPP staff contact the IBC for assistance in determining whether IBC review is required. If HRPP staff determines that the proposal does fall under the purview of the IBC, HRPP staff informs the PI of the IBC/IRB requirement.
 - c) The IBC or his/her designee provides the IRB with data safety expertise, especially with respect to risk assessment. The Biosafety Officer may either attend the convened IRB meeting or send comments in writing.
 - d) Final approval by the IRB to implement the study is not granted until the PI provides documentation indicating the IBC has reviewed and approved the protocol.
 - e) Any requests to modify an already approved study (IRB modification) that requires IBC purview will be reviewed in a similar manner, however, the IRB will not approve the modification without final IBC approval.
 - f) The HRPP Director serves as a member of the IBC to facilitate communications.
- F. Office of the Dean, Southwestern Medical School – Point of Contacts (POCs) with HRPP: Dean of Medical Students & Associate Dean Student Affairs (for Medical Students); Dean, UT Southwestern Graduate School of Biomedical Sciences (Graduate Students or Postdoctoral Fellow); Scott Smith - Office of Dean- UT Southwestern School of Health Professions (Health Professions Students); Assistant Dean, Office of the Dean (Residents/Clinical Fellows).
- 1. Research involving the inclusion of Medical students, Health Professions students, Graduate students, Postdoctoral Fellows, Residents or Clinical Fellows as research subjects requires prior approval.
 - 2. The PI should include a completed, approved, Form N in the application. The Form N documents prior approval to recruit students/fellows and residents. If the Form N was not completed, HRPP staff sends a completed Form N, the protocol and consent form (if applicable) to the appropriate POC to request review the inclusion of students/fellows/residents as research subjects.
 - 3. The POC will review the proposal and justification for the inclusion of residents and may request changes or disallow the inclusion of students/fellows/residents in the research.
 - 4. Upon final approval from POC, the communication will be uploaded to the study Smart Form in eIRB and the research may proceed for review by the IRB.

- G. Laser Committee (LC) – LC Point of Contact (POC) with HRPPO: Assistant Director, Laser Safety Officer
1. Research involving the use of lasers is required to receive approval from the Laser Safety Committee. The Laser Safety staff oversee all aspects of laser purchase, use, maintenance, and operations of all Lasers at UT Southwestern and affiliates.
 2. When a PI proposes research involving lasers, Laser Safety approval form must be obtained prior to final IRB approval. A Form X may be submitted at initial submission indicating approval from the Laser Safety office.
 3. If HRPPO staff receive an IRB application, which in their judgment may require Laser Safety approval and the PI has not included the required Form X in the submission, HRPPO staff contact the Laser Safety Office for assistance in determining whether the review is required. If HRPPO staff determines that the proposal does fall under the purview of the Laser Safety, HRPPO staff informs the PI of the requirement and requests the Form X to be completed and submitted to the Laser Safety Office.
 4. Final approval by the IRB to implement the study is not granted until the PI provides documentation indicating the Laser Safety has reviewed and approved the protocol.
- H. Information Systems Acquisition Committee (ISAC) – ISAC Point of Contact (POC) with HRPPO: Nancy Cornelison
1. ISAC approval is required for research which requires the acquisition/use of software or other applications that meet the following requirements:
 - a) All IT asset or software acquisitions greater than \$25,000
 - b) Any non-IR acquisition of networking, payment card processing, or teleconferencing equipment
 - c) All acquisitions of any 3rd party technology service requiring a HIPAA BAA
 - d) Any technology storing UTSW data offsite (e.g., Dropbox, Google Drive, GoDaddy, Network Solutions)
 - e) Any technology processing UTSW data offsite (e.g., Rackspace, Amazon EC2)
 2. Investigators are required to submit the ISAC Approval form to the ISAC and receive committee approval prior to acquiring/using technology as described above.
- I. Office of Sponsored Programs Administration (SPA) - CCO Point of Contact (POC) with HRPPO: Director of Sponsored Programs
1. Proposal Submission
 - a) An eGrants Funding Proposal (FP) must be completed for all research applications that request funding from outside sponsors that may result in a grant, contract, or other

agreement. As part of the grant, contract or agreement review process, the PI submits the FP to SPA.

- b) The FP includes questions designed to verify whether the project involves human subjects and whether the PI has obtained IRB approval, if required.
- c) The SPA staff reviews each externally sponsored grant proposal/agreement and the associated FP . When appropriate, the SPA staff advises the PI of sponsor requirements for submission of the certification of IRB approval, and/or completion of mandatory human research training, as required by the sponsor. The SPA staff refers the PI to the HRPPO in cases where the PI requires additional clarification or assistance with human research protections.
- d) The PI submits certifications of IRB approval or mandatory education requirements to SPA and the SPA Institutional Official will submit the required information to the sponsor in accordance with agency requirements. The HRPPO staff prepares agency certifications for the PI upon request.

2. Negotiation of Award Agreements

- a) SPA provides investigators with up-to-date information on sponsor requirements and institutional policy. This information is required in negotiating the terms of research agreements to ensure compliance with applicable law, university policy, and good business practice. For transparency, SPA publishes information resources on the SPA website, including regulatory resources, agreements matrix, and specific information on all research agreements including clinical trial agreements.
- b) Once UT Southwestern receives an extramural award, SPA staff reviews the proposed research agreement and negotiates acceptable terms between the sponsor and the institution. The agreement includes provisions for human research protections in compliance with all applicable laws, institutional policies for ethical conduct of research, and the written research protocol, as applicable. The PI receives a copy of the completed agreement from SPA.
- c) The SPA staff includes provisions in the research agreement outlining the plans for disseminating research findings in alignment with the UT Southwestern policies and the roles of the PI and the sponsor in publication or disclosure of research results.

3. Negotiation of Clinical Trial Agreements

- a) Additional award negotiation procedures beyond those outlined above apply to industry sponsored research designated as a clinical trial. Current institution policy related to industry sponsored agreements requires the following language be included or waived by the Clinical Research Services (CRS) Director with consultation from the HRPP Director:
 - i. If a study participant is injured as a result of the study drug or procedure that is required solely for study purposes, the sponsor will be responsible to cover the

- cost of treating the injury. Full financial responsibility for payment of such expenses resulting from an injury or illness suffered in the course of the study will rest with the sponsor, except to the extent that such expenses are attributable to the negligence or willful misconduct of the Institution.
- ii. The sponsor will promptly provide notice to the Institution and/or Principal Investigator of any information discovered through monitoring and audit efforts or through analysis of study results and for a minimum of two years after completion of the study, if such information could:
 1. adversely affect the safety of current or former study participants;
 2. adversely affect the willingness of study participants to continue participation;
 3. influence the conduct of the study; or
 4. alter the IRB approval to continue the study.
- b) The PI provides the Contract Intake through Velos with a copy of the proposed agreement and a sponsor contact as early in the process as possible.
 - c) The SPA staff reviews the terms of clinical trial agreement (CTA) for specific provisions related to IRB or Health Insurance Portability and Accountability Act (HIPAA) issues which need coordination with the IRB. Types of issues that may require IRB/SPA coordination include additional university/sponsor certifications or requirements related to human research protections, applicable federal assurances, and sponsor access to protected health information. Specific examples include, but are not limited to, the following:
 - i. Rights/permissions to subject samples and prior medical records; and
 - ii. Use of participant data in future sponsor reviews only as approved by the IRB.
 - d) When appropriate, the SPA staff notifies the HRPPO staff and provides a copy of the contract language in question. HRPPO staff advises SPA staff on pertinent existing regulatory and institutional policy, provides requested documentation or certifications, or refer the request to the IRB for review, as appropriate. The HRPPO staff act as a liaison between the IRB and SPA and respond to SPA requests on a case-by-case basis. SPA ensures that the resulting provisions incorporated into the CTA comply with the guidance obtained from the IRB/HRPPO.
 - e) As part of the IRB application, the PI submits the informed consent document consistent with the proposed contract language related to provisions for payment of injury related care and research costs to the subject. If the language in the informed consent document differs from the template language provided by the IRB, the HRPPO staff will contact SPA to confirm the language in the submitted consent(s) is consistent with the CTA prior to final

IRB approval. If changes are needed in the informed consent document, the HRPPO staff forward required changes to the PI and the IRB for review and approval.

- f) The SPA staff reviews Velos and eIRB for the current IRB approval letter. The electronic record in Velos contains all the following information:
 - i. A copy of the research protocol (becomes a part of the CTA by attachment if required by sponsor);
 - ii. The fully signed agreement;
 - iii. The IRB approval letter.
- 4. Terminations or Lapses in IRB Approval
 - a) If the IRB terminates IRB approval of a sponsored project due to non-compliance, the HRPPO Director notifies the SPA Director.
 - b) SPA takes the appropriate action in accordance with the sponsor requirements.
 - c) If an IRB approval lapses due to failure of the PI to submit a continuation review application, the HRPPO staff sends the PI a lapse of approval notice. The IRB notifies SPA that IRB approval has expired. The PI is responsible for notifying the sponsor of the lapse.
- J. Office of Compliance (OoC) - CCO Point of Contact (POC) with HRPPO: Chief Compliance Officer or Research Compliance Assistant Director
 - 1. The Office Compliance performs reviews of ongoing human research for the IRB/HRPPO. The reviews are conducted for cause, at the request of the IRB or HRPPO, or according to the annual Compliance monitoring plan.
 - 2. HRPPO is provided with reports of the audit findings for each operating quarter.
- K. Simmons Comprehensive Cancer Center (SCCC) Protocol Review Monitoring Committee (PRMC) - CCO Point of Contact (POC) with HRPPO: Chair or designee
 - 1. Protocol Review Procedures
 - a) All Simmons Cancer Center protocols are submitted to the SCCC Protocol Review Monitoring Committee (PRMC) for scientific review, preferably prior to protocol submission to the HRPPO. Occasionally, the IRB may review a cancer protocol concurrently with the PRMC. HRPPO staff notifies PRMC of any cancer related protocols that are submitted to the HRPPO without PRMC approval. The IRB is provided a copy of the disapproval, conditional approval with stipulations, and/or approval letter from the PRMC.
 - b) Research protocols that have not yet received final approval from PRMC because non-scientific design stipulations are outstanding may be approved by the IRB if all regulatory criteria for approval are met. Cancer related protocols that meet the regulatory criteria for exemption do not require PRMC approval prior to the HRPPO determination. Final approval

by the IRB/HRPPO to implement these types of studies is not granted until the PI and/or PRMC provides documentation indicating PRMC final approval has been granted.

- c) The PRMC Chair or designee may act as a consultant to the IRB in the area of cancer clinical trials, the adequacy of the information in the informed consent form pertaining to acceptable medical practice, and may advise the IRB regarding whether PRMC review is needed. The PRMC Chair or designee may attend the IRB meeting or send comments in writing.
- d) Any requests to modify an already approved cancer related study (IRB modification) with significant changes is reviewed in a similar manner.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

REVISION DATE	AUTHOR	DESCRIPTION
MAY 2019	HRPP	Updated Joint Policy/Procedures Development to remove reference to “Research Administration Leadership” as it is no longer a valid department at UTSW
JULY 2018	HRPP	Update COI POC, minor COI process clarification; revision to RSC (dissolved SHUR); clarifications to IBC review process and requirement for IBC approval prior to IRB final approval, updated approval process and POCs to approve inclusion of medical students/residents and fellows; updated Laser Safety Review process
AUGUST 2017	HRPP	New Policy Development
MARCH 2012	IRB OFFICE	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office:

HRPPO@UTSouthwestern.edu

214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

1.6 RELIANCE ON NON-UT SOUTHWESTERN IRB

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. UT Southwestern investigators frequently collaborate in research involving external investigators and institutions.
- B. When non-exempt human participant research is being conducted in collaboration with other institutions or with collaborating individual investigators, each collaborating institution and/or collaborating individual investigator engaged in the research must obtain IRB approval from an appropriately authorized IRB.
- C. The OHRP guidance document, [Guidance on Engagement of Institutions in Human Subjects Research](#) will be used as the basis for determining whether the research activities constitute engagement in human participant research. Such determinations will be made in collaboration and consultation with authorized representatives of the collaborating institution and/or the collaborating individual investigators, as applicable.
- D. In an effort to reduce duplicate submission and oversight by multiple IRBs for the same protocol, the UT Southwestern Medical Center HRPP will consider requests to rely on another institution's IRB.
- E. The Institutional Official (IO), in consultation with Legal Affairs and HRPP Director, has the authority to execute IRB Authorization Agreements (IAAs) on behalf of the UT Southwestern Medical Center. All determinations to rely upon another IRB shall be documented in an IAA or RA.

II. SCOPE

- A. This policy applies to all human subjects' research in which UT Southwestern IRB has agreed to rely on the review of a non-UT Southwestern IRB.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Requesting Reliance
 - a. Investigators considering requesting reliance on another IRB should contact the HRPP Office (HRPPO) early in the research proposal process. Decisions about whether to permit reliance on another IRB shall be determined by the IO, after review and recommendation by the HRPP Director (HRPPD).
 - b. UT Southwestern Medical Center may rely on another appropriately constituted IRB for the review of cooperative research projects under the conditions set forth below.
 - c. In deciding whether or not to rely on another IRB, the IO will consider the following criteria:

- i. Whether the use of a Central IRB mechanism has been mandated by the study sponsor,
 - ii. The number of proposed studies involved in the collaboration,
 - iii. The anticipated level of risk associated with proposed studies,
 - iv. The terms and conditions of the proposed IAA or RA,
 - v. Whether the reviewing IRB's policies and procedures meet UT Southwestern Medical Center standards. If the other IRB is AAHRPP accredited, then it will be presumed that the UTSW standards are being met; however, accredited status does not in itself necessarily suffice as a basis for the IO's decision,
 - vi. The location where the human research activities will take place,
 - vii. The capacity of the other institution and its IRB to sufficiently be informed about the UTSW local research context and applicable laws and regulations,
 - viii. Whether or not the reviewing IRB will be serving as the HIPAA Privacy Board.
 - d. Executing IRB Authorization Agreements
 - i. In order to initiate discussions with the institution requesting the reliance agreement, the UTSW investigator must provide the HRPP Reliance Program Manager with:
 - 1. contact information for the collaborating institution's IRB,
 - 2. a draft version of the protocol and consent form, and
 - 3. copy of the local context form (if applicable).
 - ii. The HRPPD, HRPP Reliance Program Manager or his/her designee will ensure that the finalized agreement is appropriately signed by the IOs for the involved institutions. Copies of all agreements will be maintained in the HRPPO electronic filing system.
- B. eIRB Submission
 - a. In order to maintain an accurate record of studies being conducted at or by UTSW and affiliates, as well as to manage required ancillary reviews, investigators are required to create an eIRB application utilizing the external pathway for studies that are reviewed by another IRB.
 - b. Updates to the eIRB application are required
 - i. at the time of continuing review (within 30 days of the Reliance IRB reapproval),
 - ii. if there is a change in local (site) PI or other local study personnel,
 - iii. if there is a change that affects any of the required ancillary reviews,
 - iv. if there is a change to the consent form which will require acknowledgment by HRPPO Reliance Team

- v. Any other changes to the protocol or documents to ensure the most up-to-date protocol records in eIRB

C. HRPPO Reliance review

- a. Investigators are encouraged to meet with HRPPO Reliance Team prior to submission
- b. HRPP Reliance will review the following before activating the research at UTSW:
 - i. Training is completed according to [5.2 RESEARCH EDUCATION AND TRAINING](#).
 - ii. COI Training and financial disclosures are completed according to [5.3 FINANCIAL CONFLICT OF INTEREST MANAGEMENT](#) and other applicable Institutional Policies.
 - iii. Ancillary committee (e.g., [Protocol Review and Monitoring Committee](#)) and other safety committee approvals (e.g., [IBC](#), [Radiation Safety](#), etc.) were received as appropriate
 - iv. Confirmation of approval by the Reviewing IRB that UT Southwestern is approved as a study site
 - v. The Informed Consent document contains all locally required elements:
 - 1. Research-related injury language consistent with UTSW template
 - 2. Contact information in the consent or related documents (as appropriate) contain contact information for local investigators and HRPP
 - 3. Radiation and risk language in consent is consistent with approved template language

D. HRPP Acceptance to begin Research

- a. All research conducted at/by affiliates of UTSW must also receive approval from affiliate research offices via Velos as required for all research
- b. A member of the HRPP Reliance Team will acknowledge receipt of the information and activate the study at UT Southwestern.
- c. Upon initial acceptance and after any modifications to consent forms, the informed consent forms will be stamped with the HRPP Acceptance Date to assist with version control.

E. Modifications

- a. External IRB Modifications resulting in changes to the local site application when UT Southwestern IRB is not the IRB of record must be approved by the Human Research Protection Program Office (HRPPO). Examples include (but are not limited to): study staff changes, changes to COI, safety committee approvals, local contact information in consent document, HIPAA language or waiver requests. (See [1.6. RELIANCE ON NON-UT SOUTHWESTERN IRB](#).)

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
OHRP Guidance – ENGAGEMENT OF INSTITUTIONS IN HUMAN SUBJECTS RESEARCH (2008)
NIH sIRB Policy – FINAL NIH POLICY ON THE USE OF SINGLE INSTITUTIONAL REVIEW BOARD FOR MULTI-SITE RESEARCH

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
(214) 648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.1 INITIAL REVIEW OF RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The IRBs must receive sufficient information from investigators to provide adequate review of proposed research and to make the determinations required by regulations for IRB approval. This policy describes the submission requirements and initial review process for research requiring IRB review.

II. SCOPE

- A. This policy and procedure applies to all on-going and future human participant research projects conducted by UT Southwestern Medical Center (UTSW) faculty, staff, or students or by anyone conducting a research activity supported by UTSW or its affiliates.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Submission and Screening
 1. The Principal Investigator (PI) or designee creates the study in Velos and “pushes” the study to eIRB to create the eIRB Draft study
 2. Once the eIRB draft is created, the PI or designee completes the “eIRB Smart Form” for initial IRB review ([details available on the HRPP website](#)).
 3. The PI indicates, in the Smart Form, whether expedited review is requested. The IRB makes the final determination regarding whether a protocol is eligible for expedited review.
 4. The PI submits a completed application to the Human Research Protection Program Office (HRPPO). Instructions for preparing the application are available on the [HRPPO website](#). The investigator may contact the HRPPO staff with questions.
 5. Upon receipt of the application, the HRPPO staff screen for completeness and accuracy and make a preliminary determination as to whether the application meets the applicability criteria for expedited review including minimal risk and the expedited review categories. If the application was submitted for expedited review but does not meet the criteria for expedited review, the HRPPO staff consult with one of the HRPPO expedited reviewers or IRB Chair to make the final determination whether the study is eligible for expedited review. If appropriate, the HRPPO staff will advise the PI to submit the revised application materials for full or exempt review.

6. The HRPPO conducts a comprehensive Administrative Pre-review (see [1.1. RECEIVING, ROUTING, AND ADMINISTRATIVE REVIEW OF IRB SUBMISSIONS](#))
 7. After completing application screening, the HRPPO staff forwards the application to the appropriate reviewer(s).
- B. Assigning Reviewers
1. Convened IRB Reviewers
 - a. The comprehensive Administrative Pre-review allows the HRPPO staff to make reviewer assignments based on study's scientific or clinical focus area, significant ethical or regulatory issues, or issues related to local context of research (e.g., cultural issues). The HRPPO staff assigns a primary reviewer to each new study based on the IRB member's educational background, experience and expertise. For research requiring expertise in multiple areas of science or ethics, additional reviewers may be assigned as determined by the HRPPO staff, HRPP Director or IRB Chair. Reviewers may request the HRPPO to provide additional expertise as well.
 - b. Information on each IRB member's earned degrees, scientific status, representative capacity (e.g., knowledge related to children, pregnant women, prisoners, economically disadvantaged, educationally disadvantaged, cognitively impaired adults or students), and indicators of experience (e.g., scientific and clinical experience, certifications, licensure, etc.) are maintained in the HRPPO membership spreadsheet.
 - c. In selecting reviewers (for either scientific/ethical pre-review or final review), at least one person must have appropriate scientific or scholarly expertise.
 - d. If a reviewer with appropriate expertise is not available, the research will be scheduled for a future meeting when a reviewer is available. This determination may be made by the IRB Chair/Alternate Chair or the HRPP Director/HRPP Associate Director.
 - e. If additional expertise is needed, the IRB reviewer may request the assistance of an ad hoc or cultural consultant as described below.
 2. Expedited Reviewers
 - a. HRPPO Expedited Reviewers - HRPPO staff includes several experienced IRB members that serve on all UTSW IRBs in the Regulatory Specialist position. These individuals include the HRPP Director or designee or other Senior Regulatory staff. These HRPPO staff/IRB members by their education and experience are designated as expedited reviewers by the IRB Chair.
 - b. IRB Chair and IRB member expedited reviewers - The IRB Chairs and other experienced board members may also serve as expedited reviewers. The Chair or other experienced members are often called on to perform expedited initial review when the HRPPO expedited reviewers have a conflict of interest, do not have the expertise to complete the review, or when the HRPPO reviewer requests assistance or another opinion on the research. Members must have served on an IRB for six months to qualify as an experienced member.

- c. In reviewing new research applications, the expedited reviewer considers whether he/she has the appropriate scientific or scholarly expertise. Given that all research eligible for expedited review must be minimal risk, the nature of the typical type of research can be adequately understood by most reviewers with a scientific background.
- d. The reviewer assigned to a specific study will consult with other expedited reviewers in the HRPPPO, the IRB Chairs or experienced IRB members to ensure the protocol receives an appropriate scientific and scholarly review. In addition, the expedited reviewer(s) may consult with members of other research related committees, UTSW schools or affiliated institutions.
- e. If a reviewer with appropriate expertise is not available, the research will not be approved until one is available or the study can be scheduled for a future convened meeting of the IRB.
- f. If additional expertise is needed, the IRB reviewer may request the assistance of an ad hoc or cultural consultant as described below.

3. Ad hoc Scientific or Cultural Consultants

- a. Ad hoc scientific or cultural consultants with appropriate expertise may be asked to participate in the pre-review and/or IRB review process (expedited or convened). Ad hoc scientific or cultural consultants are generally recruited from the membership of other UTSW IRBs, UTSW schools or affiliated institutions.
- b. HRPPPO staff may ask an ad hoc or cultural consultant who has appropriate expertise in the discipline or with non-English speaking populations or locations to participate in the review.
- c. The HRPPPO maintains a list of potential cultural consultants qualified by cultural and/or linguistic knowledge or training to assist the IRB, as appropriate, and may also contact IRB members, UTSW faculty, or department chairs for advice in identifying appropriate scientific/clinical consultants.
- d. The PI may also recommend cultural consultants provided that they are not directly involved in the study. These consultants may review consent forms, provide verifications of translated documents, provide guidance on the impact of the research on subjects and the impact of the culture on the research to be conducted.
- e. When initially contacting the potential ad hoc or cultural consultants, the HRPPPO staff query the individual about possible sources of conflict of interest in accordance with the [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#).

C. IRB Review Process

- 1. Documents available to review: IRB reviewers (Convened IRB Reviewers and Expedited Reviewers) receive access to all application documents such as:
 - a. eIRB application with research description;

- b. Informed consent/assent process and forms, including waiver requests, NIH sponsored sample consent documents (if applicable), translated consent document for non-English speaking subjects;
- c. HIPAA forms;
- d. Additional materials, including advertisements, proposal data instruments, materials/letters for off-site research, information contained in the eIRB Smart Form on the use of Investigational New Drug (IND) or use of Approved Drugs for Unapproved Use, or use of Radioactive Materials;
- e. Vulnerable populations, including forms for research involving decisionally impaired individuals, pregnant women, fetuses and/or neonates, prisoners, or children;
- f. Miscellaneous forms (as applicable) including grant application, and conflict of interest management plans;
- g. Other Required Committee/Review Approvals (as applicable) – Radiation Safety Office (RSO) approval, Institutional Biosafety committee approval, etc.

2. Convened IRB Review

- a. The IRB conducts initial review for non-exempt human subjects' research at convened meetings unless a designated member of the IRB determines the research may be eligible for expedited initial review. Review by the convened IRB will be referred to as either "full review" or "full board review". See the procedures for conducting a convened meeting, the definition of quorum, and the requirements for conducting a full review meeting in the [6.3 CONDUCT OF FULL BOARD MEETINGS](#).
- b. The Human Research Protection Program Office (HRPPO) and the IRB members perform a review of submission packages prior to the scheduled meeting. The HRPPO staff performs a screening to identify errors or omissions in the application and an identification of the regulatory issues as part of "Administrative Pre-review". IRB members may perform a targeted review to identify significant scientific and ethical issues during the "Scientific/Ethical Pre-review". The findings of both pre-review processes are communicated to the investigator to allow corrections, clarifications and communication. The application is corrected/revised as necessary and scheduled for review by the full board.
- c. All studies requiring convened IRB review may go through a two-step IRB review process. The first step is the scientific and ethical pre-review which occurs at the same time as the administrative pre-review. The purpose of this review is to identify scientific or ethical issues prior to review by the convened IRB. The second step is the convened IRB review.

3. Targeted Scientific and Ethical Pre-Review

- a. The HRPPO staff may decide to make a copy of the initial application available to one or more IRB member or consultant reviewers (when applicable) to complete the Targeted Scientific and Ethical Pre-review.
- b. The Scientific and Ethical Pre-review is a joint effort by all assigned reviewers. The review is limited to specific concerns identified during the initial administrative pre-

review related to substantive scientific and ethical/human subject protection issues, including those in both the protocol and informed consent document. Substantive issues are those directly relevant to the seven determinations required for IRB approval (45 CFR 46.111, e.g., risks to subjects are minimized).

- c. The reviewers are encouraged to communicate comments, questions or clarifications to the PI during the pre-review period. Once the review and communication process has been completed, a summary of the substantive issues identified by the reviewers is documented in an email from the primary reviewer to the HRPPO.
- d. The substantive issues should be addressed prior to convened IRB review by making appropriate corrections, additions or clarifications to the submission package. The targeted scientific and ethical pre-review comments and responses are included in the package reviewed at the convened meeting.

4. Review by the Convened IRB

- a. The UTSW has designated four IRBs operated by UTSW to review nonexempt human research conducted under its Federalwide Assurance (FWA). Initial review of research may be performed by any of the designated IRBs.
- b. The IRB reviews each initial full review application. The IRB may contact the PI or sub-investigator by phone during the convened meeting or ask the individual to attend the meeting if additional information is needed. After those with declared conflicts of interest (members, ex officio members, ad hoc and cultural consultants or others) have left the room, the IRB reviews the application and discusses any controverted issues and their resolution prior to voting.
- c. During discussion, the IRB members raise only those issues that the committee determines do not meet the federal criteria for approval as specified in 45 CFR 46.111, and 21 CFR 56.111, further discussed in [6.2 IRB APPROVAL OF RESEARCH](#). In addition, the IRB determines the overall risk level for the study. Also, the IRB considers whether the PI's preliminary assessment of federally mandated specific findings requirements (e.g., request for waiver of informed consent) is acceptable with respect to meeting federal requirements.
- d. For research involving a new drug or new device where the PI has not obtained an IND or IDE, the committee determines what action(s) is needed (whether the PI needs to get an IND/IDE or whether PI needs to contact the Food and Drug Administration [FDA] for guidance).
- e. In conducting the initial review of the proposed research, the IRB utilizes the Human Full Board Reviewer Worksheet.
- f. A member or consultant with a conflict of interest must leave the room during the vote and only participate in the review by providing information in accordance with [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#).
- g. Primary Reviewer System - review of research at a convened meeting of the IRB relies on a primary reviewer system. A primary reviewer from the membership is assigned to each business item. Generally, the same reviewers who performed the Scientific and Ethical Pre-review of the research also conduct the final review at the convened

meeting. The primary reviewer system does not prohibit any member of the IRB from obtaining, reviewing and providing input on any business item scheduled for a convened meeting. The primary reviewer is responsible for:

- i. Comparing the detailed grant application or industry protocol with the IRB application;
 - ii. Informing the full IRB of any discrepancies between the detailed protocol and the summary application materials;
 - iii. Determining whether the project involves a NIH multi-center clinical trial (e.g., cooperative group trial) and, if so, comparing the “Risks” and “Alternatives” section of the NIH-approved sample informed consent document with the UTSW proposed form to ensure that the NIH and UTSW sections of the consent are consistent;
 - iv. Reviewing the protocol related conflict of interest disclosure form and recommending a management plan from the Conflict of Interest Committee (COIC). If a disclosure is made, the review will summarize the conflict and proposed management plan to the IRB (if a management plan is not provided by the COIC, the reviewer will provide recommendations to manage the conflict to the IRB);
 - v. Reviewing the other committee review/final approvals for consistency in human subjects protection measure (as available);
 - vi. Conducting an in-depth review to ensure the protocol meets the required regulatory determinations for approval (see [6.2 IRB APPROVAL OF RESEARCH](#) for details);
 - vii. Presenting the study to the convened IRB during the meeting including any concerns and comments they have;
 - viii. Considering the IRB’s comments and concerns and make the motion for IRB determination using the Full Board Reviewer Worksheet;
 - ix. If, during the meeting, the Primary reviewer is absent and no other member is present with the appropriate scientific or scholarly expertise who conducted an in-depth review, the research will be deferred to the next convened IRB meeting. This determination will be made by the IRB Chair/Alternate Chair with the input of the members present at the time the primary reviewer is marked as absent.
- h. All IRB members receive access to submission documents being presented at the meeting (including those protocols for which the IRB member is not the primary reviewer).
 - i. All IRB members are expected to review all documents in enough depth to be familiar with the protocol, to be prepared to discuss the protocol at the meeting, and to be prepared to determine whether the research meets the regulatory criteria for approval.

- j. Ad hoc scientific or cultural consultants may provide comments or recommendations in writing to the HRPPO prior to the meeting or attend the convened meeting to participate in the review. In cases where the consultant participates in the meeting, the minutes of the meeting document the information provided by the consultant. (See [8.1 IRB MINUTES](#)).

5. Expedited IRB Review

- a. The Institutional Review Board (IRB) uses an expedited review process to review studies that meet the categories adopted by the Department of Health and Human Services (DHHS) and the Food and Drug Administration (FDA) and that involve no greater than “minimal risk”. The expedited applicability criteria, including the definition of “minimal risk”, and federally mandated categories are attached. Expedited review procedures allow the IRB Chair, HRPP Director or Designee to review and approve studies that meet the criteria in the attached document without convening a meeting of the full IRB. Collectively, these individuals will be referred to as “expedited reviewers” in this document.
- b. The expedited reviewer(s) does not participate in the review of research where the reviewer has a conflict of interest (see HRPP policy on [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#)). The reviewer(s) only approves research that meets the federal criteria for approval as specified in the common rule (e.g., 45 CFR 46.111 and 21 CFR 56.111) when research involves only procedures listed in one or more of the specific nine categories published in the Federal Register and further explained in [6.2 IRB APPROVAL OF RESEARCH](#). In addition, the expedited reviewer(s) ensures that the informed consent process and documentation as specified in 45 CFR 46.116 and 117, 21 CFR 50.25, are carried out unless the IRB can waive the requirements in accord with federal regulations. (See [3.1. INFORMED CONSENT REQUIREMENTS](#)).
- c. The expedited reviewer(s) exercises all of the authority of the IRB except that the reviewers may not disapprove the research. If an expedited reviewer is unable to approve a study, the issue may be forwarded to the convened IRB for review. Only the convened IRB may disapprove a research study as provided in the DHHS, and VA regulations.
- d. The IRB agenda report for convened meetings advises the IRB of research studies approved using expedited review procedures. Any member can request to review the entire IRB file for an expedited study.
- e. The expedited reviewer(s) reviews all information in the expedited review packet in enough depth to be familiar with the protocol, to determine whether the research is eligible for expedited review and to be prepared to determine whether the research meets the regulatory criteria for approval.
- f. The expedited reviewer(s) can determine that the research is eligible for a less stringent mechanism of review (i.e., the project is exempt from requirements for review or the activities do not fall under the purview of the IRB). In these cases, the IRB does not require a new application provided the IRB, with assistance from the HRPPO staff, documents the exempt categories or the rationale for determining that

the activities do not meet the federal definitions of research, clinical investigation or human subject.

- g. The expedited reviewer(s) will contact the PI and/or other qualified study team member (i.e.—Clinical Research Coordinator) for any clarification needed and documents the issue(s) discussed on the expedited reviewer worksheet. The expedited reviewer(s) may also use the Expedited Reviewer Checklist to confirm that the research meets the federal criteria for IRB approval.
- h. The expedited reviewer(s) will determine whether the research meets the federal criteria for approval as outlined in 45 CFR 46.111 and 21 CFR 56.111.
- i. The expedited reviewer(s) will ensure that the investigator will conduct the informed consent process and obtain documentation of informed consent, as specified in 45 CFR 46.116, 45 CFR 46.117 and 21 CFR 50.25 unless the IRB waives the requirements, per federal regulations. (See [3.3 INFORMED CONSENT WAIVERS AND ALTERATIONS](#)).
- j. The expedited reviewer(s) will only raise those controverted issues or request changes that they have determined do not meet the federal criteria or UTSW HRPP0 policies for approval.
- k. All research involving prisoners is sent for review by an appropriate IRB prisoner representative.
- l. The expedited reviewer(s) documents his/her determinations in eIRB regarding expedited eligibility, applicable expedited category, whether the research meets the federal criteria for approval, and one of the three outcome determinations as described below.

6. Review of Research Documentation in the Medical Record

- a. If flagging of the medical record is standard for a specific institution, the IRB may:
 - 1) With input from the PI, alter the study title to eliminate any content that may represent an increased risk beyond that ordinarily present in the medical record.
 - 2) Waive the requirement if identification as a participant in the study would place the participant at a greater risk of harm.

D. IRB Review Determinations – The convened IRB or IRB expedited reviewer(s) will make one of the following determinations in regard to the protocol and consent forms:

- 1. Approved – (Convened IRB and Expedited Review) IRB approval indicates that the IRB (or IRB expedited reviewer(s)) has concluded that the application (including the research plan and consent forms) meets the federal criteria for approval. IRB approval verifies that the IRB agrees with the assessment of the protocol and/or specific findings as described by the PI in the application. The investigator will receive an approval letter documenting the IRB decision. (See [8.2 REPORTING POLICY AND PROCEDURE](#))
- 2. Conditional Approval – (Convened IRB and Expedited Review) IRB conditional approval indicates that the IRB (or IRB expedited reviewer(s)) has approved the

protocol pending submission of minor revisions and that the IRB has given the individual chairing the meeting (in the case of convened review) or designee the authority to approve the minor revisions which do not involve substantive issues. The HRPPO staff sends the investigator a letter describing the revisions requested by the IRB. The PI responds to revisions requested by the IRB and sends the response to the HRPPO. The Chair or designee may forward the responses to the entire IRB for additional review (return to the convened Board), request additional information from the investigator, or approve the response (see Review of Responsive Materials below).

3. Full Board Review Required - (Expedited Review). The IRB expedited reviewer may determine that the protocol requires full review by the convened IRB.
4. Tabled/Deferred - (Convened IRB only) A vote of tabled or deferred indicates that the IRB withholds approval pending submission of major revisions/additional information. The HRPPO staff sends the investigator a letter listing the reasons for tabling and includes a description of the revisions or clarifications requested. For some studies, the IRB may appoint one or more members of the IRB to discuss the reasons with the investigator.
5. Disapproved – (Convened IRB only) A vote to disapprove research indicates that the IRB will not allow the research to be conducted. Disapproval of a protocol usually occurs when the IRB determines that the risk of the procedures outweighs any benefit to be gained or if the proposed research does not meet the federal criteria for IRB approval. Disapproval generally indicates that even with major revisions to the application the issues preventing approval will not be resolved. [Examples: part or all of the research is prohibited by a law, regulation or institutional policy; there is insufficient preliminary research to justify the proposed study; there is insufficient expertise or resources locally to safely conduct the study; the nature of the research will adversely affect the rights or welfare of the subjects]. The HRPPO staff sends the investigator a letter describing the reasons for disapproving the protocol. Investigator responses to the IRB decision to disapprove research are reviewed at a subsequent convened meeting of the IRB.

E. Length of approval: For studies approved or conditionally approved by the IRB, the IRB determines the length of approval, as appropriate to the degree of risk but not longer than one year from the meeting date that the study was approved or conditionally approved.

- a. The IRB may set a shorter approval period for:
 - 1) high risk protocols;
 - 2) protocols with high risk/low potential benefit ratios;
 - 3) studies involving the first use of an experimental drug or device in humans where safety data is limited;
 - 4) studies involving research procedures not normally reviewed by the IRB; or
 - 5) Any other study the IRB determines a shorter approval period and the resultant continuing review are appropriate.

- b. The date of the meeting (convened IRB review) or date of determination (expedited IRB review) becomes the first day (start) of the approval period with the expiration date being the first date that the protocol is no longer approved. However, studies conditionally approved by the IRB may not begin until the IRB's conditions of approval (revisions) are approved by the designated IRB reviewer (final approval).
 - c. If the research is approved for one year, the expiration date is determined to be the same date one year from the date which the IRB (or IRB expedited Reviewer) approved the protocol or conditionally approved the protocol. For example: the IRB reviews and approves a protocol without any conditions or approves a protocol with minor conditions for one year at a convened meeting on October 1, 2002. September 30, 2003 is the last day that research may be conducted under this approval. October 1, 2003 is the first day that the study approval is expired.
 - d. The expiration date is the first day that research is not approved and must stop unless the study has been re-approved (see [2.2. CONTINUING REVIEW OF RESEARCH](#)).
 - e. For studies that are tabled/deferred due to substantive issues identified during the review at one convened meeting and subsequently reviewed and approved by another convened meeting, the approval period starts with the date of the subsequent convened IRB meeting.
1. Concerns with IRB decision – If the PI has concerns regarding the IRB decision/recommendations for changes in the study, he/she may submit his/her justification for changing the IRB decision to the IRB (or IRB reviewer(s)). The PI sends the request to the expedited reviewer and/or to the IRB Chair or Vice Chair for final resolution. If the investigator is still dissatisfied with the IRB decision, HRPPO staff send the protocol to the convened IRB for review.
- E. Review of Responsive Materials
1. When the convened IRB requires modifications to the proposal in order to secure approval (conditional approval), the following procedures are followed:
 - a. The PI submits a response to stipulations to the HRPPO that may include the following response materials:
 - 1) a point-by-point response detailing how each IRB stipulation was addressed;
 - 2) If applicable, an electronic copy of each document that was revised with the changes tracked;
 - 3) electronic copies of additional documents requested
 - b. The HRPPO staff review the responsive materials to confirm the package is complete. The materials are provided to the stipulation reviewer. The stipulation reviewer may be Expedited Reviewer (HRPP Director, IRB Chair, other IRB member designated by the IRB), or an Administrative Reviewer (HRPPO staff member who need not be IRB members and can review responsive materials so long as all of the modifications for the protocol are limited to minor changes eligible for administrative review).. See tables 1 and 2 below for examples of each review type.

- c. The stipulation reviewers verify that all of the modifications to the proposal have been completed. Since the modifications to secure approval are limited to minor changes that require a simple concurrence by the investigator, the responses received are generally affirming the modification was made.
- d. If a response is contrary to the IRB’s stipulation, the stipulation reviewer may:
 - 1) Accept the investigator’s alternative explanation/solution;
 - 2) Require the original modification be followed; or
 - 3) Make no determination of approval and forward the response materials to the convened IRB that originally reviewed the study following the scheduling procedures listed in this policy.

Table 1. Examples of stipulation responses that may be approved by Administrative reviewer (a qualified HRPPO staff member who need not be an IRB member)

Examples of acceptable responses	Examples of unacceptable responses
<ul style="list-style-type: none"> ▪ Additional changes to documents (after IRB review) to correct typographical errors noted by the investigator, provided that such a change does not alter the content or intent of the statement; ▪ Additional administrative changes (after IRB review) from the study sponsor, provided that such a change does not alter the content or intent of the statement; (e.g., updated mailing addresses for shipping samples, revised information in the sponsor protocol that does not affect the conduct of research locally); ▪ Clarification from the investigator that items of omission were actually present in the application documents reviewed by the IRB; ▪ Submission of documentation of endorsement or committee approval letter ▪ Addition of language specified by the IRB to the consent document or other protocol forms (i.e., add “history of seizures” to the exclusion criteria). 	<ul style="list-style-type: none"> ▪ Addition of new study staff, study locations, or off-site research locations; ▪ Addition of new risks or safety information that will directly affect the subjects willingness to participate (e.g., new unanticipated problems involving risks); ▪ Addition of new information from another institutional committee (e.g., RSO) or official that changes the information originally reviewed by the IRB or may affect the subjects’ willingness to participate; ▪ Modification stipulated by the IRB is not addressed in the responsive materials; ▪ Modification was based on an incorrect assumption/conclusion that is disproved in the application documents reviewed by the IRB and completely addresses the issue; (e.g., a modification to include a permission for tissue banking to the consent, when the study will not include banking) ▪ Addition of language to the consent form or other protocol documents that was not specified by the IRB and is not a minor typographical or clarification change

Table 2. Examples of stipulation responses that may be approved by the expedited reviewer (HRPP Director, HRPP Associate Director, IRB Chair, other IRB member designated by the IRB)

Examples of acceptable responses	Examples of unacceptable responses
<ul style="list-style-type: none"> ▪ Clarification from the investigator that items of omission were actually present in the application documents reviewed by the IRB; ▪ Modification was based on an incorrect assumption/conclusion that is disproved in the application documents reviewed by the IRB and completely addresses the issue; (e.g., a modification to include a permission for tissue banking to the consent, when the study will not include banking) ▪ An alternative modification than requested by the IRB that will correct the problem completely 	<ul style="list-style-type: none"> ▪ Addition of new study staff, study locations, or off-site research locations; ▪ Addition of new safety information that will directly affect the subjects willingness to participate (e.g., new unanticipated problems involving risks); ▪ Addition of new information from another institutional committee (e.g., Radiation Safety Committee) or official that changes the information originally reviewed by the IRB or may affect the subjects’ willingness to participate ▪ Modification stipulated by the IRB is not addressed in the responsive materials; ▪ Modifications stipulated by another institutional committee (e.g., Radiation Safety Committee) or official that changes the information originally reviewed by the IRB or may affect the subjects willingness to participate; ▪ An alternative modification that fails to address the IRB issue or could worsen the acceptability of the risks in relation to the harms; ▪ Removal of a direct benefit to the subjects enrolled; ▪ An alternative modification based on stipulations from another institutional committee (e.g., Protocol Review and Monitoring Committee or RSO) or official that changes the information originally reviewed by the IRB or may affect the subjects willingness to participate

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
July 2018	HRPP	Revision to RSO (dissolved SHUR)
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.2 CONTINUING REVIEW OF RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The Institutional Review Board (IRB) conducts substantive and meaningful continuation review at intervals appropriate to the degree of risk. The research protocol must satisfy the criteria set forth in 45 CFR 46.111 or 21 CFR 56.111, for the IRB to approve the protocol for continuation.
- B. In accordance with federal requirements, the IRB approval period can extend no longer than one year after the start of the approval period in which the study was approved or conditionally approved. The Principal Investigator (PI) may not continue research after expiration of IRB approval; continuation is a violation of federal requirements specified in 45 CFR 46.103(a), 21 CFR 56.103(a).
- C. If the IRB approval has expired, the PI must cease all research activities and may not enroll new subjects in the study after the expiration of the IRB approval.
- D. Continuing participation of already enrolled subjects in a research project during the period when IRB approval has lapsed may be appropriate, for example, when the IRB determines the research interventions hold out the prospect of direct benefit to the subjects or when withholding those interventions poses increased risk to the subjects.
- E. During continuing review, the IRB determines whether the progress report contains information that may indicate that a study has been modified or changed without prior IRB approval.
- F. At the time of continuing review the IRB will determine whether there is any new information provided by the investigator, or otherwise available to the IRB, that would alter the IRB's previous conclusion (see [6.2 IRB APPROVAL OF RESEARCH](#)).

II. SCOPE

This policy and procedures applies to all Investigators, the Human Research Protection Program Office (HRPPO) and IRBs for continuing review of research submitted and approved by the convened IRB.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. CR Requests, Submissions, and Screening

1. Reminders are generated by eIRB and automatically sent to the PI (and a coordinator, if designated) before the IRB approval period expires (e.g., approximately eight weeks, six weeks and four weeks prior to expiration). The PI is responsible for responding to those requests in a timely manner.
2. The PI is responsible for completing the application for CR according to the instructions in eIRB.
3. The PI must submit continuation review reports (approximately one month prior to expiration) for studies as long as the research:
 - a. Remains open to enroll new subjects; or
 - b. Continues to carry out research procedures or interventions; or
 - c. Remains active for long-term follow-up (even when the research is permanently closed to enrollment and all subjects have completed all research-related interventions); and/or
 - d. Requires analysis of data with identifiers; or
 - e. For research externally supported, the project is still being funded locally.
4. See [1.4. STUDY CLOSURE AND INACTIVATION](#) for details on circumstances in which a PI may close a study.
5. Upon receipt of the CR materials, the HRPPO staff screen the application to determine whether the study is eligible for expedited review and to determine whether the submission is complete.
6. HRPPO staff also screen the application to ensure compliance with selected federal requirements, such as need for prisoner representative review.
7. If the CR submission includes information to indicate changes were made without IRB approval the HRPPO staff flag the study for further analysis and consult the HRPP Director (HRPPD), or IRB Chair, for guidance. The HRPPO staff may contact the investigator to clarify the statement, request submission of a report of non-compliance or other appropriate actions. If the information indicates possible noncompliance, the HRPPO staff requests submission of a reportable event and follows guidance provided in [9.3 NONCOMPLIANCE REVIEW](#).
8. When the HRPPO receives the CR materials, the HRPPO staff conducts a preliminary screening of the materials submitted to ensure the materials are complete and consistent with IRB requirements. The CR materials are compared with the IRB's protocol records to identify inconsistent, inaccurate or omitted information. HRPPO staff makes corrections when appropriate and contacts the PI, or other study team

member, for any remaining issues and asks the PI to review the changes made by HRPPO staff. Corrected reports are requested prior to final review, if time permits.

9. During screening, the HRPPO staff compares answers in the CR materials with the data in the existing eIRB record.
10. The HRPPO staff screen for Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and/or Family Educational Rights to Privacy Act (FERPA) concerns.
11. The HRPPO schedule the study for a convened meeting date (if applicable) or route to the Expedited Reviewer.
12. The HRPPO staff contact ad hoc and cultural consultants regarding issues for which the IRB does not have the appropriate expertise, using the same procedures as outlined in the [2.1. INITIAL REVIEW OF RESEARCH](#).
13. The HRPPO may request additional information or materials from the PI if the application is not complete or if requested by the reviewer. If the PI does not respond, HRPPO staff makes several attempts to contact the PI and/or research staff for additional information/materials, provided there is sufficient time before the end of the approval period.
14. If the HRPPO does not receive a response from the PI, the HRPPO sends the CR to the IRB. If the approval period limits the amount of time available to resolve outstanding issues, the HRPPO staff may schedule the protocol for IRB review “as is” to avoid a lapse of approval caused by further administrative procedures. The HRPPO staff forwards any applicable notes detailing the missing or incomplete materials to the IRB.

B. Continuation Review Procedures by a Convened IRB

1. UT Southwestern has designated all UT Southwestern IRBs to review non-exempt human research conducted under its Federalwide Assurance (FWA). Continuing review of research will be performed by any of the designated IRBs. The comprehensive administrative/regulatory pre-review allows the HRPPO staff to make reviewer assignments based on study’s scientific or clinical focus area, significant ethical or regulatory issues, or issues related to local context of research (e.g., cultural issues).
2. The HRPPO staff assigns a primary reviewer to each CR based on the IRB member’s educational background and expertise. For research requiring expertise in multiple areas of science or ethics, additional reviewers may be assigned as determined by the HRPPO staff, Director or Chair. Reviewers may request the HRPPO provide additional expertise as well. Generally, the HRPPO staff make the reviewer assignments, if needed, the Regulatory Specialist, HRPPD or IRB Chair may assist with this process. Information on each IRB member’s earned degrees, scientific status, representative capacity (e.g., knowledge related to children, pregnant women, prisoners, economically disadvantaged, educationally disadvantaged, cognitively impaired adults or students), and indicators of experience (e.g., scientific and clinical experience, certifications, licensure, etc.) are maintained in the HRPPO shared drive.

3. In selecting the reviewers, he/she must have appropriate scientific or scholarly expertise. If necessary, ad hoc or cultural consultants with appropriate expertise will be asked to participate in the pre-review and/or IRB review process. Ad hoc or cultural consultants are generally recruited from the membership of other UTSW IRBs, UTSW schools or affiliated institutions. This determination may be made by the IRB Chair/Alternate Chair or the HRPPD. If, during the meeting, the Primary reviewer is absent IRB Chair/Alternate Chair/Regulatory Specialist may serve as the primary reviewer with input of the members present.
4. Approximately 5 days prior to the meeting, the IRB members scheduled to attend the meeting receive access to the following items, but not limited to:
 - a. The completed Progress Report Form including a protocol summary containing the relevant information necessary to determine whether the proposed research continues to fulfill the criteria for approval and status report of the progress of the research;
 - b. Attachments (e.g., updates/changes, explanations, any relevant multi-center trial reports);
 - c. A copy of the current consent/assent form for which the investigator is seeking IRB re-approval;
 - d. Reviewer checklist.
5. All IRB members are responsible for reviewing all information in the review packet in advance of the meeting (including those protocols for which the IRB member is not the primary reviewer) in enough depth to be familiar with the protocol, to be prepared to discuss the protocol at the meeting, and to be prepared to determine whether the research meets the regulatory criteria for approval.
6. When documentation of informed consent is required, the IRB reviews the informed consent document(s) submitted for re-approval to ensure accuracy and completeness and any newly proposed consent document.
 - a. The IRB can observe or request observation of a research participant(s) being consented. The HRPP Regulatory Monitoring Analyst will observe and report findings back to the IRB. Protocols selected for observation may include those that involve:
 - 1) High risks to participants;
 - 2) Particularly complicated procedures or interventions;
 - 3) Potentially vulnerable populations (e.g., ICU patients, children);
 - 4) Study staff with minimal experience in administering consent to potential study participants;
 - 5) Other situations where the IRB has concerns that consent process might not be proceeding well.

7. The HRPPO staff ensure that the complete IRB protocol record is available to all IRB members prior to and, if requested, during the convened meeting. All IRB members have the opportunity to discuss each research protocol during the convened meeting.
8. The convened IRB assesses the CR materials using the federal criteria for approval (45 CFR 46.111, 21 CFR 56.111) (See [6.2 IRB APPROVAL OF RESEARCH](#)).
9. When the IRB reviews research that involves categories of subjects vulnerable to coercion or undue influence, the HRPPO staff ensures that adequate representation or consultation is present for discussions of research involving vulnerable human subjects ([6.2 IRB APPROVAL OF RESEARCH](#)).
10. The IRB/HRPPO staff conducts the convened meeting in accordance with [6.3 CONDUCT OF FULL BOARD MEETINGS](#). Members who have a conflict of interest follow procedures outlined in both [6.3 CONDUCT OF FULL BOARD MEETINGS](#) and [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#).
11. The HRPPO staff serves as intermediaries between the PI and the IRB primary reviewer. However, the primary reviewer may contact the PI directly for clarification. The reviewer documents the issues discussed with the PI in the CR materials.
12. Primary Reviewer review: continuing review of research at a convened meeting of the IRB relies on a single reviewer system. A reviewer from the membership is assigned to each business item. The primary reviewer system does not prohibit any member of the Board from obtaining, reviewing and providing input on any business item scheduled for a convened meeting. Approximately 1 week prior to the convened meeting, the HRPPO staff make the following information available to the primary reviewer for review:
 - a. A completed Progress Report Form (progress report) for each study, which includes, when applicable, the number of subjects enrolled and withdrawn from the study; summary of unanticipated problems involving risks to the subject or others; recent literature; complaints about the research; and any new, significant findings (new findings and implications for subject participation);
 - b. A protocol summary and status report on the progress of the research;
 - c. A copy of the currently approved sponsor protocol for externally sponsored research (including any prior IRB approved modifications) and/or research description (summary which addresses all elements of criteria for approval);
 - d. And if applicable:
 - 1) A cover memo if it contains pertinent information to review of protocol;
 - 2) Attachments (e.g., updates/changes, explanations)
 - 3) Summary of data safety and monitoring reports;

- 4) A copy of the current consent document and if different a copy of the consent form for which the investigator is seeking IRB approval;
 - 5) A revised grant application;
 - 6) Primary Reviewer Checklist for Continuation Review;
 - 7) The HRPPO staff recommendations;
 - 8) See the CR form for a complete list of information and attachments the PI must submit.
13. The reviewer is responsible for:
- a. Reviewing the progress report and comparing with their review of the complete IRB record including any previous reports and protocol modifications previously approved by the IRB;
 - b. Informing the full IRB of any discrepancies in the materials provided for CR;
 - c. Reviewing new disclosures of protocol related conflict of interest disclosure, alerting the IRB if a disclosure is made. If a disclosure is made, the review will summarize the conflict and proposed management plan to the IRB (if a management plan is not provided from the Conflict of Interest Committee (COIC), the reviewer will provide recommendations to manage the conflict to the IRB;
 - d. Conducting an in-depth review (See [6.2 IRB APPROVAL OF RESEARCH](#) for details);
 - e. Identifying information in the progress report that may indicate that changes or modifications to the study have been made without the IRB's approval and should have an external reviewer verify whether any material changes have occurred. If the information indicates possible noncompliance, the IRB follows guidance provided in [9.3 NONCOMPLIANCE REVIEW](#).
14. Ad hoc or cultural consultants may provide comments or recommendations in writing to the IRB prior to the meeting or attend the convened meeting to participate in the review. The minutes of the meeting document the information provided by the consultant. (See [8.1 IRB MINUTES](#)).
15. Primary reviewers provide recommendations to the IRB at the convened meeting on issues which they determine do not meet the federal criteria for approval, are controverted, need additional information, or concern compliance with federal regulations, IRB approval or the UTSW human research protection program policies. If the information indicates possible noncompliance, the IRB follows guidance provided in [9.3 NONCOMPLIANCE REVIEW](#).
16. If the primary reviewer is unable to attend the meeting, the reviewer's written comments or recommendations are presented by the Chair or Regulatory Specialist to the IRB at the convened meeting.

17. The IRB considers each CR scheduled for full review separately for approval. At the meeting, the IRB reviews the CR report and any controverted issues and their resolution prior to voting. During discussion, the IRB members only raise those controverted issues that the IRB determines do not meet the federal criteria for approval as specified in 45 CFR 46.111, and 21 CFR 56.111. IRB approval of the CR materials documents that the IRB agrees with the PI assessment of any specific findings included in the CR report that were not previously addressed by the IRB.
18. The IRB ensures the PI provides any significant new findings that might relate to the subject's willingness to continue participation in accordance with regulations.
19. The convened IRB makes the final determination on the outcome of the review. The meeting deliberations are documented in the meeting minutes.

C. Expedited Continuation Review

1. The IRB may only use expedited review procedures for continuation review (CR) under the following circumstances:
 - a. The study was initially eligible and continues to be eligible for expedited review procedures; OR
 - b. The research is permanently closed to the enrollment of new subjects; all subjects have completed all research-related interventions; and the research remains active only for long-term follow-up of subjects; OR
 - c. Where no subjects have been enrolled at the UTSW and no additional risks have been identified either at the UTSW or at any site if the research involves a multi-site study; OR
 - d. The only remaining research activities are limited to data analysis; OR
 - e. The IRB previously determined and documented at a convened meeting that the research is no greater than minimal risk, and all of the following are true:
 - 1) No additional risks have been identified, and
 - 2) If the research involves the study of drugs and/or medical devices the research:
 - i. Does not require an Investigational New Drug (IND) (21 CFR Part 312) and/or
 - ii. Does not require an Investigational Device Exemption (IDE) (21 CFR Part 812) application and/or
 - iii. The device is approved for marketing and being used in accordance with the approved labeling.
2. The HRPPD, IRB Chair, or designee serves as the expedited reviewer for expedited CR protocols. If the individual performing expedited review has a conflict of interest (e.g., is study personnel on a protocol for continuation review), is unavailable, or does not have the appropriate expertise to review the CR, the HRPPO staff may re-assign

responsibility for the CR to another Chair, Alternate Chair, or designated reviewer. If no other reviewer is available, the HRPPO staff may assign the CR to the convened IRB.

3. The HRPPO staff provides the expedited reviewer access to the same information provided to a convened IRB including the following, but not limited to:
 - a. A completed Progress Report Form for each study, which includes, when applicable, the number of subjects enrolled and withdrawn from the study; summary of unanticipated problems involving risks to the subject or others; recent literature; complaints about the research; and any new, significant findings (new findings and implications for subject participation described);
 - b. A protocol summary and status report on the progress of the research;
 - c. A copy of the currently approved sponsor protocol for externally sponsored research (including any prior IRB approved modifications) and/or research description (summary which addresses all elements of criteria for approval); and
 - d. If applicable:
 1. A cover memo if it contains pertinent information to review of protocol;
 2. Attachments (e.g., updates/changes, explanations)
 3. Summary of data safety and monitoring reports;
 4. A copy of the consent form for which the investigator is seeking IRB approval;
 5. A revised grant application;
 6. Primary Reviewer Checklist for Continuation Review;
 7. The HRPPO staff recommendations.
4. The designated expedited reviewer(s) is responsible for reviewing all information in the expedited review packet in enough depth to be familiar with the protocol, to determine whether the research is eligible for expedited review, and to determine whether the research meets the regulatory criteria for approval.
5. The designated expedited reviewer(s) is responsible for making the final determination that the protocol meets the criteria for expedited review as outlined above. If the expedited reviewer determines full review is necessary, (s)he documents this requirement in eIRB. Upon receipt of the reviewer's recommendation, the HRPPO staff forwards the submission to the convened IRB for review.
6. The designated expedited reviewer(s) applies the same criteria for approval as outlined above for full review (i.e., applies 45 CFR 45.111, and 21 CFR 56.111), and documents the determination in eIRB.

7. When documentation of informed consent is required, the expedited reviewer reviews the informed consent document(s) submitted for re-approval to ensure accuracy and completeness.
8. The HRPPO staff serves as intermediaries between the PI and the IRB expedited reviewer. However, the expedited reviewer may contact the PI directly for clarification. The reviewer documents in the CR materials the issues discussed with the PI.
9. The expedited reviewer documents in the CR materials any determination pertaining to specific findings, as mandated by federal regulations that were not previously addressed by the IRB. (Expedited reviewer approval of the CR materials documents that the reviewer agrees with the PI's assessment of the specific findings).
10. The expedited reviewer ensures the PI provides any significant new findings that might relate to the subject's willingness to continue participation in accordance with regulations. The reviewer uses the IRB Continuation Review Checklist as a prompt.
11. If the approval might lapse before completion of the CR, the expedited reviewer can make a determination to allow subjects currently participating to continue in accord with procedures described in the section below on lapses of approval.
12. HRPPO staff list expedited CRs on the Expedited Report to advise the IRB of the expedited CR approvals.

D. Review Outcome(s)

1. Convened Review
 - a. Generally, the primary reviewer makes a motion; another member seconds the motion, and then the convened IRB votes for or against or abstains from the motion. The motion may be one of the following four actions:
 - 1) Approved - IRB approval indicates that the IRB has concluded that the research (including the research plan and consent forms) continues to meet the federal criteria for approval. IRB approval verifies that the IRB agrees with the information/materials submitted for continuation of the protocol and/or specific findings described in the CR report by the PI.
 - 2) Conditional Approval – IRB conditional approval indicates that the IRB has approved the protocol for continuation. The investigator must submit minor revisions or clarifications to the progress report, consent, or any other applicable documents identified during the review. The submission of revisions required by the IRB must be provided within the time period specified by the IRB. Depending upon the nature of the required conditions, the IRB could designate the IRB chair, a specific IRB member with appropriate expertise, an IRB administrator, or a qualified HRPPO staff person to review the changes and determine whether the conditions

was approved or conditionally approved (unless anniversary date is used, see below).

- 2) The IRB may set a shorter approval period for:
 - i. high risk protocols or protocols with unanticipated problems (UPIRSOs);
 - ii. protocols with high risk/low potential benefit ratios;
 - iii. studies involving the first use of an experimental drug or device in humans where safety data is limited;
 - iv. studies involving research procedures not normally reviewed by the IRB;
 - v. research with a history of noncompliance issues; or
 - vi. any other study the Board determines a shorter approval period and the resultant continuing review are appropriate.
2. For expedited CR, the expedited reviewer may make the following determinations:
 - a. approved;
 - b. conditional approval; or
 - c. review by the convened Board required.
 - d. The expedited reviewer exercises all the authority of the IRB except the reviewer may not disapprove the CR. Only the convened IRB may disapprove the CR.
 - e. The expedited reviewer determines the duration of approval in the same manner as the convened review (as described above).
3. Use of anniversary dates when CR is determined to occur annually – CR approved or conditionally approved for one year by either the convened board or expedited review may retain the current expiration date (day and month) as the date by which the next continuing review must occur (expiration date), if the approval/conditional approval occurs within 30 days before the IRB approval period expires. For convened review of CR, the HRPPO staff includes the approval period in the meeting minutes.
 - a. When CR is conditionally approved by the convened IRB, the HRPPO staff issue final approval after the IRB Chair or designee reviews and approves the PI's response.
 - b. When CR is tabled/deferred by the convened IRB due to substantive issues identified during the review at one convened meeting and subsequently reviewed and approved by another convened meeting, the approval period starts with the date of the subsequent convened IRB meeting.

- c. Upon request, HRPPO staff also sends the PI and funding agency Certification of Approval form.
4. If the PI has concerns regarding the IRB decision/recommendations for changes in the study, he/she may submit his/her concerns to the IRB in writing with a justification for altering the IRB decision. The IRB reviews the request using the standard IRB review procedures.

E. Lapse of Approval

1. The length of approval determined by the IRB results in an approval period (effective date and an expiration date). The expiration date is the last date of approval for the protocol. One day after the expiration date, if the IRB has not reviewed and re-approved the research, all research activities must stop, unless the IRB finds that it is in the best interests of individual subjects to continue participating in the research interventions or interactions. Enrollment of new subjects cannot occur after the expiration of IRB approval.
2. It is the Principal Investigator's responsibility to conduct research under a current IRB approval. The PI is responsible for planning ahead to meet the required continuing review dates and prevent a lapse in approval. The PI is also responsible for stopping research that has lapsed unless it is in the best interest of the subjects. If research is conducted on or after the expiration date without IRB approval, the PI must submit a report of noncompliance (see [9.3 NONCOMPLIANCE REVIEW](#)).
3. If a PI fails to return the CR Report Form or the IRB has not completed review by the end of the current approval period, the HRPPO staff promptly notifies the PI that the approval will lapse or has lapsed. The HRPPO staff will inform the PI that research must cease and no new subject enrollment may occur after the date of lapse. The HRPPO staff also inform the PI that he/she should, if appropriate, notify subjects that the study approval has lapsed and that, if applicable, it is his/her responsibility to notify the funding agency of the expiration of the IRB approval.
4. The PI may ask the IRB for permission to allow subjects currently participating to continue due to overriding safety concerns, ethical issues, or because it is in the best interest of the individual subjects. The Board reviews the possible implications of stopping research and whether other actions should be taken to avoid a lapse in approval due to overriding safety concerns, ethical issues, or because it is in the best interest of the individual subjects. In either case, the IRB makes the final determination of whether research activities (e.g., continued administration of a study drug) may continue after the current expiration date. The HRPPO or IRB notifies the PI in writing of that determination.
5. In the case of a study was deferred and the PI is actively pursuing renewal, but he/she could not respond to the IRB request for changes before the end of the approval period, which resulted in a lapse of approval, HRPPO staff send the resubmitted materials to the same IRB that requested the changes. The IRB may subsequently approve the study for continuation.

6. If a protocol approval has expired due to failure of the PI to submit a continuation review report or to respond to the IRB’s request for revisions and the PI subsequently submits the CR materials/revisions after the study has expired, the HRPPO requests from the PI a written summary of events that occurred in the interim (if any). If the PI submitted the materials/revisions less than three months after the expiration date, HRPPO staff forward the PI’s summary and the CR materials/revisions to the IRB. The IRB reviews the materials/revisions following procedures outlined in this policy and may re-approve the study if no research activity has occurred after the expiration date. The new approval period will take into account the previous expiration date and not approve the study for a full year, rather the original expiration date will be used to avoid the potential for positive reinforcement for allowing a study to lapse.
7. If a protocol approval has expired due to failure of the PI to submit a CR report or respond to the IRB’s request for revisions the study records may be administratively inactivated (see [1.4. STUDY CLOSURE AND INACTIVATION](#)).
8. A lapse of IRB approval does not constitute a suspension of approval under Food and Drug Administration and Department of Health and Human Services.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.3 MODIFICATIONS TO RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

I. POLICY STATEMENT

- A. This procedure outlines the responsibilities of the investigator, IRB, HRPPO for the review of modifications to research previously approved by the IRB.

II. SCOPE

- A. This policy and procedures applies to all IRB members, the HRPPO and investigators responsible for modifications to previously approved research.
- B. Investigators may not initiate any minor or major changes in research protocol, procedures or consent form(s) without prior IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject. This includes single subject exceptions
- C. Investigators should promptly notify the IRB via eIRB of any change in a protocol's status, such as discontinuation or premature/successful completion of a study. See [9.2 UPIRSO and UADE, 2.2. CONTINUING REVIEW OF RESEARCH](#), and the [1.4. STUDY CLOSURE AND INACTIVATION](#) for additional procedures on reporting an activity status change to the IRB.
- D. Emergency Deviations - If the investigator makes protocol changes without prior IRB approval to eliminate apparent immediate hazards or to protect the life or physical well-being of subjects or others, investigators must promptly report the changes to the reviewing IRB (and UTSW HRPP for reliance studies) via a Reportable Event submission, as outlined in the [Reportable Event Guidance](#) and [9.2 UPIRSO and UADE](#).

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Administrative Actions taken by HRPPO staff
 - 1. Administrative changes may be accepted by HRPPO staff and do not require IRB review. Examples include (but are not limited to): Translations of approved consent forms and recruitment materials, verification of media advertisements based on IRB approved scripts, minor changes to contact information, removal of a study sites, changes requested by affiliated institutions, and changes that correct administrative errors made during previous IRB review, etc.
 - 2. Communication requesting the changes will be received by the HRPPO. The request may originate from the PI, the IRB, or other institutional research offices.
 - 3. The HRPPO staff may review and accept administrative changes to research previously approved by IRB.
 - 4. If the change is determined not to be administrative, the modification will be routed for Expedited IRB review or Convened IRB review
- B. Single subject exceptions
 - 1. Single subject exceptions require review and approval by the IRB. Examples include (but are not limited to): enrollment of a single subject who does not meet all eligibility criteria for a study, but the investigator and sponsor have agreed this subject should be enrolled These exceptions should be submitted as reportable events; see [9.5 REPORTABLE EVENTS GUIDANCE](#) for additional information about submission of exceptions

2. An Exception Request is received by the HRPPO via eIRB from the PI including necessary documentation.
 3. For greater than minimal risk studies, documentation of sponsor acknowledgement and/or approval is required for all applicable trials. Documentation of an independent assessment from another individual unrelated to the study must be obtained for all investigator initiated protocols without a sponsor and investigator sponsored protocols when enrolling subjects that do not meet inclusion/exclusion criteria. Requests will not be reviewed by a member of the IRB until appropriate documentation is provided.
 4. Approval for additional Exceptions of the same type should be requested from the IRB with the submission of a modification by the PI.
 5. All Exception requests must include a confirmation from the PI that the request does not affect the rights, safety, or welfare of the subjects or the integrity of the study data.
 6. The HRPPO staff will review and confirm whether the exception is considered a major or a minor change and will route to either Expedited IRB Review or Convened IRB review as described in this policy.
- C. Minor and Major Changes
1. The PI makes a preliminary assessment of whether the changes are administrative, minor, or major on the eIRB Modification smart form.
 2. The modification request is received via eIRB by the HRPPO staff from the PI including the revised smart forms and documents reflecting the changes
 3. The HRPPO staff will review and determine the appropriate IRB review (expedited or convened IRB) for the request. The HRPPO is responsible for opening all modification submissions within five business of assignment to conduct a preliminary assessment, to determine if convened IRB review is necessary.
 4. Minor changes may be reviewed by the Expedited IRB Review Procedure or by the convened IRB. See Table 1 below.
 5. Major changes are reviewed by the convened IRB. See Table 2 below.
 6. If the HRPPO staff determines the changes are minor, then the review follows the expedited IRB procedures listed below.
 7. If the HRPPO staff determines the changes are not minor, modification request is scheduled for review at a convened IRB following procedures outlined in the Receiving, Routing, and Administrative Review of Submissions Policy and Procedure.
- D. Minor Changes: Expedited IRB Procedures
1. Minor Changes require review and approval by the IRB. Examples include (but are not limited to): clarifications of procedures, new minimal risk procedures (not involving radiation), changes to recruitment methods/materials, new/modified safety monitoring procedures to decrease risks, etc.
 2. The IRB may use the expedited IRB review procedure to review minor changes in previously approved research during the period (of one year or less) for which approval is authorized. In all cases, the modifications are reviewed by the HRPP Director, IRB Chair, Designated

Reviewer or another experienced IRB member designated by the Chair (designee) (collectively referred to as the Designated Reviewer(s)).

3. The HRPPO Designated Reviewers performs most of the expedited IRB reviews of modifications. Depending on the study, workload, availability of other reviewers and other factors, other reviewers may be included or substituted in the process. The review is conducted outside of a convened meeting. If any of the assigned Designated Reviewers are not available or have a conflict of interest, the HRPPO staff contacts a secondary reviewer to conduct the review. In general, experienced IRB members are not asked to conduct a review alone unless they have at least one year IRB experience.
 4. The Designated Reviewers conduct the review, using standard expedited IRB review procedures and is provided all information that would be reviewed by the convened IRB. The Designated Reviewers exercise all of the authority of the IRB except that the reviewer may not disapprove the modification. The IRB is notified of the expedited IRB approvals by providing a report of Expedited IRB actions to the members of IRB 1, 2, 3, and 4 as part of each convened meeting's agenda. During the meeting, the members are reminded that they can request additional information related to the expedited IRB approvals.
 5. The Designated Reviewer also considers if the proposed changes to the study may impact:
 - a. Currently enrolled subject's willingness to continue participation in the research. If applicable, the IRB will consider whether the information should be provided to the subject through an updated consent process.
 - b. Subjects who have completed research involvement. If applicable, the IRB will consider whether the PI should re-contact these subjects and provide them with additional information
 6. If the Designated Reviewer would prefer or requires additional expertise during the review, an IRB consultant may be requested. Documentation of the consultant's review will be recorded with the Designated Reviewer's documentation to support the determination.
 7. When the modification involves the addition of categories of subjects vulnerable to coercion or undue influence, the Designated Reviewer considers whether consultation is necessary for review of the research involving vulnerable human subjects (IRB Approval of Research Policy and Procedure)
 8. The Designated Reviewer documents the determination regarding whether the convened IRB or expedited IRB review procedures are appropriate on the Expedited IRB Approval/Administrative Review Documentation.
 9. The Designated Reviewer documents the applicable approval determinations regarding expedited IRB review eligibility, whether the research meets the criteria for IRB approval, and whether any research categories of the currently approved protocol are affected by the proposed modification on the Expedited IRB Approval/Administrative Review Documentation.
- E. Major Changes: Convened IRB Review Procedures
1. Major Changes are reviewed by the convened IRB. Examples include (but are not limited to): major changes to study design, new/increased risks, change in the use of drugs, new vulnerable populations (when research is more than minimal risk), new more than minimal

risk procedures, new/revised procedures involving radiation, reducing safety monitoring procedures, etc.

2. The HRPPO staff may invite the PI to attend the IRB meeting if the modification is unusually complex, the staff anticipates a controverted issue will arise during the review, or at the request of the reviewing IRB member. The full IRB reviews the modification proposal following procedures outlined in the Initial Review of Research Policy and Procedure and apply the federal criteria for approval as applicable to the request (IRB Approval of Research Policy and Procedure).
 - c. The UT Southwestern Medical Center has designated all IRBs operated by the UT Southwestern Medical Center to review non-exempt human research conducted under its Federalwide Assurance (FWA).
 - d. Review of modifications to previously approved research may be performed by any of the designated IRBs.
 3. The HRPPO staff sends the meeting agenda, including all documents associated with the MOD via eIRB to IRB members scheduled to attend per Initial Review of Research Policy and Procedure. These documents are made available to all other IRB Members scheduled to attend the IRB meeting. Other documents may be added to the submission for all members as determined appropriate.
 4. The primary reviewer is responsible for reviewing the proposed modification and rationale for the change, determining whether the modified research continues to fulfill the criteria for IRB approval, and documenting his/her determinations on the Reviewer Worksheet. The primary reviewer reports recommendations to the IRB at a convened meeting. The primary reviewer makes recommendations on issues which he/she determines are not meeting the federal criteria for approval, involving controverted issues, or where additional information is necessary. If the primary reviewer is unable to attend the meeting, the IRB Chair or Regulatory Specialist provides the Primary Reviewer's written comments or recommendations to the IRB at the convened meeting.
 5. The IRB also considers if the proposed changes to the study may impact:
 - a. Currently enrolled subject's willingness to continue participation in the research. If applicable, the IRB will consider whether the information should be provided to the subject through an updated consent process.
 - b. Subjects who have completed research involvement. If applicable, the IRB will consider whether the PI should re-contact these subjects and provide them with additional information.
 6. When the IRB reviews research that involves categories of subjects vulnerable to coercion or undue influence, the HRPPO staff ensures that adequate representation or consultation is present for discussions of research involving vulnerable human subjects (IRB Approval of Research Policy and Procedure).
 7. Changes related to Radiation safety or Biosafety – Approval to implement the changes will not be granted by the IRB until prior RSO or IBC approval is obtained.
- F. Review Outcome(s)

1. For administrative modifications, the outcomes of review are approved by HRPPO and forwarded for IRB review.
2. For review of modifications, the outcomes of IRB review are the same as those outlined in the Initial Review of Research Policy and Procedure.
3. If the IRB approves the modification, the end date of the approval period remains the same as that assigned at initial or continuation review unless the IRB specifically shortens the current approval period (requiring continuing review earlier) as part of the motion voted on by the members.
4. Appeals. If the PI has concerns regarding the IRB decision, he/she may submit his/her concerns to the IRB including a justification for changing the IRB decision. This appeal will be reviewed by the convened IRB following the procedures outlined above.
5. After review, reporting is in accordance with the Reporting Policy and Procedure.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

Designated Reviewer:

- For Expedited IRB Review - refers to the Expedited Reviewer designated to conduct Expedited IRB Reviews on behalf of the IRB Chair. This individual must be formally designated by the Chair.
- For Administrative Review – refers to HRPPO staff member who may make administrative review decisions for items not requiring review by the IRB

IRB: Refers to both Expedited and Convened (full board) IRB review

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Clarified emergency deviations
July 2018	HRPP	Revision to RSO (dissolved SHUR)
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

TABLE 1

For expedited research that was initially approved by expedited review, the following examples of minor and major changes are provided:

Research initially approved by expedited review (expedited study)	
Examples of minor change	Example of major changes
<ul style="list-style-type: none"> -- Modifications that are minimal risk and fit within the expedited review categories 1 – 7 -- a modification that does not change the study’s eligibility for expedited review 	<ul style="list-style-type: none"> -- Modifications that are greater than minimal risk (e.g., addition of anesthesia ionizing radiation, or IV contrast for MRI imaging) -- Modifications that do not fit within the expedited review categories
<p>Note: Changes, which, in the opinion of the Designated Reviewer do not meet the criteria or intent of a minor modification, will be forwarded to the convened IRB for review.</p>	

TABLE 2

For research that was initially approved by the convened IRB (i.e., not eligible for expedited initial review), the following examples of minor and major changes are provided:

Research initially approved by the convened IRB		
Area of study affected by modification	Examples of minor change to the risk/benefit ratio	Example of major changes to the risk/benefit ratio
Elements of consent	<ul style="list-style-type: none"> -- Changes to improve the clarity of statements or to correct typographical errors, provided that such a change does not alter the content or intent of the statement; -- Alter or waive informed consent; 	<ul style="list-style-type: none"> -- Use of surrogate consent for incapacitated or incompetent adult subjects; -- Addition of new safety information that will directly affect the subjects willingness to participate (e.g., new unanticipated problems involving risks)
IRB Approval 46.111 – Risks minimized	<ul style="list-style-type: none"> -- Clarification of risks without changing the expected nature, severity or frequency of risks; -- Add a new risk to existing procedures that is considered not serious; -- Addition of research activities that would be considered exempt or expedited if considered independent from the main research protocol or that will not change, or will reduce, the likelihood or magnitude of harm while still addressing the purpose -- Modification of the study design or research activities that will not change, or will reduce, the likelihood or magnitude of harm while still addressing the purpose (e.g., increase hospital stay to improve safety monitoring); -- Modification of the study population that will not change or will reduce the likelihood or magnitude of harm while still addressing the purpose (e.g., broaden exclusion criteria or narrow inclusion criteria); -- Modification of a study procedure that will not change or will reduce the likelihood or magnitude of harm while still addressing the purpose (e.g., reduce the number procedures or reduce amount collected or administered); 	<p>The following are examples of new or modified risk information that would not be eligible for Expedited review if the change adversely impacts the overall risk/benefit relationship—</p> <ul style="list-style-type: none"> ---Add a new procedure with an expected serious harm; -- Add a new risk to existing procedures that is considered serious; -- Change in severity of an expected risk from not serious to serious; -- An increase in the incidence of an expected serious risk (either from rare to likely or less likely or less likely to likely); -- Modification of the study design that will increase the likelihood or magnitude of harm; -- Modification of the study population that will increase the likelihood or magnitude of harm; -- Modification of a study procedure that will increase the likelihood or magnitude of harm;

TABLE 2 CONTINUED

Area of study affected by modification	Examples of minor change to the risk/benefit ratio	Example of major changes to the risk/benefit ratio
IRB Approval 46.111 – Risks reasonable relative to benefits	<ul style="list-style-type: none"> -- Modifications with no effect on the risks or benefits -- Modifications that improved the acceptability of the risks in relation to the harms; -- Addition of a direct benefit to the subjects enrolled; 	<ul style="list-style-type: none"> -- Modifications that decrease the acceptability of the risks in relation to the benefits; -- Removal of a direct benefit to the subjects enrolled if the overall risk/benefit ratio is adversely impacted due to the change
IRB Approval 46.111 – equitable selection of subjects	<ul style="list-style-type: none"> -- Addition/modification of recruitment procedures or materials; -- Addition/modification of payments to subjects that will not unduly influence the subject; -- Addition of children under 46.404; 	<ul style="list-style-type: none"> -- Addition of children under 46.405 - 408; -- Addition of a pregnancy women/fetus population; -- Addition of a prisoner population;
IRB Approval 46.111 – adequate safety monitoring	<ul style="list-style-type: none"> -- Addition/modification of safety monitoring plan that will likely improve the safety of subjects; 	<ul style="list-style-type: none"> -- Modifications to the safety monitoring plan that will reduce the current protections;
IRB Approval 46.111 – adequate protection of privacy and maintenance of confidentiality	<ul style="list-style-type: none"> -- Addition/modification of privacy or confidentiality safeguards that will likely improve the protections; 	<ul style="list-style-type: none"> -- Modifications to the privacy or confidentiality safeguards that will reduce the current protections;
Qualification of the research team	<ul style="list-style-type: none"> -- Changes in study staff requiring training for specialized procedures 	<ul style="list-style-type: none"> -- Suspension/lapse of investigator privileges that directly reflect research procedures; -- New disclosures of significant related conflict of interest
Facilities available to support safe conduct of the study	<ul style="list-style-type: none"> -- Changes in study sites 	<ul style="list-style-type: none"> -- Withdraw of institution/staff support for research that directly affects safe conduct of research;
<p>Note: Changes, which in the opinion of the Designated Reviewer do not meet the criteria or intent of a minor modification, will be forwarded to the convened IRB for review.</p>		

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.4 DoD RESEARCH POLICY AND PROCEDURE

RESPONSIBLE OFFICE: Human Research Protection Program Office

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. The purpose of this policy is to describe Investigator and Institutional Review Board (IRB) requirements necessary to ensure human subjects' research involving Department of Defense (DoD) components comply with the requirements outlined in the Department of Health and Human Services (DHHS) Federal Wide Assurance for the Protection of Human Subjects.
- B. When conducting DoD research, FDA (21CFR50 & 56) and DHHS (45CFR46) human subjects research regulations apply, however when Human Research is conducted or funded by the Department of Defense (DoD), UT Southwestern commits to also apply the Department of Defense (DoD) Directive 3216.02, which includes the requirement to apply 45 CFR §46 Subparts B, C, and D. This Organization will comply with the terms of the DFARS clause or comparable language used in the agreement with the Department of Defense (DoD) Component supporting the research involving human subjects.
- C. Special considerations apply to research involving human subjects supported by a DoD Component through a contract, grant, cooperative agreement, or other arrangement.
- D. Department of Defense (DoD) Components include the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities and all other organizational entities in the Department of Defense.
- E. Any institution engaging in research that involves the DoD must possess a valid Federal Wide Assurance (FWA). Research funded by the DoD shall have a current DoD assurance of compliance.

II. SCOPE

- A. This policy applies to all DoD Research. DoD Research is research that is funded or sponsored by the Department of Defense; involving collaboration with any component of DoD; using property, facilities or other DoD resources; or when the subject recruitment is targeted at DoD personnel (whether civilian and/or military).
- B. It is the responsibility of the PI to ensure that all additional DoD and/or Specific component requirements (e.g. Army, Navy, Air Force) requirements for human subject protection are met.
- C. It also is the responsibility of the IRB to ensure that all additional requirements for human subject protection have been met before IRB approval of the research study.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. When submitting an application for human subject research to the IRB, the principal investigator (PI) must identify the research as sponsored or funded by a DoD component (as defined in Department of Defense Directive 3216.02). The PI is responsible for identifying DoD component

requirements specified in the grant application guidelines and for advising the IRB staff and IRB of the requirements.

- B. The IRB and Office of IRB staff will review protocols to ensure the following specific considerations and procedures for DoD sponsored research have been considered prior to approval.
 - 1. Educational Requirements
 - a. Initial and continuing research ethics education is required for all personnel who conduct, review, approve, oversee, support, or manage human participants' research.
 - b. If there are specific DoD educational requirements or other certification requirements for study personnel, the Human Research Protection Program Office (HRPPO) staff will ensure those requirements are met (See [5.2 RESEARCH EDUCATION AND TRAINING](#))
 - 2. Informed Consent
 - a. Funds appropriated to the Department of Defense may not be used for research involving a human being as an experimental subject unless
 - i. the informed consent of the subject is obtained in advance; or
 - ii. in the case of research intended to be beneficial to the subject, the informed consent of the subject or a legal representative of the subject is obtained in advance.
 - b. When the research meets the DoD definition of "Research Involving a Human Being as an Experimental Subject," the IRB may not waive the consent process (this prohibition does not apply to screening of records to identify possible subjects).
 - c. The Secretary of Defense may waive the prohibition with respect to a specific research project to advance the development of a medical product necessary to the armed forces if the research project may directly benefit the subject and is carried out in accordance with all other applicable laws.
 - d. Exception from Informed Consent (EFIC)
 - i. DoD regulations prohibit an exception from informed consent in planned emergency medicine research unless the PI obtains a waiver from the Secretary of Defense.
 - 3. Inclusion of Vulnerable Populations
 - a. US Military Personnel
 - i. Service members must follow their command policies regarding the requirement to obtain command permission to participate in research involving human subjects while on-duty or off-duty.
 - ii. The IRB will confirm the following additional protections are in place to minimize undue influence (as applicable):

1. Officers are not permitted to influence the decision of their subordinates.
 2. Officers and senior non-commissioned officers may not be present at the time of recruitment.
 3. Officers and senior non-commissioned officers have a separate opportunity to participate.
 4. When recruitment involves a percentage of a unit, an independent ombudsman is present.
- iii. Limitations on dual compensation:
1. Prohibit an individual from receiving pay of compensation for research during duty hours.
 2. US military personnel may be compensated for research if the participant is involved in the research when not on duty
 3. Federal employees while on duty and non-Federal persons may be compensated for blood draws for research up to \$50 for each blood draw.
 4. Non-Federal persons may be compensated for research participation other than blood draws in a reasonable amount as approved by the IRB according to local prevailing rates and the nature of the research.
- iv. Survey Research
1. Survey/questionnaire research involving DoD personnel must receive IRB approval prior to final approval by an additional level of DoD which typically is required.
 2. The PI must submit surveys and all required documentation relevant to survey research review to the requesting DoD Component. (SECNAVINST 3900.39D, para. 6e; OPNAVINST 5300.8B)
- b. Pregnant Women and Fetuses
- i. DoD research involving pregnant women is subject to the DHHS Subpart B.
 - ii. For purposes of applying Subpart B to DoD research, the phrase “biomedical knowledge” shall be interpreted as “generalizable knowledge.”
 - iii. The applicability of Subpart B is limited to research involving pregnant women as participants in research that is more than minimal risk and includes interventions or invasive procedures to the woman or the fetus; or involves fetuses or neonates as participants.
 - iv. Fetal DoD research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g.

- c. Children
 - i. DoD research involving children is subject to the DHHS Subpart D.
 - ii. DoD research involving children cannot be exempt
- d. Prisoners
 - i. DoD research involving prisoners is subject to the DHHS Subpart C.
 - ii. DoD research involving prisoners cannot be reviewed by the expedited procedure.
 - iii. When the IRB reviews research involving prisoners, at least one prisoner representative must be present for quorum.
 - iv. In addition to allowable categories of research on prisoners in Subpart C, the following two additional categories are allowable:
 - 1. epidemiological research is also allowable when:
 - a. The research describes the prevalence or incidence of a disease by identifying all cases or studies potential risk factor association for a disease.
 - b. The research presents no more than minimal risk.
 - c. The research presents no more than an inconvenience to the participant.
 - d. Prisoners are not the focus of the research
 - 2. Research involving human subjects that would meet the criteria described in 32 CFR 219.101(b) can be conducted, but must be approved by a convened IRB and meet the requirements of subpart C, DODI 3216.02, and other applicable requirements.
 - v. When a previously enrolled human subject becomes a prisoner and the relevant research protocol was not reviewed and approved by the IRB to include prisoners, the PI should promptly notify the IRB.
 - 1. The prisoner participant may continue only if:
 - a. the researcher asserts to the IRB that it is in the best interest of the prisoner-participant to continue to participate in the research while a prisoner, and
 - b. the IRB chair determines that the prisoner-participant may continue to participate until the convened IRB can review this request to approve a change in the research protocol and until the organizational official and DoD Component office review the IRB's approval to change the research protocol.

2. Otherwise, the IRB chair shall require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB can review this request to approve a change in the research protocol. 3
 3. The convened IRB shall promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy.
 - a. The IRB should consult with a subject matter expert having the expertise of a prisoner representative if the IRB reviewing the research protocol does not have a prisoner representative.
 - b. If the prisoner participant can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner participant's confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human participants from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner participant to continue to participate in the research. This approval is limited to the individual prisoner-participant and does not allow recruitment of prisoners as participants.
 4. This type of request for change in the research protocol cannot be reviewed and approved by the IRB using expedited review procedure.
 5. The research involving human subjects does not have to meet one of the six allowable categories of research involving prisoners (described in subparagraph 7.b.(2) of the DODI 3216.02).
 6. For all DoD research involving human subjects, the applicable DoD Component office conducting the reviews must concur with the IRB before the human subject can continue to participate while a prisoner.
 7. If the research involving human subjects is conducted by a non-DoD institution, the non-DoD institution shall promptly report all decisions in this matter to the HRPO.
- e. Adult subjects unable to provide informed consent
 - i. Adult subjects will be enrolled after a legally authorized representative provides consent

- ii. If consent is to be obtained from the experimental subjects' legal representative, the research must intend to benefit the individual participants.
 - iii. The determination that research is intended to be beneficial to the individual experimental subjects must be made by an IRB.
- f. Prisoners of War
- i. Research involving prisoners of war is prohibited unless:
 - 1. The activities are covered by investigational new drug or investigational device provisions for the purpose of diagnosis or treatment of a medical condition in a patient, and
 - 2. Such treatment (e.g., an investigational new drug) may be offered to detainees with the detainees' informed consent when the medical products are subject to FDA regulations investigational new drugs or investigational medical devices, and
 - 3. Only when the same product would be offered to members of the U.S. Military Services in the same location for the same medical condition and only when consistent with established medical practice involving investigational drugs and devices.
4. Compensation for Research Related Injury a. All non-exempt research involving human subjects shall, at a minimum, meet the requirement of section 219.116(a)(6). The Common Rule does not require payment or reimbursement of medical expenses, provision of medical care, or compensation for research-related injuries. However, components of the Department of Defense might have stricter requirements for research-related injury than the DHHS regulations.
5. Research Monitor
- a. The appointment of a research monitor is required for research involving greater than minimal risk, although the IRB or organizational official can require this for a portion of the research or studies involving no more than minimal risk if appropriate
 - b. For studies requiring a research monitor, the following are considered by the IRB:
 - i. The research monitor is appointed by name and shall be independent of the team conducting the research.
 - ii. There may be more than one research monitor (e.g. if different skills or experience are needed).
 - iii. The monitor may be an ombudsman or a member of the data safety monitoring board. The IRB must approve a written summary of the monitors' duties, authorities, and responsibilities.
 - iv. The IRB or HRPP official shall communicate with research monitors to confirm their duties, authorities, and responsibilities.

- v. The duties of the research monitor are determined on the basis of specific risks or concerns about the research, such as:
 - 1. Perform oversight functions (e.g. observe recruitment, enrollment procedures, and the consent process, oversee study interventions and interactions, review monitoring plans and unanticipated problems involving risks to participants or others, oversee data matching, data collection and analysis)
 - 2. Discuss the research protocol with researchers, interview human subjects, and consult with others outside of the study
 - 3. Report observations and findings to the IRB or a designated official.
- vi. The research monitor has the authority to:
 - 1. Stop a research study in progress.
 - 2. Remove individuals from study.
 - 3. Take any steps to protect the safety and well-being of participants until the IRB can assess.
- 6. Scientific Merit
 - a. For non-exempt research, the IRB considers the scientific merit of the research. b. The IRB may rely on outside experts to provide an evaluation of the scientific merit.
- 7. Reporting The following shall be promptly (within 30 days) reported to the DoD human research protection officer (HRPO) through the PI:
 - a. The following approvals must be sent to the HRPO for an administrative review of the research before human subject research activities may begin:
 - i. Initial IRB approval of the research including risk level
 - ii. IRB approval of significant changes to the research protocol
 - iii. IRB continuing review approval.
 - b. When there is a change of reviewing IRB
 - c. Any IRB determinations of serious or continuing noncompliance for any DoD research
 - d. Any IRB determinations of unanticipated problems involving risks to participants or others for any DoD research
 - e. Any suspension or termination of DoD research
 - f. Notifications by any Federal department, agency or national organization that any part of the HRPP is under investigation for cause involving a DoD research protocol.
- 8. Recordkeeping
 - a. Records will be maintained such that document compliance or non-compliance with DoD requirements shall be made accessible for inspection and copying by

representatives of the DoD at reasonable times and in a reasonable manner as determined by the supporting DoD component.

IV. DEFINITIONS

- A. [SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)
- B. Research involving an Experimental subject: An activity, for research purposes, where there is an intervention or interaction with a human subject for the primary purpose of obtaining the effect of the intervention or interaction (32 CFR 219.102(f)).
- C. Prisoner of war: any person captured, detained, held or otherwise under the control of Department of Defense personnel (military or civilian, or contractor employee). Such persons include: enemy prisoners, civilian internees, retained persons, and lawful and unlawful enemy combatants. Such persons do not include Department of Defense personnel being held for law enforcement purposes.

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
DoDI 3216.02 - DEPARTMENT OF DEFENSE (DOD) INSTRUCTION
32 CFR 219 – PROTECTION OF HUMAN SUBJECTS (DOD)
US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g - Fetal Research

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.5 EXCEPTION FROM INFORMED CONSENT FOR PLANNED EMERGENCY RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. *Emergency research* involves the most vulnerable population of study subjects, i.e., a population with no capacity to control what happens to them and no capacity to consent, in a setting where the emergency circumstances require prompt action. There is generally insufficient time and opportunity to locate and obtain consent from each subject's legally authorized representative. In order to protect these vulnerable subjects, the U.S. Food and Drug Administration (FDA) [21 CFR 50.24](#) places additional responsibilities on parties involved with such research, including sponsors, clinical investigators, and Institutional Review Boards (IRBs).
- B. The conduct of planned research in life-threatening emergent situations where obtaining prospective informed consent has been waived, is provided by [21 CFR 50.24](#). The research plan must be approved in advance by FDA and the IRB, and publicly disclosed to the community in which the research will be conducted. The information sheet "[Exception from Informed Consent for Studies Conducted in Emergency Settings: Regulatory Language and Excerpts from Preamble](#)," is a compilation of the wording of [21 CFR 50.24](#) and pertinent portions of the preamble from the October 2, 1996, Federal Register.
- C. In 1996, the U.S. Department of Health and Human Services (HHS) Secretary announced, under [45 CFR 46.101\(i\)](#), a waiver of the applicability of the regulatory requirement for obtaining and documenting informed consent for a strictly limited class of research, that is, research that may be carried out in human subjects who are in need of emergency therapy and for whom, because of the subjects' medical condition and the unavailability of legally authorized representatives of the subjects, no legally effective informed consent can be obtained. This waiver applies to research involving adults or children, but does not apply to research involving pregnant women, human fetuses, neonates of uncertain viability, nonviable neonates, or prisoners.
- D. Emergency research could be:
1. Subject only to FDA regulations ([21 CFR 50.24](#))
 2. Subject only to HHS regulations ([45 CFR 46.116\(a\)](#) and (b) and [46.408](#))
 3. Subject to both FDA and HHS regulations

II. SCOPE

- A. This policy and procedures applies to all planned emergency research requesting an exception to informed consent.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. UT Southwestern IRB reviews proposed emergency research and applies required regulations as needed. Additional information for FDA-regulated emergency research is available at [Exception from Informed Consent Requirements for Emergency Research](#) and [21 CFR 50.24](#). Additional

information for HHS regulated emergency research is available at [Informed Consent Requirements in Emergency Research](#) and [45 CFR 46.101\(i\)](#).

- B. UT Southwestern IRB requires submission of a new study application through the eIRB system.
- C. In addition, the investigator is required to submit at least the following information during initial and subsequent IRB reviews:
 - 1. Materials documenting that the criteria for the exception from informed consent requirements for emergency research are met according to FDA [21 CFR 50.24](#) and/or HHS [45 CFR 46](#).
 - 2. The investigator's commitment to attempt to contact the subject's legally authorized representative (LAR) to obtain consent, or provide the subject's family member an opportunity to object (if feasible) prior to administering the test article, within the therapeutic window according to FDA 21 CFR 50.24 and/or HHS 45 CFR 46.
 - 3. The proposed investigational plan, including informed consent procedures and an informed consent document, procedures and information to be used when providing an opportunity for a subject, LAR, or family member to object to a subject's enrollment and/or continued participation in the study according to FDA 21 CFR 50.24 and/or HHS 45 CFR 46.
 - 4. Procedures and information to be used to inform a subject's LAR or family members about the subject's participation in the investigation in the event of a subject's death according to FDA 21 CFR 50.24 and/or HHS 45 CFR 46.
 - 5. Plans for additional protections of the rights and welfare of the subjects, including, at least, plans for community consultation and public disclosure prior to the start of, and following completion of, the research according to FDA [21 CFR 50.24](#) and/or HHS [45 CFR 46](#). Plans for public disclosure following completion of the research.
- D. FDA Regulated Research - Approval of Exception from Informed Consent
 - 1. The IRB must find and document the following, as per 21 CFR 50.24(a):
 - a. The IRB responsible for the review, approval, and continuing review of the clinical investigation described in this section may approve that investigation without requiring prospective informed consent of all research subjects be obtained if the IRB (with the concurrence of a licensed physician who is a member of or consultant to the IRB and who is not otherwise participating in the clinical investigation) finds and documents each of the following:
 - i. The human subjects are in a life-threatening situation, available treatments are unproven or unsatisfactory, and the collection of valid scientific evidence, which may include evidence obtained through randomized placebo-controlled investigations, is necessary to determine the safety and effectiveness of particular interventions.
 - ii. Obtaining informed consent is not feasible because:
 - 1. The subjects will not be able to give their informed consent as a result of their medical condition;
 - 2. The intervention under investigation must be administered before consent from the subjects' LARs is feasible; and

- contacted, information about the clinical investigation is to be provided to the subject's legally authorized representative or family member, if feasible.
- c. If an IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in the exception or because of other relevant ethical concerns, the IRB must document its findings and provide these findings promptly (no longer than within 30 days) in writing to the clinical investigator and to the sponsor of the clinical investigation.
- E. IRB Approval of Additional Protections
1. For this step, the IRB must find and document the following, as per 21CFR50.24(a):
 - a. Additional protections of the rights and welfare of the participants will be provided, including, at least:
 - i. Consultation (including, where appropriate, consultation carried out by the IRB) with representatives of the communities in which the clinical investigation will be conducted and from which the subjects will be drawn;
 - ii. Public disclosure to the communities in which the clinical investigation will be conducted and from which the subjects will be drawn, prior to initiation of the clinical investigation, of plans for the investigation and its risks and expected benefits;
 - iii. Public disclosure of sufficient information following completion of the clinical investigation to apprise the community and researchers of the study, including the demographic characteristics of the research population, and its results;
 - iv. Establishment of an independent data monitoring committee to exercise oversight of the clinical investigation; and
 - v. If obtaining informed consent is not feasible and a legally authorized representative is not reasonably available, the investigator has committed, if feasible, to attempting to contact within the therapeutic window the subject's family member who is not a legally authorized representative, and asking whether he or she objects to the subject's participation in the clinical investigation. The investigator will summarize efforts made to contact family members and make this information available to the IRB at the time of continuing review.
- F. IRB review of research not subject to FDA regulations according to the waiver of applicability of the requirement in 45CFR46 to obtain and document informed consent
- a. This provision in emergency setting research is seldom used at UT Southwestern. Although there are many similarities with EFIC requirements for FDA regulated research, the OHRP guidance document should be consulted for further information when the research is not subject to FDA regulations under 21 CFR 50 (The 1996 OPRR (now, OHRP) Report titled, "Informed Consent Requirements in Emergency Research.").

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
HRPP GUIDANCE - GUIDANCE ON PLANNED EMERGENCY RESEARCH, EXCEPTION FROM INFORMED CONSENT, AND WAIVER OF APPLICABILITY OF INFORMED CONSENT
FDA INFORMATION SHEET: EXCEPTION FROM INFORMED CONSENT FOR STUDIES CONDUCTED IN EMERGENCY SETTINGS: REGULATORY LANGUAGE AND EXCERPTS FROM PREAMBLE – INFORMATION SHEET
FDA GUIDANCE FOR INSTITUTIONAL REVIEW BOARDS, CLINICAL INVESTIGATORS, AND SPONSORS - EXCEPTION FROM INFORMED CONSENT REQUIREMENTS FOR EMERGENCY RESEARCH
OHRP REPORT: INFORMED CONSENT REQUIREMENTS IN EMERGENCY RESEARCH

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.6 RESEARCH INVOLVING INDIVIDUALS WITH DIMINISHED AUTONOMOUS DECISION-MAKING CAPACITY

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

I. POLICY STATEMENT

- A. The Institutional Review Board (IRB) gives special consideration to protecting the rights and welfare of individuals with diminished autonomous decision-making capacity (DADMC). The IRB regards protections from coercion, undue influence, manipulation and physical control as critically important to protecting human subjects. DADMC refers to a person with limits in either mental capacity or voluntariness. Research involving individuals with DADMC is permitted if the IRB finds that it is appropriate and that sufficient safeguards have been incorporated into the protocol to protect the subjects.
- B. Presumption of capacity: Subjects with diminished autonomous decision-making capacity who have not been documented to have impaired decision making (by medical documentation), to be incapacitated (by medical or legal documentation) or to be incompetent (by legal documentation), are to be considered capable of giving informed consent for research unless and until IRB approved plans to assess mental capacity reveal otherwise.
- C. The following populations are routinely considered to have DADMC due to regulation, policy, or circumstance:
 - 1. Those with limited mental capacity that require consideration of additional protections:
 - a) Children,
 - b) individuals with impaired decision-making capacity, and
 - c) incompetent or incapacitated individuals.
 - d) Mentally handicapped,
 - e) Cognitively impaired
 - 2. Those with limited voluntariness who may be more likely to be affected by undue influence or coercion:
 - a) Prisoners,
 - b) Institutionalized individuals,
 - c) Individuals in hierarchical social/economic structures (i.e., employees, students, military personnel, family members of the research team)
 - d) Individuals in emergency situations
 - e) Individuals who are economically or educationally disadvantaged
 - f) Individuals who are marginalized in society, or
 - g) Individuals with fatal or incurable diseases

II. SCOPE

- A. This policy and procedure applies to the following:
1. UTSW researchers, investigators and staff who are responsible for providing sufficient information concerning the inclusion of individuals with DADMC.
 2. The Human Research Protection Program Office (HRPPO) staff who are responsible for forwarding of the draft package for IRB review for pre-review submission documents for indications of DADMC populations.
 3. IRB members who are responsible for approving the inclusion of individuals with DADMC in research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. Pre-review and Guidance

1. The PI identifies the categories of vulnerable subjects (e.g., cognitively-impaired, children, prisoners, pregnant women, fetuses, employees, and students) involved in the research in the IRB application.
2. The investigator answers specific questions in the IRB application which focus on ethical and regulatory issues pertaining to conduct of research involving the identified vulnerable population(s).
3. Upon receipt of an IRB application, HRPPO staff conducts a preliminary screening. When applicable, HRPPO staff provides regulatory and educational materials to the IRB pertaining to DADMC populations as outlined in the [2.1. INITIAL REVIEW OF RESEARCH](#), [2.2. CONTINUING REVIEW OF RESEARCH](#), or [2.3 MODIFICATIONS TO RESEARCH](#) policies. IRB members may also use the provided reviewer checklist, as a guide to conducting reviews.
4. The HRPPO Staff, HRPP Director, IRB Chair, or designee requests a consultant review if additional expertise is needed. (See [2.1. INITIAL REVIEW OF RESEARCH](#), [2.2. CONTINUING REVIEW OF RESEARCH](#) or [2.3 MODIFICATIONS TO RESEARCH](#)).
5. IRB membership includes representation with expertise in selected vulnerable populations routinely reviewed by the IRB, such as children pregnant women, and prisoners. HRPPO staff pre-review the application to ensure that designated representatives review research involving children or prisoners. Depending upon the type of review (Convened IRB or Expedited Review), designated representatives may either attend the convened meeting or provide comments in writing.

B. IRB Review Process

1. The IRB shall consider whether including individuals with DADMC in the research is appropriate by considering the following:
 - a) The research should focus on an issue relevant to the DADMC population (should bear some direct relationship to the population's condition or circumstances). This population should not be chosen for research that bears no relation to their situation just because it would be convenient for the researcher.

- b) Inclusion/exclusion criteria.
 - c) Applicable or local laws that bear on the decision-making process (i.e., emancipated individuals, legally authorized representatives, age of majority for research consent).
 - d) Over-selection or exclusion of certain groups based on perceived limitations (i.e., targeting prisoners as research subjects because they are a readily available “captive” population).
 - e) If it is feasible to use another, non-DADMC population. The inclusion of a DADMC population is considered appropriate if the IRB determines that:
 - i. the research could not be conducted without inclusion of the DADMC population, and
 - ii. there exist compelling reasons that mitigate any additional risk.
2. The IRB should consider whether the research incorporates sufficient safeguards to ensure that the rights of the individual participants are protected, by considering the following circumstances.
- a) Safeguards concerning mental capacity
 - i. In research likely to involve persons with conditions or circumstances that are associated with possible diminished mental capacity and for those already determined to have DADMC (those with documented impaired decision-making capacity, incapacitated or legally incompetent), the IRB should determine whether the protocol has:
 - a. sufficient plans to assess mental capacity; and
 - b. whether additional protections should be included to protect this vulnerable population.
 - ii. The assessment process should include acceptable physical and mental evaluation criteria at time intervals determined appropriate, given the specifics of the study.
 - iii. In research likely to involve persons with diminished mental capacity, including those with impaired decision-making, incapacitated or incompetent, the IRB shall apply additional protections required under the applicable policy (e.g., state law)
 - b) Safeguards concerning voluntariness
 - i. Researchers should include plans to protect individuals with limited voluntariness. Examples of such individuals are:
 - a. Students/employees of the research team
 - b. Family members of the research team
 - c. Individuals in emergency situations or those with fatal or incurable diseases
 - d. Individuals who are economically or educationally disadvantaged

6. The IRB may require more frequent review than once a year, for protocols involving vulnerable populations, based on the nature of the research and the level of risk.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Limited voluntariness include family members of study team and expanded safeguard requirements
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL GUIDANCE

2.7 Guidance on Planned Emergency Research, Exception from Informed Consent, and Waiver of Applicability of Informed Consent

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

The objective of this guidance document is to assist investigators in planning, and the IRB in reviewing, protocols meeting the requirements for research that is designed for life-threatening, emergency situations, including the requirements that must be met for exception from, or waiver of applicability of, informed consent in these situations.

I. *Planned Emergency Research*

The term "Planned Emergency Research" refers to human subjects' research designed to test medical interventions, drugs, or devices in urgent, life-threatening situations.

The UT Southwestern IRB will accept applications for planned emergency research using the UT Southwestern IRB application and processes for initial review. However, prior consultation with the UT Southwestern HRPP office is strongly recommended to ensure all details in this guidance are covered. Note that all planned emergency research is reviewed by the UT Southwestern IRB regardless of funding source. Research that is planned emergency research requires strict attention to regulations found in 21 CFR 50.24 for FDA regulated research, which describe the process for 'exception to informed consent.' There is also a separate provision for waiving the 45 CFR 46 requirement to obtain prospective informed consent for emergency research that is not FDA-regulated. FDA and OHRP provide guidance documents to inform the planning and implementation of planned emergency research. These are followed closely by the IRB, and the PI is expected to incorporate their guidance into protocol design. This guidance document is an adjunct to the FDA and OHRP guidance and will be used in conjunction with their guidance and regulations. Reference to these documents are listed in the reference section below.

II. *IRB review of FDA-regulated Planned Emergency Research – Exception from Informed Consent (EFIC)*

A. Approval in principle of the protocol and subsequent informed consent procedures

The IRB reviews the protocol and subsequent informed consent procedures to ascertain 'approvability.' 'Approval in Principle' by the IRB means that the study will likely be approved when and if community consultation demonstrates a positive consensus in the community. For this step, the IRB must find and document the following, as per 21 CFR 50.24(a):

1. The IRB responsible for the review, approval, and continuing review of the clinical investigation described in this section may approve that investigation without requiring prospective informed consent of all research subjects be obtained if the IRB (with the concurrence of a licensed physician who is a member of or consultant to the IRB and who is not otherwise participating in the clinical investigation) finds and documents each of the following:
 - a. The human subjects are in a life-threatening situation, available treatments are unproven or unsatisfactory, and the collection of valid scientific evidence, which

may include evidence obtained through randomized placebo-controlled investigations, is necessary to determine the safety and effectiveness of particular interventions.

- b. Obtaining informed consent is not feasible because:
 - i. The subjects will not be able to give their informed consent as a result of their medical condition;
 - ii. The intervention under investigation must be administered before consent from the subjects' LARs is feasible; and
 - iii. There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the clinical investigation.
- c. Participation in the research holds out the "prospect of direct benefit" to the subjects because:
 - i. Subjects are facing a life-threatening situation that necessitates intervention;
 - ii. Appropriate animal and other preclinical studies have been conducted, and the information derived from those studies and related evidence support the potential for the intervention to provide a direct benefit to the individual subjects; and
 - iii. Risks associated with the investigation are reasonable in relation to what is known about the medical condition of the potential class of subjects, the risks and benefits of standard therapy, if any, and what is known about the risks and benefits of the proposed intervention or activity.
- d. The clinical investigation could not practicably be carried out without the waiver.
- e. The proposed investigational plan defines the length of the potential therapeutic window based on scientific evidence, and the investigator has committed to attempting to contact a legally authorized representative for each subject within that window of time and, if feasible, to asking the legally authorized representative contacted for consent within that window rather than proceeding without consent. The investigator will summarize efforts made to contact legally authorized representatives and make this information available to the IRB at the time of continuing review.
- f. The IRB has reviewed and approved informed consent procedures and an informed consent document consistent with 50.25. These procedures and the informed consent document are to be used with subjects or their legally authorized representatives in situations where use of such procedures and documents is feasible. The IRB has reviewed and approved procedures and information to be used when providing an opportunity for a family member to object to a subject's participation in the clinical investigation.

2. The IRB is responsible for ensuring the following with regards to informed consent :

- a. Procedures are in place to inform, at the earliest feasible opportunity, each subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, of the subject's inclusion in the clinical investigation, the details of the investigation and other information contained in the informed consent document.
 - b. There is a procedure to inform the subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, that he or she may discontinue the subject's participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.
 - c. If a legally authorized representative or family member is told about the clinical investigation and the subject's condition improves, the subject is also to be informed as soon as feasible.
 - d. If a subject is entered into a clinical investigation with waived consent and the subject dies before a legally authorized representative or family member can be contacted, information about the clinical investigation is to be provided to the subject's legally authorized representative or family member, if feasible.
3. If an IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in the exception or because of other relevant ethical concerns, the IRB must document its findings and provide these findings promptly (no longer than within 30 days) in writing to the clinical investigator and to the sponsor of the clinical investigation.

Tips for preliminary review and approval by the IRB:

- The IRB evaluates the relative risk of the research based on standard of care locally and in other regions. Areas to include in a risk assessment include, but are not limited to, the following: medical risk, risk of standard of care in a research context, risk of using investigational drugs and devices in the setting, risks of offending the cultural sensibilities of the community, etc.
- The PI is to provide information about the prevalence of the particular condition being studied. Such information should include the frequency of presentation to the affiliated institution's Emergency Department (ED) as well as to the EDs of other institutions with which UT Southwestern is collaborating. If the research begins in the field, provide geographic references and frequencies for emergency intervention.
- The IRB should ask for PI clarification about whether the ambulance, after picking up the patient/subject, is directed to the nearest ED or bypasses in favor of an ED participating in the research. If the latter occurs, the IRB should consider how and whether emergency treatment is impacted and how research risk is affected.
- For EFIC studies originating in the field, the PI provides information about human subjects and protocol training for first responders. Collaborating first responder organizations are to have an FWA (for federally funded research) in place and provide their own IRB review, or request to defer to the UT Southwestern IRB.

- If children are included in the research, ensure that additional regulatory criteria is addressed, i.e. Subpart D, 21 CFR 50.50. Pregnant women and prisoners are excluded from this type of research.
- The inclusion of children and other scientific aspects of the study may require that the IRB consult with experts. Such consultation is carefully documented.

B. Approval of a community consultation plan and its implementation (this step is done in conjunction with the Approval in Principle)

The required community consultation aspect for EFIC research has ethical goals that include enhanced protections and benefits for the community participants, and legitimacy and shared responsibility for the conduct of the research by informing the impacted community and soliciting its views. The 'community' may have a geographic identity as well as a condition-specific identity that need not depend on living in the research catchment area.

The submitted protocol must include a plan for community consultation. Community consultation activities are "designed to help ensure that the communities in which the emergency research will be conducted and from which subjects will be drawn are adequately informed about the risks and expected benefits of the research and are given the opportunity to ask questions about it as well as express their views prior to the IRB making a determination about the research." (March 2011 Guidance Document). Section VIII of the FDA Draft Guidance Document provides extensive information about community consultation. For this step, the IRB must find and document the following, as per 21CFR50.24(a):

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

investigation. The investigator will summarize efforts made to contact family members and make this information available to the IRB at the time of continuing review.

Tips for investigators and the IRB about community consultation:

- Consider goals of community consultation:
 - Show respect for persons by informing the community about the study in advance;
 - Show respect for the community by allowing representatives of the community to identify potential community-level concerns and effects of the research;
 - Show respect for subjects' autonomy. Respect may be shown by including in community consultation activities individuals who may have, or be at risk for, the condition under study (and thereby obtain input from a group that is expected to be similar to the eventual study subjects).
 - Provide a means for affected communities to provide meaningful input to the IRB before its decision to approve, require modifications to, or disapprove the study; and
 - Identifying group 'leaders' who are willing to function as intermediaries for continued communication with the community about the study is helpful. PI and/or IRB consultation with the group 'leaders' is encouraged.
- Community consultation activities can include:
 - Standing meetings. Standing meetings, such as local civic public forums, may be better attended because such meetings are already on community members' calendars.
 - Plan for at least 10 meetings with affected groups, depending on the risk of the research and the size of the community potentially impacted by the research. Meetings can be town hall style or can be added onto a regularly scheduled meeting of the group. The latter generally ensures a larger number of participants. The number of meetings and additional susceptible populations may be further identified by the IRB.
 - Plan to advertise the meetings via mainstream and alternative media, if possible. Publicity that asks for feedback about the study is also solicited via websites, material distributed in faith communities or other settings frequented by identified susceptible groups. A multi-faceted approach is recommended. Random digit dialing, as a method to survey large portions of the community, is another way to solicit opinion and feedback. However, it is not required.
 - Public community meetings or other special meetings specifically organized to discuss the research. Such meetings may be valuable in attracting participation from individuals with strong interest in the research.
 - Local radio and/or television talk shows. Such programs allow viewers to "call in" to express their views and concerns.

- Interactive websites, focus groups and surveys.
- The contribution of non-affiliated IRB members is very important in this endeavor. If possible, a nonaffiliated member should serve, in addition to the primary and secondary reviewer, as a reviewer on the protocol.
- The plan for community consultation requires full board approval. Outside meetings with the PI/research staff may be necessary to facilitate the process. A designated IRB representative should be the primary contact with the PI/staff about matters related to community consultation.
- All materials utilized in community consultation, including presentations and tools designed to elicit feedback, are to be IRB approved prior to their use.
- Community consultation should make every effort to reach out to limited-English proficient individuals who may be susceptible to becoming research subjects in the study. All materials designated for community consultation activities must first be IRB approved in English. Translations by duly qualified translators are subsequently submitted for IRB approval by way of an Amendment.
- When the study receives an Approval in Principle, the community consultation plan has also been approved, and the PI implements the plan. The PI/Research team are expected to present the study at these meetings in a way that is understandable to a lay audience. Transcripts and other feedback, such as anonymous survey results, are provided to the IRB for review for approval of the research to begin enrollment. IRB members are encouraged to attend one or more community consultation meetings.
- The IRB must approve that community consultation has been ‘adequate.’ ‘Adequacy’ generally means that an acceptable number of individuals have been directly exposed to consultation activities and the preponderance of the feedback has been positive toward the research. Plan on ‘touching’ at least 100 individuals who could be potential subjects. This number is highly fluid and subject to IRB request.

C. Approval of public disclosure before the study begins and after the completion of the study:

Public disclosure means dissemination of information about the emergency research sufficient to allow a reasonable assumption that the communities are aware of the plans for the investigation, its risks and expected benefits. The public disclosure phase requires a positive response by the community before the IRB can grant approval of the research to begin enrollment; a largely negative response to public disclosure by the community may cause the IRB to require additional actions.

- Additional protections of the rights and welfare of subjects will be provided, including, at least:
 - Public disclosure to the communities in which the clinical investigation will be conducted and from which the subjects will be drawn, prior to initiation of the clinical investigation, of plans for the investigation and its risks and expected benefits;

- Public disclosure of sufficient information following completion of the clinical investigation to apprise the community and researchers of the study, including the demographic characteristics of the research population, and its results;

See Section XI in the FDA Draft Guidance document for specific information about methods suggested by the FDA for public disclosure.

Tips for investigators and the IRB on Public Disclosure:

- Plan to send public disclosure materials to many, if not most, of the same venues receiving community consultation materials. Utilize identified group 'leaders' if possible.
- Public disclosure activities may include:
 - Multiple forums
 - Media resources
 - Targeted mailings to households in the communities with information about how to obtain further details;
 - Advertisements and articles in the English language, and if appropriate, foreign language, newspapers (Public outreach documents should be translated into languages that are common in the area served by the facility where the investigation is being conducted and in the communities from which subjects will be drawn.);
 - Clearly marked links and information on the sponsor's and participating hospitals' Internet websites
 - Summary materials that are accessible to non-English speaking or homeless populations who reside in the community from which research subjects are likely to be drawn;
 - Presentation or distribution of information at meetings of community, local government, civic, or patient advocacy groups;
 - Letters to local and regional community leaders and first responders (e.g., police, paramedics); ○ Announcements to local/regional hospital staff(s); ○ Public service announcements and interviews or discussions on "talk" radio or television programs;
 - Press conferences and briefings; and ○ Meetings or activities provided by hospitals' and institutions' existing community outreach programs.
- A lengthy description of risks and expected benefits may not be feasible in all of the disclosure materials. If a website is used, ensure that the website:
 - Points community members to location where additional information can be obtained; and ○ Provides contact information (telephone number and email addresses) so community members may contact for additional questions.
- The IRB approves the public disclosure plan to occur before the study begins, prior to the plan's publication and dissemination.

- The PI provides a summary of the information that was disclosed, which is approved by the IRB as having been adequate. In some cases, pieces of the disclosure plan may not have been implemented due to unforeseen circumstances. The summary must explain these exceptions.

Tips for investigators and the IRB on Public Disclosure after Study Completion:

- Submit a plan for public disclosure to take place after completion of the study. This plan may include many of the same features as the plan for disclosure prior to the initiation of the study and must be approved by the IRB. Any meetings can be town hall style or can be added onto a regularly scheduled meeting of the group, perhaps revisiting some of the same groups or venues. Since study completion may not occur for years, the plan may need re-review by the IRB before its implementation at the completion of the study.
- The information disclosed should provide sufficient detail to allow a clear understanding of the study design and its results, both positive and negative, including:
 - Information about the primary outcome(s) of the study
 - The number and nature of adverse events associated with the test article
 - Whether the study was terminated and the basis for that decision.
- At the IRB's discretion, the PI may be asked to provide plans for continued public disclosure at intervals during the course of the research, especially if the research will continue for a year or more. Such plans may be required and approved at the IRB's request. The PI is expected to provide a public disclosure summary of each implementation during the course of the research.

D. IRB approval of the research to begin enrollment

The IRB must also find and document the following, as per 21CFR50.24(a):

- Additional protections of the rights and welfare of subjects will be provided, including, at least:
 - Establishment of an independent data monitoring committee to exercise oversight of the clinical investigation; and
- The protocol is performed under a separate investigational new drug application (IND) or investigational device exemption (IDE) that clearly identified such protocols as protocols that might include participants who are unable to consent.
 - The submission of those protocols in a separate IND/IDE is required even if an IND for the same drug product or an IDE for the same device already exists.

See especially Sections II, III, IV, V, VIII, IX, and, X in the EFIC FDA Draft Guidance for full information on these regulatory requirements.

Tips for the IRB in approving the research to begin enrollment:

- Ensure that all regulatory aspects are considered before final approval. For example, the EFIC criteria at 50.24 must be fully addressed, in addition to regulatory criteria for children.

- Ensure that a licensed physician concurs with the initiation of the study and with continuing review. The licensed physician member's affirmative vote or licensed physician consultant's concurrence should be recorded in the minutes.
- The IRB should consider the frequency of continuing review.
- The IRB promptly provides to the sponsor, by way of PI in writing, a copy of the information that has been publicly disclosed about the initiation of the study under 50.24a7ii and 21CFR56.109g
- Any site additions or modifications to the protocol must be approved by the IRB prior to implementation, including site-specific community consultation and public disclosure.
- Noncompliance has the potential to lessen public support for research if there are numerous instances or it becomes widely known. The PI must act very promptly with a corrective action plan whenever noncompliance (e.g., deviation) occurs, especially when it affects eligibility and treatment.

E. IRB review of research not subject to FDA regulations according to the waiver of applicability of the requirement in 45CFR46 to obtain and document informed consent

As noted above, this provision in emergency setting research is seldom used at UT Southwestern. Nonetheless, the PI and IRB should know that it is available. Although there are many similarities with EFIC requirements for FDA regulated research, the OHRP guidance document should be consulted for further information (The 1996 OPRR (now, OHRP) Report titled, "Informed Consent Requirements in Emergency Research.")

References

1. [The 2011 Guidance for Institutional Review Boards, Clinical Investigators, and Sponsors "Exception from Informed Consent Requirements for Emergency Research,"](#)
2. [The 1996 OPRR \(now, OHRP\) Report titled "Informed Consent Requirements in Emergency Research"](#)
3. [21 CFR 50.24](#)
4. [45 CFR 46.116\(c\)2](#)

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Overview of Planned Emergency Research Review and Approval Process



HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.8 COLLABORATIVE RESEARCH INVOLVING EXTERNAL INVESTIGATORS/INSTITUTIONS REVIEWED BY UTSW IRB

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: JULY 1, 2018

I. POLICY STATEMENT

- A. UT Southwestern investigators frequently collaborate in research involving external investigators and institutions.
- B. When non-exempt human participant research is being conducted in collaboration with other institutions or with collaborating individual investigators, each collaborating institution and/or collaborating individual investigator engaged in the research must obtain IRB approval from an appropriately authorized IRB.
- C. The OHRP guidance document, [Guidance on Engagement of Institutions in Human Subjects Research](#) will be used as the basis for determining whether the research activities constitute engagement in human participant research. Such determinations will be made in collaboration and consultation with authorized representatives of the collaborating institution and/or the collaborating individual investigators, as applicable.
- D. In an effort to reduce duplicate submission and oversight by multiple IRBs for the same protocol, the UT Southwestern Medical Center HRPP will consider requests for other institutions and individual investigators to rely on UTSW for IRB review.
- E. The Institutional Official (IO), in consultation with Legal Affairs and HRPP Director, has the authority to execute IRB Authorization Agreements (IAAs) on behalf of the UT Southwestern Medical Center. All determinations for another institution to rely on UTSW IRBs shall be documented in an IAA or RA.
- F. For Investigators who are not affiliated with an assured institution, an Individual Investigator Agreement (IIA) may be signed to extend the UTSW assurance to cover that individual. The IO or designee in consultation with the Principal Investigator's Department Chair, has the authority to extend the UTSW FWA for individual investigators on a study-by-study basis.

II. SCOPE

- A. This policy applies to all human subjects' research in which UT Southwestern IRB has agreed to review research on behalf of another assured institution or non-assured individual investigators.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Requesting Reliance on UTSW IRB
 - a. Investigators considering collaboration with another assured institution who wish to utilize UTSW IRB for non-UTSW affiliated sites should contact the HRPP Office (HRPPO) early in the research proposal process. Decisions about whether to permit

another institution to rely on UTSW shall be determined by the IO, after review and recommendation by the HRPP Director (HRPPD).

- b. UT Southwestern Medical Center may accept another institution to rely on UTSW IRBs for the review of cooperative research projects under the conditions set forth below.
- c. In deciding whether or not to provide IRB review for another IRB, the IO will consider the following criteria:
 - i. The number of studies being proposed under the agreement.
 - ii. The number of sites engaged in the research.
 - iii. The risk level of the study.
 - iv. Whether the study is being conducted under an investigator-initiated IND or IDE.
 - v. The location where the interventional human research activities will take place.
 - vi. Whether the use of a Central IRB has been mandated by the sponsor.
 - vii. Whether adequate funding is provided to cover the additional costs associated with managing the approval and necessary IRB oversight at the other sites.
 - viii. UT Southwestern's capacity to be sufficiently informed about the other institution's local research context and local applicable laws and rules.
- d. Executing IRB Authorization Agreements
 - i. In order to initiate discussions with the relying institution, the UTSW investigator must provide the HRPP Reliance Program Manager with:
 - 1. contact information for the collaborating institution's IRB,
 - 2. a draft version of the protocol and consent form, and
 - 3. copy of the local context form (if applicable).
 - ii. The HRPPD, HRPP Reliance Program Manager or his/her designee will ensure that the finalized agreement is appropriately signed by the IOs for the involved institutions. Copies of all agreements will be maintained in the HRPPO electronic filing system.

B. eIRB Submission

- a. In order to maintain an accurate record of studies being conducted at or by UTSW and affiliates, as well as all relying sites, investigators are required to update the eIRB Smart Form to list the relying site.
- b. The completed local context form must be uploaded to the eIRB system

C. IRB Review

- a. Review and approval of the research will commence according to [2.1. INITIAL REVIEW OF RESEARCH](#), [2.2. CONTINUING REVIEW OF RESEARCH](#) and [2.3 MODIFICATIONS TO RESEARCH](#) policies.

D. IRB Knowledge of Local Regulatory Issues

- a. In accordance with OHRP guidance, when UT Southwestern IRB serves as the Reviewing IRB for another institution or when the research involves distinct subject populations (non-English speaking populations, veterans, etc.), UT Southwestern IRB ensures that it possesses or obtains sufficient knowledge of the local regulatory issues even when the IRB is geographically removed from the off-site research location.
- b. Additionally, in accordance with FDA requirements, an IRB may review studies performed at off-site locations as long as the requirements for 21 CFR parts 50 and 56 are met. In these cases, a written agreement, which the local IRB or the administration of the institution signs, allows review by a non-local IRB (See Negotiation of an IRB Authorization Agreement with Collaborating Institutions for more information)
- c. Review of the proposed research by one or more ad hoc or cultural consultants with knowledge of the local regulatory issues. Ad hoc or cultural consultants may provide comments or recommendations in writing to the IRB prior to the meeting or attend the convened meeting to participate in the review, either physically or through audiovisual or telephone conference, when participation is deemed warranted by the consultant(s) or any one member of the IRB;
- d. Systematic reciprocal documented interchange between the IRB and elements of the local regulatory issues through periodic visits to the research site, occurring several times per year, by one or more IRB members in order to obtain and maintain knowledge of the local regulatory issues; periodic discussion with appropriate consultants knowledgeable about the local regulatory issues; regular interaction with one or more designated institutional liaisons; and/or review of relevant written materials;
- e. Site visit by a representative of the IRB;
- f. Appointment of an IRB member from the community in question.
- g. The research staff assists the PI in addressing the requirements for information on the local regulatory issues upon request.
- h. The research staff assists the IRB in identifying appropriate consultants and distributing appropriate review materials pertaining to the local regulatory issues to IRB members, as appropriate.
- i. The research staff maintains documentation in the database and the study file of the local regulatory issues and the measures taken to ensure sufficient IRB knowledge of that context.
- j. The IRB includes the name and contact information for an IRB contact in the consent document for non-local IRB review or designates an individual at the research site to serve as the contact to relay reports to the IRB.
- k. In the minutes of the meeting during which non-local research review occurs, research staff document the procedures used to ensure that the IRB adequately considered community attitudes.

E. Non-Assured Sites

- a. UTSW HRPP will first consider whether the non-assured site should obtain an FWA
 - i. OHRP notes that if HHS-conducted or supported human research activities routinely occur at non-assured institution, the institution should obtain an OHRP approved FWA.
 - ii. If the Non-Assured institution is the prime awardee for HHS supported award, the institution must obtain its own FWA.
 - iii. If the institution must obtain an FWA, then an IRB Authorization Agreement (IAA) as described above would be executed with the site or the institution would obtain another IRB review.
- b. If the Non-Assured Site will not obtain an FWA, the UTSW HRPP will consider whether an Individual Investigator Agreement (IIA) is appropriate as described below.
- c. For non-affiliated, non-assured sites that are not engaged in research, the UTSW IRB will request a letter of support from the performance site when applicable.

F. Cooperative Research Involving Off-Site International locations engaged in research

- a. Collaborative research activities at off-site international locations that are funded or supported by HHS must be conducted under an active international assurance issued by the Office for Human Research Protections. International collaborative research that is not funded or supported by HHS should be conducted under applicable national or international procedural standards that are at least as stringent as the requirements of 45 CFR part 46.
- b. The PI arranges for the international site IRB (or equivalent entity) to review the research and submit official correspondence addressing the following information:
 - i. For HHS funded or supported research, the international site's International FWA number and the appropriate IRB approval from the assured institution's designed IRB (including the OHRP registration number for the IRB/IEC).
 - ii. For non-HHS funded or supported research, the appropriate IRB (or equivalent entity) approval.
 - iii. Cooperative Research Involving Off-Site International locations not engaged in research. Follow procedures for local institutional approval to conduct research at the site.
- c. All policies and procedures applied to domestic research are also applied to research conducted at international research site.
 - i. Initial Review, Continuing Review and review of modifications (see Initial Review of Research Policy and Procedure, Continuation Review Policy and Procedure, Modification and Amendments Policy and Procedure)
 - ii. Handling Complaints, Noncompliance, and Unanticipated Problems

- iii. Informed consent process (including language issues). See Informed Consent Policy and Procedure.

G. Serving as IRB of Record for non-affiliated Investigators

- a. UTSW may choose to extend the Federalwide Assurance (FWA) to cover research activities by engaged non-UTSW investigators who work for non-assured (FWA) institutions.
- b. Researchers collaborating with a non-assured individual should contact the HRPPO Reliance Program Manager to discuss inclusion of the individual on the research. The individual may be added to a research protocol by utilizing one of the following methods:
 - i. The PI research department may request Person of Interest (POI) status for the individual (preferred).
 - 1. This is required if the individual will be engaged in research at UTSW.
 - ii. An Individual Investigator Agreement (IIA) may be signed if the individual is engaged in human subjects' research and the following apply:
 - 1. The institution the individual works with does not wish to obtain an FWA, and
 - 2. The research activities will not be conducted at UTSW.
- c. When a non-affiliated investigator is identified, the PI should contact the HRPPO to determine the appropriate method for covering the individual
- d. The non-affiliated individual must be added to the eIRB Smart Form.
- e. When an individual is covered by UTSW FWA (either via IIA or POI status), the investigator must comply with all UTSW investigator requirements (e.g., CITI human subjects training, COI training and COI disclosure).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Related regulations, policies, websites, and documents that provide supplemental information to the policy

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Brief description of any revisions to the policy

Revision Date	Author	Description
July 2018	HRPP	Addition of IRB Knowledge of Local Regulatory Issues section
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office

HRPP@UTSouthwestern.edu

(214) 648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

2.9 REPOSITORY POLICY AND PROCEDURE

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 1, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The collection, storage, and distribution of human data and/or tissue/specimens for future research purposes are separate “repository operations”. In most cases, these repository operations constitute “human research” and requires Institutional Review Board (IRB) approval.
- B. The operation of a human data management center (e.g., data centers, data banks, or database) or human biospecimen repository (e.g., registry, bank, or library) for research purposes by UTSW employees or agents must be approved by a UTSW designated IRB if the activity meets the definition of Human Subjects Research.
 1. The repository Principal Investigator (PI) has primary responsibility for the collection, storage and distribution of data and/or specimens.
 2. The repository operation must comply with all applicable policies regarding establishment, maintenance and use of databases containing personal identifiers including IRB approval. In addition, the operation of the repository must be capable of:
 - a) Identifying when the material is originally received and whether the person from whom the material was obtained signed a legally effective consent/gave authorization under HIPAA (unless consent and/or authorization were waived by the IRB).
 - b) Identifying data/samples for which consent has been withdrawn and ensuring no future use.
 3. The security and confidentiality of the materials are protected by providing the following minimum measures:
 - a) Coding. A method to code the data/specimens, including a process to protect/maintain the key to the code and limit access to the key. The coding system must be adequate to reduce the possibility of re-identification by unauthorized individuals.

- b) Controlled access to the data/specimens - access to the un-coded data/specimens must be restricted to a limited number of repository staff. Accountability for controlling and monitoring access must be provided.
 - c) Security procedures - a method to limit access to the coded data/specimens (including computer security and specimen storage security measures) must be provided.
 - d) A Certificate of Confidentiality is recommended, but not always required by the IRB, as an additional protective measure.
4. Distribution of Data/Specimens from a UTSW Repository.
- a) Repositories will not (generally) provide access to the identities of donor-subjects or to information through which the identities of donor-subjects may readily be ascertained to individuals or entities outside of the repository investigators and staff (with the exception of 4b).
 - b) Repositories will require proof of IRB review for each specific research study (from researchers outside of the repository team) that requests identifiable data/specimens from the repository. Each study is considered to be a research activity that is separate from the data center/repository itself.
 - c) In the situation where the recipient investigator is also a member of the repository team, there must be a process to either:
 - (1) prevent this person from being able to access the identifiable information; or
 - (2) allow access but restrict activities to only involve the use of repository materials, 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; and this is an IRB approved distribution activity under the repository protocol.
 - d) Repositories may require a signed agreement from the recipient-investigator stating (as applicable):
 - (1) that use of repository materials is governed by UTSW IRB,
 - (2) only specimens or data that are not otherwise identifiable to the recipient may be provided by a UTSW repository (except those with IRB approval to do so),
 - (3) the recipient agrees not to attempt to re-identify the materials (except those with IRB approval to do so),
 - (4) if identifiable materials are distributed, they may only be utilized in accordance with the conditions stipulated by an IRB, and
 - (5) any additional use of the materials requires prior review by the repository and an IRB (if identifiable).
 - e) Tracking. Repositories must include a plan to track the distribution of materials to recipient investigators. This tracking should include (as applicable):

- (1) Name of recipient,
 - (2) title of protocol,
 - (3) type of materials distributed (data, blood samples, tumor samples, etc.),
 - (4) whether the materials were provided with/without identifiers, and
 - (5) confirmation that IRB approval was received (for identifiable material distribution)
- C. The collection of materials (data or specimens) for inclusion in a research data center or repository by UTSW employees/agents must be submitted to the UTSW IRB.
1. The data center or repository may be either local or external.
 2. Collection of materials (data/specimens) must be authorized by obtaining the legally effective informed consent and authorization of the subject or the subject's legally authorized representative (unless consent and authorization were waived by the IRB).
 3. Prior consent and authorization for collection and use of materials in future research may be waived only if the criteria for a waiver of consent and HIPAA authorization are met, *and*:
 - a) The protocol includes a plan for allowing subjects to opt-out of the repository or certain aspects of the repository, or
 - b) It involves materials (data, documents, records, or specimens) that have been collected, solely for non-research purposes such as medical treatment or diagnosis, or
 - c) It involves existing materials (data, documents, records, or specimens) that have been collected for research purposes under another IRB-approved research study, however consent and authorization for future research use could not/cannot be obtained.

II. SCOPE

This policy applies to human subject research repositories established for the purpose of storing data and/or human biospecimens for future research purposes.

This policy does not apply to data/human biospecimens that are collected and stored solely as part of routine clinical care or hospital procedures, such as blood banks, pathology, surveillance, or quality assurance. However, it does apply to data/human biospecimens from these sources that are then stored for future research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- D. Submission for a **local repository** involving **collection, storage, and distribution** of human data and/or tissue/specimens.
1. A repository application is submitted for eIRB review. The package includes a completed repository protocol, repository consent form or waiver request, and other supporting documents as appropriate.

2. If the local repository will accept specimens/data from other IRB approved research studies, the consent form (or waiver) used in the collection of specimens/data from the other studies must be included in the repository application. The Repository PI may either:
 - a) Add the individual collector-investigator(s) (from the other study) as a repository team member(s) and utilize the consent approved for the repository to collect specimens/data from subjects enrolled in the other research study, or
 - b) Add the entire study staff of the contributing study to the study personnel list and the study staff will use the consent form approved under the repository protocol. The personnel role will be "collector-investigators."
 3. The IRB will consider exceptions to the consent requirement for studies which are contributing existing data/specimens where consent for banking has already been obtained.
- E. Submission procedures for repository activities limited to **local collection** of materials to be sent to a separate repository (either *internal* or *external repositories*).
1. An eIRB application is submitted for review. The information related to the local collection of materials for inclusion at a separate repository which should be submitted are:
 - a) For repository studies only collecting and contributing to a separate (external) repository:
 - (1) A UTSW eIRB Application,
 - (a) Provide information about collection of materials
 - (b) If you will maintain a link (code) to the identifiers, information about the coding plan must also be provided
 - (2) UTSW Repository consent form (current version)
 - (3) a copy of the external institution's IRB approval for the storage/distribution operations of the repository, and
 - (4) other supporting documents as appropriate.
 - b) For research studies that will also collect and contribute to separate repositories:
 - (1) The repository sponsor's protocol or study's research description providing information on collection activities and transport of materials to the repository,
 - (2) Repository consent form (current version) or research consent with added information about the repository and an opportunity for subjects to opt in to the repository or a copy of the external repository consent form,
 - (3) A copy of the IRB/ethics committee approval for the storage/distribution operations of the repository (if applicable), and

- (4) Other supporting documents as appropriate,
- (5) The new contributing protocol must be added to the repository protocol collection plan for internal repositories,

F. Procedure common to all repository submissions

1. The HRPP staff conducts an administrative review of the submission (see [1.1 Receiving, Routing, and Administrative Review of IRB Submissions Policy and Procedure](#)).
2. The submission is forwarded to the appropriate review team (convened board or expedited review) and is reviewed by the IRB (expedited reviewer or convened board) following guidance provided in the [6.2 IRB Approval of Research Policy and Procedure](#) and [2.1 Initial Review of Research Policy and Procedure](#).
3. Following approval by the appropriate review procedure, the determinations are reported in accordance with the [8.2 Reporting Policy and Procedure](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
June 2018	HRPP	New Policy

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 (214) 648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY

3.1 INFORMED CONSENT REQUIREMENTS

RESPONSIBLE OFFICE: Human Research Protection Program Office

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A.** Obtaining legally effective informed consent of individuals before involving them in research is one of the central protections provided in the regulations governing research. Informed consent in research is founded on the Belmont Principle “respect for persons”
- B.** Informed consent is an ongoing process. The informed consent document may be used to document the process as appropriate.
- C.** Informed consent must be sought from each potential subject or the subject's legally authorized representative, in accordance with, and to the extent required by 45 CFR 46.116.
- D.** Informed consent must be appropriately documented in accordance with, and to the extent required by 45 CFR 46.117.
- E.** The IRB is responsible for the review and approval of the informed consent process and form submitted by the investigator. The wording on the informed consent form must contain all required elements and must meet all other requirements as described in this policy.
- F.** The investigator may use a short form if approved by the IRB in accord with applicable federal requirements (see Informed Consent of Non-English Speaking Subjects Policy and Procedure).
- G.** The IRB may determine that monitoring of the informed consent or assent process is necessary in accordance with [2.2. CONTINUING REVIEW OF RESEARCH.](#)

II. SCOPE

- A.** This policy and procedure applies to the process, documentation, required elements and approval of informed consent in human subjects’ research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. Informed Consent Process

1. The consent process must always:
 - a. provide relevant information in language comprehensible to the prospective subject or representative;

- b. provide the prospective subject or representative sufficient opportunity to consider whether or not to participate; and
 - c. minimize the possibility of coercion or undue influence.
2. No informed consent, whether oral or written, may include exculpatory language through which the subject or the representative is made to waive or appear to waive any of the subject's legal rights.
3. A person knowledgeable about the consent process and the research to be conducted (i.e., a member of the project's research team) must obtain the informed consent.
4. If a member of the study team (other than the investigator) conducts the interview and obtains consent, the investigator should formally delegate this responsibility and the person so delegated must have received appropriate training to perform this activity.
5. The investigator is responsible for ensuring that informed consent is obtained from each research subject or his/her legally authorized representative after the subject or the subject's legally authorized representative has had an adequate opportunity to read the form and before that subject participates in any part of the research study, using the process and form approved by the IRB.

B. Documentation of Informed Consent (Signature Requirements)

1. Unless documentation of informed consent is waived, the informed consent must be appropriately documented in accordance with, and to the extent required by, 45 CFR 46.117 and institutional requirements:
 - a. Informed consent is documented by the use of a written consent form approved by the IRB. The consent must be signed, timed and dated by the subject and/or the subject's legally authorized representative at the time of consent.
 - b. Informed consent may also be documented by including a visit note describing the consent interview and outcome in the research record
 - c. *Note:* If the IRB approves a waiver of documentation of consent, the researcher must still document the consent process in the research record.
2. The subject or the subject's legally authorized representative and the person providing the information to the subject sign, time and date the informed consent document at the time of consent. Only study team members authorized (in the IRB approved application) to obtain informed consent should sign as the person obtaining consent.
3. The person authorized by the investigator to obtain the informed consent signs, times and dates the form and provides a copy of the informed consent form to the subject or the subject's legally authorized representative (as applicable).
4. The PI may request approval by the IRB to document the informed consent of the subject by receiving the signed and dated informed consent document from the subject by facsimile, email, mail or other means.

5. The PI is responsible for keeping the original signed informed consent form and, in accord with the requirements specified in the UT Southwestern Policy on Record Retention and the study procedures as approved by the IRB.

C. Required Elements of Informed Consent

1. The UT Southwestern IRB provides consent form templates available for download on the IRB website. Investigators should use these templates as a guide to create study specific consent forms unless the IRB grants exceptions or a waiver. The consent templates contain the eight required elements (as applicable), the six additional elements of informed consent (as applicable), and any additional institutional requirements for UT Southwestern research involving human subjects.
2. Federally required elements of Informed Consent. At a minimum, the proposed consent process and form include the name of the study, the name of the principal investigator and the following eight federally required elements and additional elements where appropriate:
 - a. *Research statement:* a statement that the study involves research, an explanation of the purpose of the research, an explanation of the expected duration of participation, a description of the procedures involved, and identification of any procedures which are experimental. Informed consent documents should also identify any procedures that are done for research purposes.
 - b. *Reasonably Foreseeable Risks or Discomforts:* a statement that describes any reasonably foreseeable risks or discomforts associated with the research, an estimate of the severity of the harms or discomforts.
 - c. *Reasonably Expected Benefits to Subjects or Others:* a statement that describes any benefits to subjects or others that may be reasonably expected from the research or no benefit, if this is applicable. Payment for participation in a research project is not considered a benefit.
 - d. *Appropriate Alternatives:* a statement that describes with enough detail any alternative procedures or course of treatment that may be advantageous to the subject, if this is applicable.
 - e. *Extent of Confidentiality:* a statement that describes the extent to which confidentiality of records identifying the subject will be maintained or not maintained (e.g., law requires reporting child abuse, etc.), describes how the research team will protect subjects' private records during and after the conclusion of proposed research studies. Any research that is subject to audit or inspection must identify those entities that will have access to the subject's record (e.g., FDA, National Institutes of Health (NIH), UT Southwestern, sponsors, or contract research organizations).
 - f. *Compensation or Treatment for Injury:* for studies with greater than minimal risk, a statement containing an explanation of: any compensation and an explanation of any medical treatments available if injury occurs or where

further information may be obtained. The informed consent template contains standard statements in accordance with UT Southwestern policy.

- g. *Contact Information*: a statement that describes contact information details, including telephone numbers, and whom to contact for the following situations:
 - i. questions about the research study (e.g., investigator and/or other team members),
 - ii. concerns about the research study or questions about the subjects' rights (e.g., the HRPP Director or HRPPO),
 - iii. complaints, comments/suggestions, or concerns (e.g., the HRPP Director or HRPPO), and
 - iv. in the event of a research-related injury (depending on the nature of the research, the PI or a physician on the research team).
 - h. *Voluntary Participation Statement*: a clear statement that: participation in the research is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.
3. Additional (Federal) Elements where appropriate: The IRB determines whether the additional elements are necessary (i.e., when the element(s) does not apply given the nature of the research or the proposed procedures (e.g., subjects will not be paid for participation):
- a. *Unforeseeable risks to subjects, embryos, or fetuses*: a statement warning subjects that some risks are currently not known or foreseeable should be included when applicable (e.g., an early human study where very limited information related to risks);
 - b. *Investigator-initiated termination of participation*: a statement that describes the instances an investigator may terminate a subject's participation (e.g., subject non-compliance, subject not benefiting from research, etc.);
 - c. *Additional costs*: a statement that describes any additional costs a subject may encounter such as: health-related costs, etc.;
 - d. *Early withdrawal/procedures for termination*: a statement that describes a subject's right to withdraw from research and any procedures that may be necessary after an early withdrawal for subject's safety, and any possible harms that may result if the recommended withdrawal procedures are not followed (e.g., tapering a drug);
 - e. *Significant new findings*: a statement that subjects will be told of any new findings which may affect willingness to continue in the research;
 - f. *Approximate number of subjects*: a statement that explains the approximate number of subjects to be enrolled in the study;

4. UT Southwestern additional elements where appropriate:

- a. *Disposition of subject's biologic specimens:* a statement of what will be done with any biologic specimens collected during the study (e.g., further DNA testing, cell lines, development of future commercially valuable products);
- b. *Payment:* a statement which includes all information concerning the amount and schedule of payment for participation.
- c. *Conflict of Interest:* The IRB determines whether disclosure of an investigator's conflict of interest is warranted in the informed consent process and document (See [5.3 FINANCIAL CONFLICT OF INTEREST MANAGEMENT](#));
- d. *Studies of investigational drugs, devices, or biologics:* inform the subject that the study includes evaluation of both safety and effectiveness of the test article and state the test article is investigational, and, if applicable, not approved by the FDA;
- e. *The process of dose escalation;* include description of how dose will be adjusted;
- f. *Reproductive Risks:* risk for an unborn child, a man or woman's ability to procreate or a woman's ability to conceive or carry a child. Suggested wording in the consent form template may be revised to meet the needs of the study;
- g. *Vulnerable populations or sensitive issues,* the investigator addresses additional regulatory and/or institutional requirements. The investigator may consult the HRPPO staff for guidance. The vulnerable populations and sensitive issues include, but are not limited to:
 - Research involving children (e.g., what information may be shared/provided to parents);
 - Research involving decisionally impaired subjects;
 - Research involving HIV screening and/or AIDS research (e.g., mandatory reporting responsibilities);
 - Research involving DNA Banking, Genetic Research or Gene Therapy;
 - Research activities directed toward pregnant women;
 - Research involving prisoners.
 - Illiterate subjects
 1. The PI may obtain consent from an individual who is unable to read and/or write using the IRB approved consent document. A Short Form consent document is not necessary.
 2. If the subject is unable to read but able to sign their name or "make their mark," the investigator must read the entire consent document verbally to him or her while a witness follows along to ensure information is being presented accurately. If the subject agrees to participate in the study, he or she must sign their name or "make their

mark". The witness must write a note on the consent form that he or she was present during the entire consent process, that the entire consent form was read to the subject, and that the subject willing agreed to participate in the study.

3. If the subject is unable to write or "make their mark," a witness must be present during the entire consent process. The witness must write a note on the consent form that he or she was present during the entire consent process, the subject was unable to sign the consent form, the subject willing agreed to participate in the study, and the method used to communicate their decision (e.g. nodding head, verbal agreement, etc.).

D. Submission and Approval of Informed Consent (Process and Document)

1. Submission by the PI

- a. The PI submits a description of the consent procedure. The IRB Smart Form application includes information about the location of the consent interview, the individuals from the research team who will be participating in the informed consent process or individuals who are authorized to obtain informed consent on behalf of the PI.
- b. In addition to the written form with the IRB application prior to initiation of research. The exceptions to this include situations such as:
 - i. exempt research proposals (although informed consent(s) may be used- See Exempt Research Policy and Procedure), and
 - ii. research that include a request for waiver of informed consent or waiver of documentation of informed consent (See [3.3 INFORMED CONSENT WAIVERS AND ALTERATIONS](#)).

2. Review by the IRB

- a. The IRB is responsible for reviewing the proposed informed consent process and document to ensure that all applicable federal and UT Southwestern requirements are met.
- b. The UTSW IRB will consider the location of the consent interview, and the individual(s) who will be obtaining consent (e.g., the investigator, collaborator, or qualified designee) in determining the appropriateness of the consent process.
- c. When the timing, location, or status of the individuals participating in the proposed consent process may impair the potential participant's understanding of the research, the IRB will require an alternative process.
- d. The IRB assesses the PI's description of the informed consent process to ensure that the process meets the following general requirements of informed consent:

- i. consent be obtained from the subject or subject's legally authorized representative;
 - ii. the process protects privacy;
 - iii. be in language understandable to the subject;
 - iv. be obtained under circumstances that provide the subject with the opportunity to consider whether or not to participate, and that minimize coercive influences;
 - v. does not include language through which the subject is made to waive his/her legal rights or releases the investigator, sponsor, or institution from liability for negligence.
- e. NIH-sponsored multicenter clinical trial must include a copy of the NIH-approved sample informed consent document in the IRB application. The investigator must justify in writing any deletion or substantive modification of information concerning risks or alternative procedures contained in the sample informed consent document, and the IRB must approve these deletions or modifications. For trials sponsored by the National Cancer Institute, investigators must forward copies of such IRB-approved changes, with their justifications to the appropriate Cooperative Group headquarters;
- f. Once the IRB approves the study or modification, the HRPPO staff affixes an approval stamp to the approved informed consent document. Investigators may only enroll subjects using informed consent/assent forms which have a valid "IRB approval" stamp unless the IRB grants a waiver from the requirement for informed consent or documentation. The consent must also be the most current version. If the consent form is modified during the protocol approval period, the form must bear the approval date of the modification rather than the date of the approved protocol.

E. Electronic Consent (eConsent)

1. Unless the IRB waives the requirement for the investigator to obtain a signed consent or grants a waiver of documentation of consent as described above, the standard expectation is that a signature will be handwritten using a permanent medium (i.e. ink pen) by the subject or subject's LAR. However, agreement to participate in the research study can be documented electronically.
2. The IRB makes the following considerations regarding the electronic documentation of Informed consent.
3. The mechanism used to obtain consent should:
 - a. Ensure safeguards of the protection of privacy and confidentiality;
 - b. Have the ability to display or use most current version of the IRB approved consent form;

- c. Have the ability to re-consent subjects who are already enrolled in the research study (if applicable);
- d. Have a mechanism for the subjects or subjects LAR to document willingness to participate in the research study, if applicable (i.e. checkbox, capture of signature by mouse or finger pad);
- e. Allow the subject to print or download and save a copy of the consent form or updated consent form.
- f. Provide a method to ensure that the person signing the informed consent is the subject (or the subject's legally authorized representative) who will be participating in the research study, if applicable based on the risk level of the study.

F. Participant Withdrawal

1. When a participant withdraws from a study, the data collected on the participant to the point of withdrawal remains part of the study database and may not be removed. The consent document cannot give the participant the option of having data removed.
2. A researcher may ask a participant who is withdrawing whether the participant wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the participant distinguishes between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through non-invasive chart review, and address the maintenance of privacy and confidentiality of the participant's information.
3. The researcher must obtain the participant's consent for this limited participation in the study (assuming such a situation was not described in the original consent document). The PI may submit:
 - a. A request for a single subject exception (using the Reportable Event submission process)
 - b. Modification and Addendum consent document
 - c. Modification and revised informed consent.
 - d. The IRB must approve the single subject exception or modification before the activity commences. (See [2.3 MODIFICATIONS TO RESEARCH](#)).
4. If a participant withdraws from the interventional portion of a study and does not consent to continued follow-up of associated clinical outcome information, the researcher must not access for purposes related to the study the participant's medical record or other confidential records requiring the participant's consent. However, a researcher may review study data related to the participant collected prior to the participant's withdrawal from the study, and may consult public records, such as those establishing survival status.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM POLICY AND PROCEDURE

3.2 INFORMED CONSENT BY SURROGATE (PARENTS OR LEGALLY AUTHORIZED REPRESENTATIVES)

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY RATIONALE AND TEXT

- A. Obtaining legally effective informed consent of individuals before involving them in research is one of the central protections provided in the regulations governing research. Informed consent in research is founded on the Belmont Principle “respect for persons”
- B. This policy is designed to protect human subjects from exploitation and harm and, at the same time, make it possible to conduct research on problems that are unique to persons who have an impaired decision-making capacity.
- C. Ordinarily, an investigator must obtain informed consent directly from prospective research subjects. When the prospective research subject is a child or an adult whose own consent would not be legally effective because s/he lacks the capacity to give or communicate comprehending, informed consent, then research may be conducted only with the consent of the potential subject’s parent, guardian or legally authorized representative (the “LAR”), which is also known as “surrogate consent.”
- D. The UTSW IRB may waive the requirement for obtaining surrogate consent (from a parent, legal guardian, or legally authorized representative) if the research meets the provisions for waiver in 45 CFR 46.116(d)(1-4) (see [3.3 INFORMED CONSENT WAIVERS AND ALTERATIONS](#))
- E. Assent (affirmative agreement) is required if the subject is able to give it. However, the IRB may waive the requirement to seek assent if the subject is not competent to give it.

II. SCOPE

- A. This policy and procedure applies to all human subjects’ research involving children and decisionally impaired or otherwise incompetent adults.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. **Assent** - The PI must develop processes and forms consistent with guidance provided in several IRB forms and policies: [2.6 RESEARCH INVOLVING INDIVIDUALS WITH DIMINISHED AUTONOMOUS DECISION-MAKING CAPACITY](#), eIRB smart form, [6.2 IRB APPROVAL OF RESEARCH](#) and [2.1. INITIAL REVIEW OF RESEARCH](#) policies concerning review related to assent. The PI is responsible for including in the IRB application a description of the process/procedure for obtaining and documenting assent when research includes:

1. Minors (Children)

- a. A minor is a person who is under the age of 18.
- b. Because “assent” means an affirmative agreement to participate in research, (45 CFR 46.402(b)), the child must actively show his or her willingness to participate in the

research, rather than just complying with directions to participate and not resisting in any way.

- c. When judging whether children are capable of assent, the IRB must 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.
- d. The IRB reviews the proposed process and, if applicable, the assent process to ensure compliance with IRB guidance and federal requirements. In general in determining whether assent of children is required in all, some or none of the children in a study the IRB is guided by the following age ranges:
 - i. Ages 0-6 – The capability of children of this age group is so limited that they cannot reasonably be consulted. Assent is not required.
 - ii. Ages 7-10 – Children of this age group may be capable of providing assent depending on the maturity and psychological state of the children involved in the research. Assent may be required.
 - iii. Ages 10 – 17 – Children of this age group are expected to be capable of providing assent. Assent is usually required unless waived by the IRB.
- e. If assent is determined appropriate the investigator must obtain assent from minors he/she deems capable of understanding the nature and consequences of participation in the study regardless of the age. The child should be given an explanation, at a level appropriate to the child's age, maturity and condition, of the procedures to be used, their meaning to the child in terms of discomfort and inconvenience, and the general purpose of the research.
- f. If assent is determined appropriate, documentation of assent is required. Generally, assent of the child is documented by having the child sign the consent form in the designated signature section.
- g. The IRB may waive its requirements for obtaining or documenting assent if the IRB determines:
 - i. Capability of some or all of the children are limited such that they cannot be reasonably consulted, or
 - ii. The research intervention or procedure(s) involved hold 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 investigation, or
 - iii. The research meets the following requirements:
 - the research involves no more than minimal risk to the participants; and
 - the waiver will not adversely affect the rights and welfare of the participants; and
 - the research could not practicably be carried out if assent was required; and
 - When appropriate, pertinent information is provided after participation.

2. Decisionally impaired and/or incompetent adults

- a. The IRB determines whether assent is required in research involving decisionally impaired adults, and/or incompetent adults based on their condition, the research procedures to be used, and the general purpose of the research.
- b. If assent is determined appropriate in decisionally impaired adults, and/or incompetent adults, the individual should be given an explanation, at a level appropriate to the individual's condition, of the procedures to be used, their meaning in terms of discomfort and inconvenience, and the general purpose of the research.
- c. If assent is determined appropriate in decisionally impaired adults, and/or incompetent adults, documentation of assent is required. Generally, assent is documented by having the individual sign the consent form in the designated signature section.
- d. The IRB may waive its requirements for obtaining or documenting assent appropriate in decisionally impaired adults, and/or incompetent adults, if the IRB determines:
 - e. the research involves no more than minimal risk to the participants; and
 - f. the waiver will not adversely affect the rights and welfare of the participants; and
 - g. the research could not practicably be carried out if assent was required; and
- h. When appropriate, pertinent information is provided after participation.

B. Consent

1. Minors (Children)

- a. In accordance with 45 CFR 46.408(b) the IRB must determine that adequate provisions have been made for soliciting the permission of each child's parent or guardian.
- b. Parents or guardians must be provided with the basic elements of consent as stated in 45 CFR 46.116(a)(1-8) and any additional elements the UTSW IRB deems necessary (see [3.1. INFORMED CONSENT REQUIREMENTS](#)).
- c. Children are persons who have not attained the legal age for consent to treatments or procedures involved in the research. Unless "emancipated," minors may not legally give consent. Therefore, the researchers must obtain the parent(s) or legal guardian(s) permission before enrolling a minor in the research as follows:
 - i. Permission of one parent is sufficient for research involving:
 1. minimal risk (§46.404/§50.51), or
 2. more than minimal risk with the prospect of direct benefit (§46.405/§50.52).
 - ii. Both parent's permission is required 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 for research:
 1. involving greater than minimal risk with no prospect of direct benefit but likely to yield generalizable knowledge about the subjects' disorder or condition (§46.406/§50.53), or
 2. not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children (§46.407/§50.54).

- d. A minor is only “emancipated” (and therefore able to consent for him/herself) in Texas by a court order, though the proper legal terminology is that the person has had the disabilities of minority removed. If the person under age 18 is “emancipated”, then the subject is treated as an adult and may provide informed consent for themselves.
 - e. In Texas, a minor may consent to medical, dental, psychological, and surgical treatment for him or herself, and hence may also consent to research for the same circumstances/treatment, if the minor is:
 - i. is on active duty with the armed services of the United States of America;
 - ii. is:
 - 1. 16 years of age or older, and
 - 2. residing separate and apart from the his/her parents, managing conservator, or guardian (with or without consent and regardless of duration), and
 - 3. managing his/her own financial affairs (regardless of the source of the income);
 - iii. is seeking the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;
 - iv. is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
 - v. is seeking an examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use; or
 - vi. is serving a term of confinement in a facility of the Texas Department of Criminal Justice.
 - f. A provider may rely on the written statement of the child containing the grounds on which the child has capacity to consent to the medical treatment
 - g. When conducting the study, investigators may need to make decisions on a subject-by-subject basis regarding the applicable state statutory requirements. If there are questions relating to whether an individual meets the state statutory requirements to be emancipated or to give consent without an LAR, the investigator should consult the UT Southwestern legal counsel.
2. Research Involving Decisionally Impaired Subjects
- a. The federal regulations define “legally authorized representative” as “an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research.” Under Texas law, this means the consent must come either from the legal guardian of the subject, or, in the case of research that is part of medical treatment, from the subject’s health care agent
 - b. The PI may obtain consent by a legally authorized representative only in situations where the prospective subject is incompetent or has impaired decision-making capacity, as determined and documented in the person’s medical record in a signed and dated progress note.

- c. The determination that a subject is incompetent or has an impaired decision-making capacity must be made by a legal determination or a determination by the practitioner (e.g., a psychiatrist or licensed psychologist may be consulted if based on mental illness diagnosis). This determination may be made independently, in consultation with another qualified individual or after appropriate medical evaluation it is determined that the prospective subject lacks decision-making capacity and is unlikely to regain it within a reasonable period of time.
 - d. The IRB may require investigators to conduct a preliminary competency assessment whenever there is a possibility of either impaired mental status or decision-making capacity in prospective subjects
 - e. The investigator advises the LAR of his/her role and responsibilities in serving as the decision-maker for the subject. The investigator also advises the LAR that it is his/her obligation to try to determine what the subject would do if competent, or if the subject's wishes cannot be determined, what he/she thinks is in the incompetent person's best interest.
 - f. If feasible, the investigator explains the proposed research to the prospective subject even when the LAR gives consent.
 - g. For subjects whose decision-making capacity may fluctuate and either regain capacity to consent or those with decreasing capacity to give consent, a re-consenting plan may be necessary.
3. Obtaining Informed Consent of Children or persons with DADMC outside the State of Texas
- a. If the PI is conducting the research outside the state of Texas and the research involves children or persons with diminished autonomous decision-making capacity (DADMC) the investigator must follow the requirements of the state/country in which he/she will conduct the research to determine which individuals meet the applicable legal or regulatory definitions for child/children, LAR, or guardian.
 - b. The PI should consult UTSW legal counsel when preparing the IRB application.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
Title 2, Texas Family Code § 31.001 - REMOVAL OF DISABILITIES OF MINORITY REQUIREMENTS
Title 2, Texas Family Code § 32.003 - CONSENT TO TREATMENT BY A CHILD
Title 4, Texas Health and Safety Code § 313.004 - CONSENT FOR MEDICAL TREATMENT

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

3.3 INFORMED CONSENT WAIVERS AND ALTERATIONS

RESPONSIBLE OFFICE: Human Research Protection Program

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

A. Alterations and Waivers of Informed Consent

1. Obtaining legally effective informed consent of individuals before involving them in research is one of the central protections provided in the regulations governing research. Informed consent in research is founded on the Belmont Principle “respect for persons”
2. The IRBs have the authority to approve a consent procedure that does not include or which alters some or all of the federally mandated elements of informed consent provided the approved procedure meets applicable federal regulations. The FDA and DHHS requirements for waivers differ. Consequently, the investigators and IRB must comply with the applicable regulations, which differ depending upon study sponsor or regulatory status of the proposed research.
3. The IRB may approve an investigator’s request to waive or alter the requirement to obtain informed consent if the investigator demonstrates with specificity that the criteria under 45 CFR 46.116(c) or 46.116(d) are met.
4. FDA regulations do not provide for a waiver or alteration of the informed consent process; the only exceptions to the informed consent requirements are for clearly defined circumstances of emergency use of a test article, and waivers granted for planned emergency research (See [2.5 EXCEPTION FROM INFORMED CONSENT FOR PLANNED EMERGENCY RESEARCH](#)).

B. Waiver of Documentation of Informed Consent

1. As allowed by OHRP (45 CFR 46.117 (c)) and FDA regulations (21 CFR 56.109(c)), the IRB may waive the requirement to obtain written documentation of informed consent. This provision can be used only for the waiver of documentation of consent, not for waiver or alteration of the consent process itself. A waiver of documentation of consent does not mean that requirements of the consent process are removed.
2. To approve a waiver of documentation, the IRB must find that the protocol-specific justification for waiving documentation satisfies regulatory criteria:
 - a. FDA regulated studies: IRB may waive documentation for some or all of the subjects if the conditions listed in 21 CFR 56.109(c) are met.
 - b. Non-FDA regulated studies: the IRB may waive the requirement to obtain a signed consent form for some or all of the subjects if requirements in 45 CFR 46.117(c) are met.

3. Even if a waiver of the participants' signatures is granted by the IRB, the investigator still must provide the participants with all of the information described in [3.1. INFORMED CONSENT REQUIREMENTS](#) to constitute a complete and appropriate consent process. The IRB may require submission of one of the following:
 - a. an information sheet, or
 - b. an oral script in a language understandable to the participants.
4. In all cases in which the requirement for documentation of consent is waived, the IRB may require the Researcher to provide participants with the written consent document with an option to sign the consent document, or with a written statement regarding the research.
5. When a waiver of documentation is approved by the IRB, the investigator must document the consent process and determination of the subject in the research records.

II. SCOPE

- A.** This policy and procedure applies to all human subjects' research requesting a waiver or alteration of the consent process under either OHRP and/or FDA regulated research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. Waiver or Alteration of Informed Consent for Non-FDA Regulated Studies:

1. The PI may request a waiver or alteration of informed consent by submitting a justification for the request in the IRB application. Alternatively, the IRB may determine that a waiver or alteration is appropriate without a request from the PI.
2. To waive or alter informed consent requirements, the IRB must find and document that the requirements in 45 CFR 46.116(d) are met. To approve such a request under 46.116(d), the IRB must find and document the following:
 - a. The research involves no more than minimal risk to the subjects;
 - b. The waiver or alteration will not adversely affect the rights and welfare of the subjects;
 - c. The research could not practicably be carried out without the waiver or alteration; and
 - d. Whenever appropriate, subjects will be provided with additional pertinent information after participation.
3. If the IRB reviews the protocol at a convened meeting, HRPPO staff document the waiver of informed consent approval in the IRB meeting minutes following [8.1 IRB MINUTES](#).
4. If the protocol is eligible for expedited review, the expedited reviewer documents on the expedited review documentation in eIRB whether each of the criterion has been met.

B. Waiver or Alteration of Informed Consent for Non-FDA Regulated Studies determined to be public benefit or service programs

1. The IRB may also waive the requirement to obtain informed consent or alter some of the elements if the IRB finds and documents (under 45 CFR 46.116(c)) that the research or demonstration project is to be conducted by or is subject to approval of state or local government officials and is designed to study, evaluate or examine:
 - a. public benefit or service programs; or

- b. procedures for obtaining benefits or services under those programs; or
 - c. possible changes in or alternatives to those programs or procedures; or
 - d. possible changes in methods or levels of payment for benefits or services under those programs; AND
 - e. The research could not practicably be carried out without the waiver or alteration.
2. If the IRB reviews the protocol at a convened meeting, HRPPO staff document the waiver of informed consent approval in the IRB meeting minutes following [8.1 IRB MINUTES](#).
 3. If the protocol is eligible for expedited review, the expedited reviewer documents on the expedited review approval documentation in eIRB whether each of the criterion has been met.

C. Waiver of Informed consent for Non-FDA regulated Planned Emergency Research

1. The PI submits an IRB application for review by the convened IRB. The HRPPO staff screen the application using procedures outlined in the [2.1. INITIAL REVIEW OF RESEARCH](#) HRPP Policy. The guidance document entitled *Harmonized Rule on Waiver of Consent For Emergency Research* is used by the PI, HRPPO staff and IRB members to ensure the regulatory requirements are met. The PI must address any additional issues not included in the standard IRB application, such as plans for public disclosure in communities prior to initiation.
2. At a convened meeting, the IRB must find and document that the research meets the requirements of the HHS Secretarial waiver under 45 CFR 46.101(i) that permits a waiver of the general requirements for obtaining informed consent in a limited class of research in emergency settings [Federal Register: Oct 2, 1996 (Vol. 61, Issue 192)]. Note: this waiver is not applicable to research involving prisoners (subpart C of 45 CFR Part 46). See [2.5 EXCEPTION FROM INFORMED CONSENT FOR PLANNED EMERGENCY RESEARCH](#) for review and approval requirements.
3. The individual chairing the meeting goes through each regulatory requirement. The IRB discusses whether the research meets each requirement and raises any applicable controverted issues. HRPPO staff record the discussion in the minutes, following the procedures in [8.1 IRB MINUTES](#).

D. Research Involving Children.

1. A waiver of parental or guardian permission in non-FDA regulated studies may be granted:
 - a. In public benefit or service programs under 45 CFR 46.116(c), as described above.
 - b. In general research under 45 CFR 46.116(d), as described above (“non-FDA regulated studies”).
 - c. When the IRB finds the research meets the requirements for HHS Secretarial waiver, under 45 CFR 46.101(i), that permits a waiver of the general requirements for obtaining informed consent in a limited class of research in emergency settings as described above (Planned Emergency Research).

- d. When consent of parents or guardians is not a reasonable requirement because it poses additional risk to the potential subject or the parents' interest may not adequately reflect the child's interest (e.g., neglected or abuse children), in accord with 45 CFR 46.408(c) and 46.116(c).
- 2. Review Procedure
 - a. The PI makes a preliminary decision to seek waiver of parental or guardian permission for participation of children in accord with 45 CFR Subpart D 46.408 (c) or 45 CFR 46.116(c)(d). The PI includes justification for the waiver and a description of a substituted appropriate mechanism for protecting the children who will participate in the research.
 - b. The IRB may approve the request provided the conditions outlined for waivers of consent in a.i-iv. above are satisfied in addition to the following:
 - a. The research is designed for conditions or for a participant population for which parental or guardian permission is not a reasonable requirement to protect the participants.
 - b. An appropriate mechanism for protecting the children who would participate as participants in the research was substituted.
 - c. The research is not FDA-regulated.
 - c. If the IRB reviews the research at a convened meeting, HRPPO staff record the discussion on each criterion in the minutes.
 - d. If the IRB reviews the study using expedited procedures, the expedited reviewer documents on the expedited review documentation in eIRB whether the research meets each of the criteria
- E. Alternatives to informed consent for FDA Regulated studies:
 - 1. Exceptions for informed consent requirements for planned emergency research: are approved if all of the requirements specified in 21 CFR 50.24 are met. See [2.5 EXCEPTION FROM INFORMED CONSENT FOR PLANNED EMERGENCY RESEARCH](#).
 - a. At the convened meeting, the HRPPO staff provide the IRB Chair or designee with a copy of regulatory requirements explained in 21 CFR 50.24 and/or the HHS Secretarial waiver under 45 CFR 46.101(i). The individual chairing the meeting goes through each regulatory requirement. The IRB discusses whether the research meets each requirement and raises any applicable controverted issues. The outcomes of the review are the same as those listed in the [6.2 IRB APPROVAL OF RESEARCH](#). HRPPO staff record the discussion in the minutes, following the procedures in [8.1 IRB MINUTES](#).
 - 2. Emergency use of an investigational drug or biologic product (unapproved drug or biologic) or an unapproved medical device: exception from informed consent for emergency use is allowed if the investigator certifies the requirements in 21 CFR 50.23(a) are met. It is recommended that investigators consult with the IRB Chair or HRPP Director before using an investigational drug/biologic in an emergency without informed consent to review the requirements listed in 21 CFR 50.23. See [7.5 EMERGENCY USE OF AN INVESTIGATIONAL DRUG OR DEVICE](#) for more information.
- F. Waiver of Documentation of Informed Consent - Federal regulations permit an IRB to waive the documentation requirements for obtaining informed consent under special circumstances. Waiver of documentation of informed consent is not necessary when informed consent has been waived by the IRB.

1. Non-FDA regulated research
 - a. The PI makes an initial request to waive the documentation requirements for obtaining informed consent, as specified in the IRB application.
 - b. The IRB may waive the documentation requirements to obtain a signed consent if:
 - a. The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject must be asked whether the subject wants documentation regarding the research and the participant's wishes will govern; or
 - b. The research presents no more than minimal risk of harm to participants and involves no procedures for which written consent is normally required outside of the research context
 - c. When the IRB waives the requirement to obtain written documentation of informed consent, the IRB reviews a written description of the information that the PI will provide to the subjects (i.e., a cover letter or a phone script).
 - d. In cases in which the IRB waives the documentation requirement, the IRB has the authority to require the investigator to provide subjects with a written statement regarding the research.
 - e. If the IRB reviews the request at a convened meeting, HRPPO staff include the discussion on each of the criteria in the meeting minutes.
 - f. If the IRB reviews the protocol using expedited procedures, the expedited reviewer documents on the expedited review documentation that 45 CFR 46.111(4) has been appropriately satisfied
2. FDA regulated research:
 - a. The PI makes an initial request to waive the documentation requirements for obtaining informed consent, as specified in the IRB application.
 - b. The IRB may waive the documentation requirement to obtain a signed consent if the research procedures for which the waiver is requested presents no more than minimal risk and involves no procedures which normally require written consent. 21 CFR 56.109(c)(1)
 - c. When the IRB waives the requirement to obtain written documentation of informed consent, the IRB reviews a written description of the information that the PI will provide to the subjects.
 - d. In cases in which the IRB waives the documentation requirement, the IRB has the authority to require the investigator to provide subjects with a written statement regarding the research.
 - e. If the IRB reviews the request at a convened meeting, the meeting minutes include the discussion on each of the criteria.
 - f. If the IRB reviews the study using expedited procedures, the expedited reviewer documents on the expedited review documentation form whether the research meets each of the criteria.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

3.4 INFORMED CONSENT OF SUBJECTS WITH LIMITED ENGLISH PROFICIENCY

RESPONSIBLE OFFICE: Human Research Protection Program Office

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The federal regulations on informed consent require the information be presented in a language understandable to the subjects. Where informed consent is documented in accordance with 46.117(b)(1), the written consent document should embody, in language understandable to the subject, all the elements necessary for legally effective informed consent.
- B. UT Southwestern Medical Center is located in a culturally diverse area. Investigators are encouraged to recruit and include all segments of the community in research, including individuals whose primary language is not English.
- C. The UTSW HRPP strongly encourages the use of a full consent form translated into the participant's language whenever possible. When all of the participants in a study (i.e., the target population) are anticipated to be non-English speaking, a full translated consent is required.
- D. Researchers should prepare both English language and translated consent forms for proposals that include non-English-speaking subjects. The IRB may consult with language experts or require a "back-translation" into English. In such cases, the investigator may be asked to provide documentation to verify the accuracy of the translation and back-translation.
- E. If a non-English-speaking subject is encountered unexpectedly, the subject cannot be enrolled until the IRB has reviewed and approved the consent process and the process for documentation of consent.
- F. In studies where written consent is indicated, and a potential subject understands English but does not read or write English, a witness should document that the subject understands the research and the consent process and has consented to participate.

II. SCOPE

- A. This policy and procedure applies to all human subjects' research involving subjects with limited English proficiency (LEP).

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Potential subjects who do not speak English should be presented with a consent document written in a language understandable to them. The UTSW IRB, however, recognizes that not every eventuality can be planned for ahead of time in every protocol.
- B. Investigators must deliver all information regarding informed consent/assent to potential subjects or their legally authorized representatives in the subject's native language(s) or

one that the subject understands. The investigator must provide the IRB and prospective subjects a translated version of the consent form (long form or short form as approved by the IRB).

- C. Investigators may use language translators or interpreter services to obtain consent in a language understandable to the participant or the participant's legally authorized representative.
- D. Documenting Informed Consent of individuals with limited English Proficiency (LEP).
There are two possible methods which may be used:
 - 1. Full translation of the long consent
 - a. When all of the participants in a study (i.e., the target population) are anticipated to be non-English speaking, a full translated consent is required.
 - b. The IRB requires that appropriately translated consent documents be submitted to the IRB for review and approval prior to their use in enrolling participants.
 - 2. Short Form
 - a. Short Form - Federal regulations permit oral presentation of informed consent information in conjunction with a short form written consent document (stating that the elements of consent have been presented orally) and a written summary of what is presented orally.
 - i. IRB may permit informed consent in this manner for some or all of the subjects (see 21 CFR 50.27(b)(2)) or 45 CFR 46.117(b)(2).
 - ii. This method of consent may be used if subjects do not speak English and a translated long consent document is not available.
 - iii. A witness to the oral presentation is required, and the subject must be given copies of the short form document and the summary.
- E. PI Responsibilities
 - 1. Full translation of the long consent
 - a. The PI must obtain appropriate translation.
 - b. The PI must provide appropriate verification of the translation.
 - i. Verification may include a statement from the PI of the procedures used to verify the translation or by providing a certificate of translation from a professional translation company.
 - c. The PI is responsible for ensuring appropriate resources (translators, language phones, etc.) are available to communicate with the subjects at recruitment, enrollment (informed consent) and all future encounters. The PI should provide a description of the plan to communicate with LEP subjects in the research protocol.
 - 2. Short Form
 - a. The PI must obtain appropriate translation. The HRPP has numerous Short Form translations available in numerous languages on the website. If the language needed for the research is not available, it is the PIs responsibility to obtain the translated consent.
 - b. If the PI does not use one of the templates provided by HRPP, appropriate verification of the translation must be provided.

- i. Verification may include a statement from the PI of the procedures used to verify the translation or by providing a certificate of translation from a professional translation company.
- c. The PI is responsible for ensuring appropriate resources (translators, language phones, etc.) are available to communicate with the subjects at recruitment, enrollment (informed consent) and all future encounters. The PI should provide a description of the plan to communicate with LEP subjects in the research protocol.
- d. Short Form Procedures:
 - i. The oral presentation must be in a language understandable to the subject. The short form should also be in a language understandable to the subject, however it may be in English if translation would represent an unreasonable delay that could be detrimental to the potential participant; researchers may not avoid translating the short form out of mere convenience or to reduce study expenses.
 - ii. If the short form is translated, the form must be submitted to the IRB for review and approval. If the researcher uses the English version but anticipates additional non-English speaking subjects, then the researcher should have the long or short consent forms translated and submit the form to the IRB for review and approval.
 - iii. The IRB-approved English language informed consent document may serve as the summary, and the interpreter and witness must both be conversant in both English and the language of the participant. When the person obtaining consent is assisted by an interpreter, the interpreter may serve as the witness.
 - iv. Signature Requirements:
 - 1) Short Form (in participant's language):
 - a) Signature of participant or legally authorized representative (required by OHRP/FDA)
 - b) Signature of witness (required by OHRP/FDA)
 - 2) English Informed Consent Document or summary:
 - a) Signature of person obtaining consent (OHRP)
 - b) Signature of witness (required by OHRP/FDA)
 - v. A copy of the summary is given to the subject or the subject's LAR, in addition to a copy of the short form.
 - vi. The PI is responsible for keeping the original signed informed consent form and, according with the requirements specified in the [UTSW Records Retention Policy](#) and the study procedures as approved by the IRB

F. IRB Review and Approval

1. Long Form translation

- a. The IRB may utilize administrative review procedures in approving translations of such documents if the English language consent/assent document has already been approved by the IRB, and a qualified individual has verified the accuracy of the translation
 - b. The HRPPO staff may identify a cultural consultant to review the study and informed consent/assent document for accuracy and cultural appropriateness. If the HRPPO staff is unable to identify an individual to serve as a cultural consultant, the investigator may provide a cultural consultant for review of accuracy of the informed consent form and cultural appropriateness. The cultural consultant must not have any affiliation with or investment in the research.
 - c. The HRPP staff ensures that the consultant does not have a conflict of interest. (See [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#))
2. Short Form
- a. Use of the short form in lieu of the long translated consent form requires IRB approval.
 - b. The PI may request to use a short form written consent document stating that the elements of informed consent have been presented orally to the subject or the subject's legally authorized representative.
 - c. The IRB must approve a written summary (typically the long English consent is used as the summary) of what is to be said to the subject or the subject's legally authorized representative (LAR) which embodies the basic and appropriate elements of disclosure.
 - d. The IRB reviews the request and may approve the short form option for documentation only if all of the requirements outlined in 45 CFR 46.117(b), and as applicable, 21 CFR 50.27(b) are met.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office

HRPP@UTSouthwestern.edu

214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

4.1 IDENTIFICATION AND RECRUITMENT OF PARTICIPANTS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. UT Southwestern appreciates and is supportive of the importance of clinical research as a means to improving the health of UT Southwestern patients and aims to facilitate patient participation in clinical research. As such, UT Southwestern patients may be contacted for potential participation in clinical research unless they have expressly indicated their desire not to be contacted for potential participation in clinical research; to “opt-out” of such contact. Patients cared for at UT Southwestern Hospitals and Clinics have the opportunity to state their preference **not** to be included in lists of potential research participants to be contacted which was obtained by review of their electronic health record (opt-out). This does not prevent their treating providers from informing them of research opportunities ongoing in their practice. Patients may change their preference to be included or excluded from potential research participant lists at any time.
- B. The method used to contact patients for potential participation in research studies will be described in the recruitment plan. Recruitment methods used to solicit volunteers into human research must be equitable and free of bias, undue influence and coercion. Recruitment methods must respect the privacy of potential research participants. The Institutional Review Board (IRB) must review and approve the methods, materials, procedures, and tools used to recruit potential research participants before they are implemented. Regardless of whether the contact occurs by letter, telephone, email, MyChart message or any other means, it must respect the patient’s privacy and the confidentiality of their PHI. The appropriateness of one method of contact versus another will depend on the condition under study and the nature of the research, and is thus specific to each research protocol.
- C. All contact with potential research participants must be initiated by a member of the research team (principal investigator, sub-investigator, coordinator, etc.) who has the appropriate training for research recruitment, and has been approved by the IRB as part of the recruitment plan described in the IRB application.
- D. Individual privacy will be protected and the confidentiality of identifiable information maintained in accordance with applicable federal regulations and institutional policies. The process of identification and recruitment of research participants must comply with the privacy and confidentiality regulations.

1. Privacy - The degree to which a researcher is allowed to use private identifiable information is limited, in part, by whether the researcher has an established relationship (either treatment or research) with the individual.
2. Confidentiality –treatment team and research team members are required to have an adequate plan to protect against the unintentional breach in confidentiality.
 - a) When responsible for private identifiable information, research team members must ensure the information is protected against improper disclosure.
 - b) Many improper disclosures are unintentional. All research team members should avoid discussing sensitive information concerning individuals where they may be overheard or leave individual’s information, either on paper or on computer screens, where they can be seen by other patients/participants, unauthorized health care staff or the public. Reasonable steps to ensure that confidentiality of private identifiable information should be described in protocols submitted for IRB approval.
- E. The identification and recruitment must not be tied to payments to employees to enroll participants which have potential for conflict of interest and undue influence.

II. SCOPE

- A. This policy and procedure applies to all human subjects’ research.
- B. Summary of responsibilities
 1. Individuals engaged in research or providing healthcare are responsible for ensuring the prospective study participants’ privacy is protected and the confidentiality of their data is maintained.
 2. HRPPO staff are responsible for providing guidance (in addition to that provided by the covered entity when HIPAA applies) to identify circumstances where additional permission/authorization is/is not required and processing requests for waivers through expedited or full IRB review.
 3. IRB Chair, or designee (as members of the IRB/Privacy Board) is responsible for approving, disapproving, or requiring changes in to secure approval of requests for HIPAA Waivers when expedited review is applicable.
 4. The convened IRB acts as the Privacy Board at UT Southwestern and is responsible for approving requests for HIPAA Authorization Waivers when expedited review is not applicable.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. This procedure starts when a researcher or treatment team member considers authority to use or disclose private identifiable information for identification or recruitment in a research study.
- B. This procedure ends when the recruitment activity ceases.
- C. Studies only involving record review (not involving interaction or intervention with participants)

1. The HRPPO receives the request to access private identifiable information for the purpose of identification of records eligible for inclusion in the research.
 2. The IRB (or designated reviewer) may permit investigators to access, obtain and record identifiable private information for the purposes of conducting research by waiving the requirement for informed consent and HIPAA authorization (if involving protected health information) for such activities. See the Office of Compliance Privacy Program Policy: [7.23 Waiver or Alteration of Research Authorizations](#).
- D. Studies involving record review for recruitment of research participants (studies involving interaction or intervention with participants)
1. The HRPPO receives the request to access private identifiable information for the purpose of identification and recruitment of participants.
 2. The IRB (or designated reviewer) will consider the degree to which private identifiable information can be used for identification and recruitment based upon whether the individual obtaining the information has an established relationship (either treatment or research) with the individual or where permission to obtain private information has been provided by the individual.
 3. Research with Patients who have not “opted-out” of recruitment for participation in research
 - a) Researchers with an established relationship
 - (1) The IRB (or designated reviewer) may permit these researchers to use private identifiable information to identify (by waiving the requirement for informed consent and granting a partial waiver of HIPAA authorization as applicable) and make initial contact (recruit) individuals who may be eligible for a new study.
 - b) Researchers without a treatment or established research relationship:
 - (1) The IRB (or designated reviewer) may permit these researchers to access, obtain and record identifiable private information for the purposes of identifying potential participants (by granting a partial waiver of HIPAA authorization as applicable).
 - i. Investigators must obtain a partial waiver of HIPAA authorization for access, use and disclosure (as applicable) of protected health information (PHI) from the UT Southwestern IRB (as the Privacy Board). This waiver allows investigators and/or the Office of Community Engagement and Participant Recruitment and Retention personnel to review the electronic health records of all patients seen by providers in the UT Southwestern Hospitals and Clinics.
 - ii. This partial waiver applies to clinical research activities at UT Southwestern and any other institutions (affiliate and non-affiliate) engaged in the research.
 - iii. Additional waivers are not required to review the medical records of patients seen at affiliated facilities (E.g., Parkland Hospital, Children’s Health, or Texas Scottish Rite Hospital). However, the fully completed, signed HIPAA Waiver form (Form H) must be available for review by any other institution where investigators wish to utilize the waiver. Each institution has the right to accept

the UT Southwestern HIPAA waiver or to refuse to accept it and either grant their own, require signed authorization, or refuse participation in the study.

- (2) The IRB (or designated reviewer) may permit these researchers to use private identifiable information for the purposes of making initial contact (cold calling). If a UT Southwestern patient is approached for participation in a research project, it is usually appropriate for their treating provider to be notified. The IRB-approved recruitment plan will state whether or not permission from the treating provider to contact a patient for research participation will be obtained **prior** to research recruitment. Based on the condition under study and the nature of the research project the IRB may require explicit approval of the treating provider for contact with their patient(s). Alternatively, the researcher could consider (and the IRB may require) other approaches such as:
 - (a) Advertisements
 - (b) Dear Doctor Letters
 - (c) Request assistance from other healthcare professionals or researchers who already have an established relationship
 - (d) Request assistance from the institutions who hold the private information
- c) Potential Research Participants Identified Through the Use of the UTSW Volunteer Research Participant Registry
 - 1) All patients seen at UT Southwestern Hospitals and Clinics who **have not** 'opted out' of the possibility to be contacted directly for potential research participation by investigators who are not their treating providers are automatically included in the Volunteer Research Participant Registry
 - 2) If the IRB-approved recruitment plan includes review of PHI contained in the EHR or derivatives of the EHR such as the Clinical Data Warehouse (CDW), the investigator will contact the Office of Community Engagement and Participant Recruitment and Retention to assist in the creation of a cohort of individuals who meet specific clinical, demographic, and/or laboratory criteria and have not opted out of direct contact by investigators who are not their treating providers. This Office is responsible for updating the status of potential participants who **have** opted out of direct contact on a regular basis and will inform investigators of any changes to their recruitment lists. Contacts will be monitored at the subject level and participants will be released in a controlled manner to ensure the participants will not receive numerous recruitment calls.
4. Research involving patients who have opted-out
 - a) The PHI of UT Southwestern patients who have opted out of direct contact by investigators not involved in their treatment will still be maintained in the Epic EHR, as well as IRB-approved activities such as the Clinical Data Warehouse, local specialty-specific registries, and investigator-maintained registries. Their PHI can be shared with registries outside UT Southwestern such as specialty-specific clinical registries and

registries required by the Federal or State government through standard HIPAA-compliant business arrangements.

- 1) Aggregate, de-identified counts of patients, including those who have opted out of direct contact by investigators not involved in their treatment can be obtained through tools such as SlicerDicer®, i2b2, and TriNetX. This is generally considered not human subject research and does not need prior IRB approval.
- 2) The PHI of patients who have opted out of direct contact by investigators not involved with their treatment will still be available to investigators doing IRB-approved research on existing data (i.e., retrospective chart reviews). This data may be abstracted from the CDW and provided directly to investigators by the Academic Information Service in either identified or de-identified formats. Alternatively, investigators can be given lists of research subjects meeting certain criteria for their own data abstraction, although there should be no contact of subjects who have opted-out.

E. Compensation for Recruitment

1. The UT Southwestern IRB must consider ethical issues and potential conflicts of interest that may arise when financial compensation (i.e., finder's fees, bonus payments) is offered to researchers or clinicians for referring or identifying participants in research. There is a possibility that such financial arrangements may result in an increased chance for the researchers or clinicians to act in a manner which is not in the best interest of the participant. Therefore, it is not permissible to pay or receive Finder's Fee payments or Bonus Payments.
2. It may be acceptable to pay or receive compensation for recruitment and screening related activities that are unrelated to whether the participant ultimately enrolls in or completes the research study if the activity is approved by the IRB.
 - a) In general, the compensation paid by UT Southwestern investigators should be limited to non-UT Southwestern individuals who are not engaged in the research. The service being rendered involves identifying potential participants and/or asking the potential participant if he/she would be willing to talk to a researcher about a relevant study. If the potential participant is not interested, no further encouragement should occur.
 - b) Compensation to the person assisting in identifying potential participants should be made whether or not the potential participant enrolls in the study.
3. All payments for the conduct of a research project must be negotiated at the beginning of the study and not provide for additional payments to UT Southwestern employees/agents based on either number or rate of participant enrollment. Payments tied to the number or rate of participant enrollment are considered to be bonus payments and are not permissible.
4. If an investigator wishes to consult the IRB regarding the approval to use compensation for recruitment services, the following questions should be answered as part of the protocol submission:
 - a) What compensation will be offered (for example, money, textbook, dinner, movie pass)?
 - b) Who will obtain consent or HIPAA authorization (if applicable) from the participant?

- c) To whom is the compensation being offered and what is the person being asked to do?
- d) Could the compensation provided be coercive or appear to be linked to successful enrollment in the study?
- e) Will the participant or their insurance be charged for any study-related activity?
- f) If a person is enrolled in the study, will there be a change in the responsibility for patient care? For example, will the study investigators now provide primary treatment for a problem?
- g) The responses to the questions above must be reviewed by the IRB Chair, or designated reviewer.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
NATIONAL INSTITUTES OF HEALTH - CLINICAL RESEARCH AND THE HIPAA PRIVACY RULE

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Updated to add opt-out requirements and resulting recruitment procedures
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL GUIDANCE

4.2 GUIDANCE FOR ADVERTISING TO RESEARCH SUBJECTS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. RATIONALE AND TEXT

- A. UT Southwestern Institutional Review Board interprets federal regulations and Institutional policy, in accordance with the interpretation of OHRP and FDA, to provide IRB authority and responsibility for review of study recruitment material, including advertisements.
- B. Because recruitment is considered part of the informed consent process, this guidance applies to the UT Southwestern Institutional Review Board (IRB) and the HRPPO who must review and approve all recruitment methods, as well as the content of the recruitment materials. Recruitment activities cannot be initiated until approval is received from the IRB. In addition, any changes to an approved recruitment tool must be submitted to the IRB for review as an amendment prior to implementing the changes (See [2.3 MODIFICATIONS TO RESEARCH](#)).

II. SCOPE

- A. This guidance applies to all materials intended for use to solicit or otherwise recruit participants into research studies reviewed by a UT Southwestern IRB.

III. GUIDELINES

- A. The IRB must review:
 - The information contained in the advertisement.
 - The mode of its communication.
 - The final copy of printed advertisements.
 - The final audio/video taped advertisements.
 - Amount and schedule of any payments
- B. ADVERTISEMENTS MAY CONTAIN THE FOLLOWING INFORMATION:
 - the name and address of the investigator and/or research facility;
 - the purpose of the research and, in summary form;
 - basic eligibility criteria;
 - a brief list of participation benefits, if any (e.g., a no-cost health examination);
 - the time or other commitment required of the subjects; and
 - the name and phone number of the person to contact for further information.

C. **ADVERTISEMENTS FOR RESEARCH REQUIRING IRB REVIEW:**

1. Direct advertising for study subjects is the start of the informed consent and subject selection process and IRB review is required for direct recruitment materials that are intended to be seen or heard by prospective subjects to solicit their participation in a research study. Advertisements to recruit participants should be limited to the information the prospective participants need to determine their eligibility and interest.
 - Claims should not be made in recruitment materials, either explicitly or implicitly, that the drug, biologic or device is safe or effective for the purposes under investigation, or that the test article is known to be equivalent or superior to any other drug, biologic or device or make any claims that are inconsistent with applicable FDA labeling.
 - Recruitment materials for investigational drug, biologic or device studies should not use terms such as "new treatment," "new medication" or "new drug" without explaining that the test article is investigational. A phrase such as "receive new treatments" leads prospective study subjects to believe they will be receiving newly improved products of proven worth, and is inappropriate.
 - IRBs reviewing advertisements, including clinical trial websites that exceed basic listing information above, also should assess the types of incentives, if any, that are being offered to prospective subjects. Monetary and non-monetary incentives (e.g., access to services or programs) can create undue influence on a potential subject's decision about research participation. IRBs must ensure it is clear that participation in a study is voluntary, and that incentives for participation are not so great that they compromise a prospective subject's assessment of the risks or affect the voluntariness of his or her choices. Recruitment materials should not promise "**free medical treatment**", when the intent is only to inform subjects that they will not be charged for taking part in the investigation. Recruitment materials may state that subjects will be paid to compensate for their time and/or travel, but should not emphasize the payment or state the amount to be paid by such means as larger or bold type. IRBs review advertising to ensure that advertisements do not allow compensation for participation in a trial offered by a sponsor to include a coupon good for a discount on the purchase price of the product once it has been approved for marketing.
 - It is advisable to point out when study participation is strictly altruistic versus providing potential benefit.
 - When recruitment materials are to be recorded for broadcast, the IRB reviews the final audio/video or may review and approve the wording of the recruitment materials prior to recording to preclude re-recording because of inappropriate wording. The review of the final recorded message prepared from IRB-approved text may be reviewed through expedited procedures.

D. **INTENT OF IRB REVIEW:**

- a. Identify misleading or coercive language. Determine whether the amount of payment and the proposed method and timing of disbursement is neither coercive nor presents undue influence. The IRB considers whether any amount paid as a bonus for completion is reasonable and not so large as to unduly induce participants to stay in the study when they would otherwise have withdrawn.
- b. Ensure for treatment protocols, that no claims, either explicitly or implicitly, are made that a proposed treatment is safe and effective or equivalent or superior to any other treatment. IRBs also ensure all information concerning payment, including the amount and schedule of payments, is set forth in the consent document.
- c. The IRB reviews the final copy of printed advertisements to evaluate the relative size of type used and other visual effects.
- d. The IRB ensures that advertisements do not state or imply a favorable outcome or other benefits beyond what is outlined in the consent document and the protocol or include exculpatory language.
- e. When such recruitment materials are to be taped for broadcast, the IRB reviews the final audio/video tape or may review and approve the wording of the recruitment materials prior to taping to preclude re-taping because of inappropriate wording. The review of the final taped message prepared from IRB-approved text may be reviewed through expedited procedures.
- f. The IRB reviews payments to determine that credit for payment accrues as the study progresses and not be contingent upon the participant completing the entire study.

E. Examples

2. **Examples of direct advertisement include:** posted notices, paid and unpaid newspaper solicitations or magazine advertisements (which may include public service announcements), websites, radio or television advertisements (which may include public service announcements), bulletin board announcements, recruitment posters, flyers, video recruitment tapes, Internet/website postings and solicitations by electronic mail.
3. **Examples of similar release of information that do not constitute advertisement requiring IRB review:** Clinical Trials Websites under specific conditions; Press Release / News Stories under specific conditions; Communication intended to be seen or heard by health professionals, such as “dear doctor” letters and doctor-to-doctor letters (even when soliciting new subjects); and Publicity intended for other audiences, such as financial page advertisements directed toward prospective investors. (Note: use of the term “dear doctor” letter is not meant as used in distributing important information about drugs under 21 CFR 200.5 (commonly referred to as "Dear Doctor Letters").
4. **Clinical Trials Website:** When information posted on a clinical trial website goes beyond directory listings with basic descriptive information (or information listed in

clinicaltrials.gov), such information is considered part of the informed consent process and therefore requires IRB review and approval. Basic descriptive information includes:

- study title
 - purpose of the study,
 - protocol summary,
 - basic eligibility criteria,
 - study site location(s),
 - how to contact the study site
 - Information exceeding such basic listing information includes descriptions of clinical trial risks and potential benefits, or solicitation of identifiable information.
5. **Press Release or News story:** University press releases that mention human volunteers for research studies are to be considered as “news stories.”
- g. News stories are not subject to the Common Federal Rule governing direct advertising for research subjects.
 - h. Stories should avoid creating a “therapeutic misconception” that just because this is a research study, it must provide benefit to the participant.
 - i. The word “research” should be included with “study” on first reference in stories, although it is not strictly required on later references.
 - j. Press releases in general should not overstate the benefits versus risks of participation in a research study.
 - k. It is advisable for release writers to point out when study participation is strictly altruistic versus providing actual benefit.
 - l. Consequently, no IRB stamp of approval is necessary before distribution of university press releases mentioning human study volunteers.
 - m. However, External Affairs writers are advised to avail themselves of the trusted counsel that the IRB is ready to provide on stories mentioning human study volunteers.
 - n. This counsel may be provided by e-mail between writers and the HRPP Director or Designee.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
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214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

5.1 PRINCIPAL INVESTIGATOR RESPONSIBILITIES IN THE CONDUCT OF HUMAN RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The purpose of this policy is to provide an outline of responsibilities of the principal investigator involved in the conduct of human subjects' research.
- B. The term Principal Investigator (PI) is used to identify a researcher with primary responsibility for a research project

II. SCOPE

- A. This policy applies to the following:
 - a. Individuals with faculty appointments qualify as PIs by the nature of their appointments. Individuals with other appointments may be able to serve as PI under certain circumstances.
 - i. UT Southwestern Individuals without faculty appointments may qualify as PI only with a faculty sponsor.
 - b. Refer to the institutional policies to learn more about other staff appointments that can serve as the PI on the institutional review board (IRB) protocol submission.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. Compliance with Applicable Regulations, Laws, and Policies Governing Human Subjects Research

- a. For UT Southwestern to receive federal funding to support human subjects research, the institution must have a Federalwide Assurance (FWA) with the U.S. Department of Health and Human Services (DHHS), Office for Human Research Protections (OHRP). The FWA states that **all human subjects research activities will be guided by the ethical principles** outlined in the Belmont Report and that federally supported research activities comply with the Common Rule. Investigators should become familiar with these principles and regulations to ensure that their research complies with them. Failure to comply with these principles can place both subjects and the institution at risk.

B. Conflict of Interest Policy

- a. Investigators are required to file a UT Southwestern Outside Activities Report/Disclosure prior to the submission of a protocol to an IRB for review and are responsible for keeping

these disclosures current. Additionally, investigators must comply with the campus Conflict of Interest policies related to human subjects research, including disclosing potential conflicts of interest to the IRB and abiding by any management plans issued by the campus Conflict of Interest Committee. See HRPP [5.3 FINANCIAL CONFLICT OF INTEREST MANAGEMENT](#)

C. Oversight and Supervision

- a. Although PIs may delegate certain research-related tasks to other members of the research team, they retain **ultimate responsibility** for the conduct of the study. The PI is the person ultimately responsible for the legal and ethical conduct of the study in accordance with the protocol, signed investigator agreements, and applicable regulations. The PI must be qualified by education, training, or experience to assume this responsibility.
- b. Oversight and responsibility for the study extend to the affiliated performance sites. PI is responsible for conducting the study in compliance with affiliate sites policies and procedures and notifying sites of unanticipated events or complaints.
- c. Investigators are responsible for certifying that key personnel have received adequate training to ensure they are aware of the regulations governing human subjects research and **understand and adhere to the IRB-approved research protocol**. Compliance with these standards provides assurance that the rights, safety, and well-being of human subjects are protected and the integrity of the data collected.
- d. Certain tasks may be delegated to qualified members of the research team, but the responsibility for ensuring tasks are performed in accordance with the protocol and regulations is the PI's, and cannot be delegated.
- e. The PI should ensure that a member of the research team to whom a task is delegated is qualified by education, training, and experience (and state licensure where relevant) to perform the delegated task(s).

D. PIs must also ensure that adequate resources are available for the conduct of the study. The investigator should have sufficient time and adequate resources to properly and safely conduct the research.

E. Obtaining IRB Approval or Exemption to Conduct Human Subjects Research (See HRPP Policy [2.1. INITIAL REVIEW OF RESEARCH](#))

- a. **Before initiating a study**, a PI must obtain approval by the IRB to conduct human subjects research or a determination by the IRB that the study is exempt from IRB review.
- b. To be considered "human subjects research", a project must meet both the federal definitions of "research" and "human subjects".
- c. *Research* is defined under the Common Rule as "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."

- d. The Common Rule defines a “*human subject*” as a living individual about whom an investigator (whether professional or student) conducting research obtains
 - i. Data through intervention or interaction with the individual, or
 - ii. Identifiable private information.
- e. Exempt Human Subjects Research (See HRPP Policy [1.3. EXEMPT REVIEW OF RESEARCH](#))
 - i. The federal Common Rule identifies six categories of human subjects research that may be eligible for exemption from IRB review. UT Southwestern IRBs apply these six exemption categories only to studies determined to be no more than minimal risk and are not FDA-regulated.
 - ii. Human subjects research that qualifies as exempt under one of the federal categories must nonetheless satisfy UT Southwestern's ethical standards for the protection of human research participants.
 - iii. If an investigator thinks his or her research falls into one of these exemption categories, he or she must still submit a protocol to an IRB. Only an IRB can determine whether the human subjects research is exempt. The IRB has the right not to exempt a protocol and to require full review by the convened IRB or expedited review by an IRB member or IRB subcommittee, particularly if the research involves a sensitive population or sensitive topic.
 - iv. If a study is determined to be exempt from IRB review, it is not subject to continuing review or other rules governing human research, such as rules on informed consent. However, the HIPAA Privacy Rule applies to all exempt research that uses protected health information (PHI). HIPAA Privacy Rule requirements do not apply to exempt research using information that has been de-identified.

F. Study Initiation and Participant Enrollment

- a. PIs must ensure that the study may not be initiated and no subject may be enrolled in a study until:
 - i. the IRB has approved the study for human subject enrollment;
 - ii. the involved study sites (e.g., PHHS, CMC, University Hospitals, Scottish Rite, etc.) have approved the study; and
 - iii. all study agreements or grant documentation has been finalized and appropriately executed.

G. Informed Consent (See HRPP Policy [3.1. INFORMED CONSENT REQUIREMENTS](#))

- a. Unless the IRB determines that a waiver of informed consent or waiver of a signed informed consent document is appropriate for a study or has determined a study to be exempt, an investigator is responsible for ensuring:
 - i. informed consent is obtained and documented using only current IRB approved consent forms, and

- ii. the subject receives a copy of the informed consent document, and
 - iii. informed consent is obtained prior to the conduct of research procedures.
 - b. Consent documents with the IRB approval and expiration dates should be used to obtain written consent from subjects. All subjects must be given a copy of the consent form.
- H. PIs are responsible for ensuring the conduct of an adequate and appropriate consent process.** When referring to “Informed Consent”, it is important to differentiate between the informed consent document and the informed consent process. Obtaining informed consent is a process and not solely obtaining a signature on a form. PIs are required to ensure that the consent process is conducted and is appropriate for the research study and subject population.
- I. PIs are responsible for ensuring the consent process is documented appropriately.** Unless the IRB has granted a waiver of informed consent or a waiver of informed consent documentation, the study team should have a process in place to document the consent process, and any assent process (in the case where minors or individuals with impaired decision-making capacity are enrolled) in the research files for each subject.
- J. HIPAA Privacy Rule** (See Office of Compliance Policies: [7.22 Research Authorizations](#) and [7.23 Waiver or Alteration of Research Authorizations](#)).
- a. All researchers who are part of the UT Southwestern Health Care Component (UCC) or Affiliated Covered Entity (ACE) or collaborating with someone within the UCC or ACE and who are using or disclosing protected health information (PHI) must obtain written permission (i.e., an authorization) from subjects for the use of the PHI or obtain a waiver or alteration of authorization from the IRB.
- K. Compliance with the IRB Approved Protocol and Application**
- a. Research teams must adhere to the conditions of IRB approval, which includes the information provided in the IRB application and any supporting materials such as a formal study protocol. **This means the research team cannot perform any procedures, visits, or interactions that are not in the IRB approved protocol and they must also perform what is specified in the protocol.**
- L. Requirements after IRB Approval: Changes of Protocol** (See HRPP Policy: [2.3 MODIFICATIONS TO RESEARCH](#))
- a. If modifications to the IRB approved materials are necessary, a change of protocol must be submitted to, and approved, by the IRB prior to implementing the change. Failure to conduct the study according to the IRB approved protocol is considered noncompliance.
 - b. To change any aspect of a research study, including revisions to an approved protocol, consent documents, HIPAA authorization forms, instruments, and recruitment methods and materials, a change of protocol must be submitted to the IRB for review and approval.
- M. Requirements after IRB Approval: Continuing Review** (See HRPP Policy: [2.2. CONTINUING REVIEW OF RESEARCH](#))

- a. Federal regulations require IRBs to review and approve all research protocols at intervals appropriate to the degree of risk, but not less than once per year. As a courtesy, the IRB sends email reminder notices to study teams, including PIs, prior to the expiration of approval date. However, investigators are responsible for monitoring their approval periods and submitting a *Continuing Review Protocol Progress Report* form for IRB review in a timely manner (i.e., within 2 months prior to the expiration date). If IRB approval of a protocol expires, research activities must cease until re-approval of the protocol is obtained unless the PI demonstrates that procedures are necessary to ensure subject safety.
- N. Closure Report:** When the research is completed, investigators are expected to provide the IRB with a *Protocol Closure* report. (See HRPP Policy: [1.4. STUDY CLOSURE AND INACTIVATION](#))
- O. Requirements after IRB Approval: Unanticipated Problems** (See HRPP Policy: [9.2 UPIRSO and UADE](#))
- a. Federal regulations and institutional policies require that investigators report to the IRB any unanticipated problems that pose risks to subjects or others that are related to the research. These should be reported to the IRB in accordance with the campus unanticipated problems policy.
 - b. Unanticipated problem is a broad term that includes not only unfavorable outcomes that have occurred that were not expected, but also the development of potentially increased risks of harm occurring in the future. According to guidance developed by the Office for Human Research Protections (OHRP), an unanticipated problem is an incidence, experience, or outcome that meets all 3 of the following criteria:
 - i. The incidence, experience, or outcome is unexpected given the research procedures described in protocol-related documents (e.g., the study protocol, the consent documents) and the characteristics of the subject population being studied. An event may be considered unexpected if it exceeds the nature, severity, or frequency described in the study-related documents.
 - ii. The incidence, experience, or outcome is related or probably related to participation in the research study. Probably related means the incidence, experience, or outcome is more likely than not to be caused by the research study procedures.
 - iii. The occurrence of the incidence, experience, or outcome suggests that the research places subjects or others at a greater risk of harm (physical, psychological, economic, or social) than was previously known or recognized.
 - c. The phrase “unanticipated problems involving risks to subjects or others” is found but not defined in the HHS regulations at 45 CFR part 46. OHRP considers unanticipated problems, in general, to include any incident, experience, or outcome that meets all of the following criteria:

1. 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;
2. related or possibly related to participation in the research (in this guidance document, 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
3. 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.

P. Requirements after IRB Approval: Noncompliance (See HRPP Policy: [9.3 NONCOMPLIANCE REVIEW](#))

- a. Federal regulations and institutional policies require that investigators report noncompliance with IRB approved documents or research regulations to the IRB. Noncompliance means any failure to follow (1) federal regulations, state laws or institutional policies relevant to human subjects' research, or (2) the requirements and determinations of the reviewing IRB.

Q. Record Keeping and Record Retention

- a. State and federal regulations require study teams to maintain complete and accurate study records. Study records should be stored in a secure manner to protect the privacy of subjects and to reduce the risk of damage. Any or all of the study related documents may be subject to, and should be available for, audit or inspection by a regulatory authority. Study records can be archived after completion, but must be maintained for a specified amount of time, depending on the requirements of the funding agency, sponsor, FDA or entity providing oversight. There may be other requirements that researchers must look into before disposing of research records; for example, the institution recommends maintaining records for at least seven years to dispute any allegations of research misconduct.

R. ClinicalTrials.gov Registration and Results Reporting

- a. Many clinical research studies involving human subjects must be registered on and have results posted to ClinicalTrials.gov as mandated by the Food and Drug Administration (FDA), National Institutes of Health (NIH) and/or International Committee of Medical Journal Editors (ICMJE).
- b. The ICMJE requires registration of any interventional health outcome studies – including Phase I trials – prior to subject enrollment. Failing to register trials covered by the ICMJE requirements in a timely manner can result in the rejection of publications based on the failure to register the trial.

S. Additional Responsibilities for Multi-Site Research (See HRPP Policy: [1.6. RELIANCE ON NON-UT SOUTHWESTERN IRB](#))

- a. When IRB review of a study is deferred to a non-UT Southwestern IRB, the PI and study team must still comply with relevant UT Southwestern requirements and must also be familiar with the requirements of the IRB of record, which may differ from that required by UT Southwestern. These responsibilities include complying with the requirements of the reviewing IRB in addition to those of the PI’s own institution and ensuring all institutional requirements are met in addition to the PI’s own institution.
- b. When UT Southwestern IRB serves as the coordinating center for a study, some of the additional PI and study team responsibilities include ensuring IRB approvals from all sites are in place before human subjects research occurs at those sites and promptly communicating changes of protocol, new information, and unanticipated problems to all study sites and ensuring that any changes are implemented.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
UT Southwestern Human Research Protection Program Departmental Policies and Procedures
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	Research Administration	PI Responsibilities

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM POLICY AND PROCEDURE

5.2 RESEARCH EDUCATION AND TRAINING

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The University of Texas Southwestern Medical Center recognizes the importance of promoting the highest ethical standards in the conduct of research. As such, University of Texas Southwestern Medical Center has a comprehensive educational program that ensures that individuals involved in the conduct or oversight of exempt and/or non-exempt human subjects' research understand the ethical principles and regulatory requirements related to the protection of human subjects. With the exception of the Institutional Official, this education must be refreshed every three years to ensure the most up-to-date knowledge. HIPAA in Research training is completed one time.
- B. All investigators and research staff engaged in exempt and non-exempt human research under the UT Southwestern FWA must complete appropriate education in research ethics, human research protections and regulatory policy prior to final IRB approval to conduct the research.
- C. All IRB members and chairs must complete appropriate education in research ethics, human research protections, IRB responsibilities and regulatory policy within three months of appointment to the board or appointment as IRB Chair or Vice Chair.
- D. All Human Research Protection Program Office (HRPPO) staff must complete appropriate education in human research protections and regulatory policy within three months of employment in the HRPPO.
- E. The Institutional Official (IO) must complete appropriate education in human research protections and institutional responsibilities under the federalwide assurance within three months of designation as the IO.

II. SCOPE

- A. This policy and procedure applies to the following:
 - 1. UT Southwestern Medical Center investigators and Research staff
 - 2. IRB Members and IRB Chairs
 - 3. Human Research Protection Program Office (HRPPO) staff

4. Institutional Official

III. PROCEDURE FOR POLICY IMPLEMENTATION

A. INVESTIGATOR AND RESEARCH STAFF EDUCATION

1. Training is hosted on the Collaborative Institutional Training Initiative (CITI) website.
2. Investigators and research staff engaged in research must complete the Human Subjects Protection Course and the HIPAA in Research Course. The following modules are required for each course:
 - a. Human Subjects Research (HSR)
 - i. Belmont Report and CITI Course Introduction
 - ii. History and Ethics of Human Subjects Research
 - iii. Basic Institutional Review Board (IRB) Regulations and Review Process
 - iv. Informed Consent
 - v. Social and Behavioral Research (SBR) for Biomedical Researchers
 - vi. Records-Based Research
 - vii. Genetic Research in Human Populations
 - viii. Populations in Research Requiring Additional Considerations and/or Protections
 - ix. Vulnerable Subjects - Research Involving Children
 - x. Vulnerable Subjects - Research Involving Pregnant Women, Fetuses, and Neonates
 - xi. FDA-Regulated Research
 - xii. Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research
 - xiii. Defining Research with Human Subjects
 - xiv. Assessing Risk
 - xv. Privacy and Confidentiality
 - b. HIPAA in Research
 - i. Facing The Privacy Rule Challenges for Clinical Researchers
 - ii. Why The Privacy Rule Is Important to Clinical Researchers
 - iii. How Do Researchers Obtain, Create, Use and/or Disclose PHI?
 - iv. UT Research Authorizations
 - v. IRB Waiver of Authorizations
 - vi. De-identification of PHI
 - vii. Limited Data Set
 - viii. Data Use Agreements and Limited Data Sets
 - ix. Recruitment for Participation in Research Studies
 - x. Use of PHI for Research on Decedents
 - xi. Transition Provisions
 - xii. Research Accounting Statements

3. Investigators and research staff conducting: a) research involving a drug or device or b) Clinical Trials supported by the National Institute of Health (NIH) must complete the GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus) course

- a. The following modules are required for this course:

- i. The CITI Good Clinical Practice Course for Clinical Trials Involving Drugs and Devices
- ii. Overview of New Drug Development
- iii. Overview of ICH GCP
- iv. ICH – Comparison Between ICH GCP E6 and U.S. FDA Regulations
- v. Conducting Investigator-Initiated Studies According to FDA Regulations and GCP
- vi. Investigator Obligations in FDA-Regulated Research
- vii. Managing Investigational Agents According to GCP Requirements
- viii. Overview of U.S. FDA Regulations for Medical Devices
- ix. Informed Consent in Clinical Trials of Drugs, Biologics, and Devices
- x. Detecting and Evaluating Adverse Events
- xi. Reporting Serious Adverse Events
- xii. Monitoring of Clinical Trials by Industry Sponsors
- xiii. Audits and Inspections of Clinical Trials
- xiv. Completing the CITI GCP Course
- xv. Humanitarian Use Devices (HUDs)
- xvi. Phase I Research: Understanding Phase I Research
- xvii. Phase I Research: Protecting Phase I Subjects

4. Renewal of UTSW CITI training is accomplished by completing the applicable refresher courses

5. The Human Research Protections Program (HRPPO) staff screen applications for appropriate training of investigators and research staff engaged in research during initial/ continuation review and during review of amendment/modification requests as appropriate. The staff is able to confirm CITI training by accessing the administrative page of the CITI website.

B. IRB Members and Chairs

1. IRB members and chairs complete the IRB Member CITI training.

- a. The UTSW IRB Member Course is designed to provide the members with information about all types of research. This course includes HSR, GCP, and HIPAA in Research courses as well as the following modules to enhance the IRB Member knowledge of the federal regulations:

- i. Vulnerable Subjects - Research Involving Prisoners
- ii. Avoiding Group Harms - U.S. Research Perspectives
- iii. Avoiding Group Harms - International Research Perspectives
- iv. Research and HIPAA Privacy Protections
- v. International Research - SBE

- vi. Internet-Based Research - SBE
 - vii. Cultural Competence in Research
 - viii. International Studies
 - ix. Are You Thinking About Being in a Research Study?
 - x. I Have Agreed to be an IRB Community Member. Now What?
 - xi. The IRB Member Module - "What Every New IRB Member Needs to Know"
 - xii. Vulnerable Subjects - Research Involving Workers/Employees
 - b. IRB Chairs will complete the following modules:
 - i. Role and Responsibilities of an IRB Chair
 - ii. IRB Chair Meeting Responsibilities
 - iii. The IRB Chair's Role Outside of the IRB Meeting
 - c. The HRPPO staff use the HRPPO database to monitor IRB member training and provide regular reports to the members, chair and HRPP Director of training status and impending expiration dates.
2. Orientation of new IRB Members - following appointment as a member on the IRB and prior to serving as reviewers (primary or secondary), IRB members, ex-officio members, and alternate members receive the following training:
- a. The HRPPO staff provides new members with a general orientation. Following the annual assignment of members, the HRPPO provides an orientation session for all new and current board members.
 - b. A new member unable to attend the general orientation session or added to the board later in the year, may meet with the HRPP Director, Chair or designee to review roles and responsibilities
3. IRB members are provided with continuing education as part of each meeting's standard agenda. The education topic is generally selected to coincide with an issue from one of the studies scheduled for review at the meeting.
- a. Additional educational materials containing ethical and regulatory guidance for the review of protocols involving a specialized area, (i.e., gene therapy or tissue banking) or selected vulnerable subject populations (i.e., prisoners) are provided specifically to primary reviewer or to all members as appropriate.
4. The HRPPO provides funding for the Chairs to attend national continuing education conferences, as budgets permits
- C. The Human Research Protection Program Office (HRPPO) staff
- 1. The HRPPO staff must complete the UTSW IRB Member education (as described above).

2. The HRPPO staff must complete individualized on-the-job training and orientation as determined by their job description. New staff must review all existing HRPPO/IRB policies and procedures.
 3. The HRPPO staff is provided with continuing education during regularly scheduled staff meetings (generally weekly). The education topic is generally selected to coincide with an issue from one of the studies scheduled for review at the meeting or related to a recent issue or problem.
 4. The HRPPO subscribes to IRB related educational materials (i.e., IRB Forum listserv, Quorum listserv, the Human Research Report) which is circulated to the staff.
 5. The HRPPO provides funding for the staff to attend national continuing education conferences, webinars, etc. as budgets permit.
 6. The HRPP Director or designee tracks training status of the staff.
- D. The Institutional Official (IO)
1. *Required* All three training models provided in the Office for Human Research Protection's (OHRP) "[Human Subject Assurance Training](#)"
 - a. HHS Regulations & Institutional Responsibilities
 - b. Investigator Responsibilities & Informed Consent
 - c. Human Research Protections Program
 2. *Optional* Institutional Official Training hosted on the Collaborative Institutional Training Initiative (CITI) website. Modules include:
 - a. Introduction to Being an Institutional Official (IO)
 - b. IO Knowledge Requirements: Human Subject Protections
 - c. Expectations of the IO
 - d. Challenges of Being an IO: Human Subject Protections
- E. Optional Educational Offerings for research community
1. UT Southwestern regularly offers courses to provide supplemental education for research teams. Courses available include (but are not limited to):
 - a. IRB Orientation
 - b. Research Coordinator 101
 - c. Research Coordinator 201
 - d. Topics in Informed Consent
 - e. Demystifying the IRB
 - f. ClinCard Training
 - g. Budget Estimation and Negotiation

- h. Clinical Research Coordinator Forum
- i. Hot Topics (as needed)
- 2. Other educational offerings as available and applicable include (but are not limited to):
 - a. Research Matters
 - i. These educational sessions are designed to allow the research community the opportunity to provide direct feedback to the HRPPO staff, allow for a question-and-answer period, and a formal presentation on topics related to human research protection.
 - ii. The HRPPO schedules these sessions on a regular basis and as needed.
 - b. Annual Research Conference
 - i. This is a one-day conference which is a collaborative effort by the research departments at UTSW, Texas Scottish Rite, Children’s Health, Parkland
 - ii. The theme is variable each year and guest lecturers are invited to present on current topics related to human research
 - c. Webinars
 - i. As applicable webinar topics are available, the HRPPO may fund access to webinars for appropriate audiences (research offices, IRB members, HRPPO staff, researchers, etc.).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
NIH GCP Policy - POLICY ON GOOD CLINICAL PRACTICE TRAINING FOR NIH AWARDEES INVOLVED IN NIH-FUNDED CLINICAL TRIALS; NOT-OD-16-148

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
June 2017	HRPP	Added GCP renewal requirements per NIH
January 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office

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214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

5.3 FINANCIAL CONFLICT OF INTEREST MANAGEMENT

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. As a state agency and university, UT Southwestern has a responsibility to the public to promote an environment that endorses the highest standards of integrity, honesty, and objectivity in its research activities. At the same time, independent relationships with outside entities established by faculty, staff, and students can enhance the institution's research and educational missions, while also presenting opportunities for personal financial gain. Additionally, UT Southwestern has an obligation to commercialize technologies derived from university research for the public good, and these activities frequently result in royalty income for the university inventors.
- B. Faculty and staff engagement in relationships with outside entities is not in principle unacceptable, and commercialization activities can align with the university's missions, but in practice, such interactions must be carefully managed. If the perceived, potential or actual conflicts of interest created by these relationships and activities are not appropriately disclosed, reduced, managed, or eliminated, they will undermine the public's trust in the research and business conducted at UT Southwestern, and they may violate federal or state law and regulations, as well as policies of The University of Texas System (UT System). To meet the challenges presented by these competing values, missions, and obligations, UT Southwestern has developed policies to address financial conflicts of interest in research.
- C. To meet the above stated goals, UT Southwestern has centralized the Conflict of Interest (COI) management program within the Conflict of Interest Office. A standing committee is charged to review the disclosure forms submitted to make recommendations on how to manage, mitigate or eliminate individual conflicts of interest and commitment as they arise. The COI Committee exists to protect the integrity of all faculty and investigators at UT Southwestern, and maintain the public trust. The COI Committee carries out this charge in a manner that is intended to foster, not hinder, research and other entrepreneurial faculty relationships.
- D. UT Southwestern Institutional Review Boards (IRBs) evaluate individual financial Conflict of Interest (see Policy [RES-401 FINANCIAL CONFLICTS OF INTEREST IN RESEARCH: DISCLOSURE, MANAGEMENT, AND REPORTING](#)). Principal Investigators and study team members involved in the conduct or support of human subject research in which UT Southwestern is engaged must disclose related financial conflict of interest as a part of the initial study application, at each continuing review, and update as needed with modifications.
- E. UT Southwestern HRPP also considers Institutional Conflict of Interest (see Policy [ETH-304 INSTITUTIONAL CONFLICTS OF INTEREST](#)). Where institutional conflicts may arise from royalties or intellectual property rights associated with a technology that is the subject of the research or from UT Southwestern financial interests or of its Institutional Officials, UT Southwestern manages these potential institutional conflicts of interest in addition to the management of any related individual conflict of interest on a protocol specific basis.

- F. The final determination regarding the COI management is made by the IRB (UTSW IRB or external IRB) when the study involves human subjects.
- G. Humanitarian Use Device (HUD) protocols do not constitute research and are not covered by this policy. Therefore Financial Interests or COI Management Plans are not required to be considered with initial protocol application or at the time of continuing review. UT Southwestern will address these as part of addressing potential clinical conflicts of interest.

II. SCOPE

This policy applies to all “covered individuals” engaged in the design, conduct, and/or reporting of human subjects research under UT Southwestern’s HRPP ([RES-151: HUMAN RESEARCH PROTECTION PROGRAM](#)). “Covered Individuals” must comply with the UT Southwestern’s Policy [RES-401 FINANCIAL CONFLICTS OF INTEREST IN RESEARCH: DISCLOSURE, MANAGEMENT, AND REPORTING](#); disclosure process and management plans, as applicable; sponsor requirements and federal regulations concerning conflict of interest management.

- A. Covered Individuals for the purposes of this policy include:
 - a. Faculty members;
 - b. Study team members (including students and post-graduate trainees);
 - c. Non-UT Southwestern employees and trainees that participate in human subject research protocols under the authority of UT Southwestern IRBs.
- B. Covered individuals’ disclosures must include family members which are defined as:
 - a. a spouse;
 - b. a dependent child or stepchild;
 - c. any other person financially dependent on the covered individual; and
 - d. any other person with whom the covered individual has joint financial interests, such that an objective third party could reasonably conclude that the covered individual’s decisions or other exercise of institutional responsibilities could be influenced by their effect on the other person’s financial interest.
- C. Any person may meet the above definition and be identified as a covered family member without regard to whether a legal or biological family relationship exists with the covered individual.
- D. Where a non-UT Southwestern employee or trainee is an employee or trainee of an affiliated hospital or research center that has a separate conflict of interest program, the non-UT Southwestern employee or trainee must still file a disclosure and, if applicable, a COI Management plan with the IRB. The HRPPO will coordinate with the COI office and with the respective office at the affiliated hospital or research center when necessary.

III. PROCEDURE FOR POLICY IMPLEMENTATION

- A. Individual Conflict of Interest (COI) Management
 - a. Investigators must self-identify any financial interests for all research personnel on New

Protocol Submissions and at Continuing Review. If there has been any change in the financial interest status relating to the research at the time of Continuing Review, the IRB will review of the financial interest (as described below) as part of its continuing review.

- b. HRPPO staff review the following information in the eIRB and eCOI system to determine whether a Financial Interest related to the research exists and if so, whether the Financial Interest is a Significant Financial Interest (SFI) that has the potential for a COI:
 - i. Name of study sponsor
 - ii. Name of drug/device manufacturers for all products used in the study
 - iii. The disclosed interest
 - iv. Whether the business entity matches with the study sponsor, the drug/device manufacturer on any products used in the study
 - v. The COI disclosure review status or COI management decision
 - vi. Amount of interest as reported in the most recent COI disclosure
- c. If the related Financial Interest is found to be a Significant Financial Interest (as defined by [RES-401 FINANCIAL CONFLICTS OF INTEREST IN RESEARCH: DISCLOSURE, MANAGEMENT, AND REPORTING](#)), the HRPPO staff coordinates with the COI Office staff to ensure that the Financial Interest is considered in light of the protocol and reviewed by the COI Committee to determine how to manage, mitigate or eliminate the potential COI.
 - i. A recommendation is made by the COI Committee as to the appropriate components of a management plan for that particular protocol but the final determination regarding the management plan is made by the IRB when the study involves human subjects.
 - ii. Based on the significance of the conflict and the potential adverse effects on the protection of subjects, COI management plans can include:
 1. Disclosure to research subjects through the consent process;
 2. Modifications in the research plan and data analysis plan;
 3. Changes of personnel or personnel responsibilities, or disqualification of personnel from participation in all or a portion of the research;
 4. Monitoring by independent reviewers;
 5. Divestiture or reduction of financial interests;
 6. Severance of the relationship that create an actual or potential conflict of interest;
 7. Appointment of a non-conflicted Principal Investigator or change of personnel or personnel responsibilities, or disqualification of personnel from participation in all or a portion of the research;
 8. Reduction of some or all financial Interests;

9. Severance of the relationships that create an actual or potential COI; or ;
 10. Disallowing the conduct of research (or a portion of) at UT Southwestern;
- iii. As part of its review process, the Convened IRB (full board) or IRB Designated Reviewer (expedited) will make a determination as to whether the conflict adversely affects the protection of human subjects. Considering the protocol and the approved COI management plan (if applicable), the IRB will determine if subjects are adequately protected
 - iv. The Convened IRB (full board) or IRB Designated Reviewer (expedited) may make any of the following determinations:
 1. Approve the COI management plan as written; or
 2. Request changes in the COI management plan and conditionally approve the plan with those changes; or
 3. Request changes in the COI management plan, and defer review until a revised plan is received; or
 4. An IRB Designated Reviewer may refer the review to the Full Board.
 - v. Review of COI management plans are documented in the IRB minutes for full board review and in the eIRB protocol file for expedited review. If a conflict of interest exists, final IRB approval should not be given until an approved COI management plan that adequately protects the human subjects in the protocol is in place.
- d. If the financial interest is a non-Significant Financial Interest, the HRPPO staff will prepare the information about the Financial Interest related to the research and provide it to the Convened IRB (full board) or IRB Designated Reviewer (expedited) for review and consideration.
 - i. The IRB will consider the following:
 1. Relationship between the study personnel and Sponsor and/or Manufacturer;
 2. Amount of financial interest
 3. Role of conflicted study personnel on the study;
 4. Design of the study; and
 5. Whether the risk/benefit to the research subjects are impacted.
 - ii. The Convened IRB (full board) or IRB Designated Reviewer (expedited) will review the protocol and the information described above to determine whether additional actions to protect human subjects are required. Examples of additional actions include (but are not limited to):

1. Disclosure to subjects through the consent process
 2. Modifications in the research plan and data analysis plan
- e. Final approval of an initial or continuing review submission will not be granted until:
- i. the Principal Investigator and study personnel have completed their annual COI disclosure to the COI office, and
 - ii. the IRB has verified there are no Financial Interests that could affect the protocol, or
 - iii. any Financial Interests that could affect the protocol have had a COI management plan approved by the IRB.
- f. A copy of the final, approved COI management plan is stored within the eCOI system that is integrated with the eIRB system and accessible to the HRPP Office, as well as to the COI Office.
- g. If the COI status of an investigator or study personnel changes during the course of a study, the individual is required to notify the HRPP Office and the COI Office within 30 days of the change. If the COI now represents a significant financial interest, the Convened IRB (full board) or IRB Designated Reviewer (expedited) will review the change as a modification to the protocol.

B. Institutional Conflict of Interest Management

- a. An institutional conflict of interest (“ICOI”) may exist when the financial interests of UT Southwestern or of an institution official, acting within his or her official capacity on behalf of the institution, may compromise or bias, or appear to compromise or bias, the research, education, clinical care, business transactions, investments, or other activities of the institution
- b. An institutional financial conflict of interests exists when any of the following might affect the design, conduct, and/or reporting of research:
 - i. Licensing activities
 - ii. Gifts to UT Southwestern
 - iii. Equity interests
 - iv. Financial interests of senior administrative officials
 - v. Other financial interests
- c. UT Southwestern has integrated the institutional conflict of interest management program with its existing COI program as described herein.
- d. HRPPO staff must review information in the eIRB system to determine whether a financial Conflict of Interest exists and if so, whether UT Southwestern Medical Center has an interest in the product(s) being used/developed in the protocol.
- e. If an institutional Conflict of Interest is identified, HRPPO staff must coordinate with the

COI Office staff to ensure that the financial COI is considered.

- f. The Institutional Official (IO) shall makes the final determination as to whether a UT Southwestern IRB may review the protocol or whether the review should take place at an external IRB.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
RES-401 – FINANCIAL CONFLICTS OF INTEREST IN RESEARCH: DISCLOSURE, MANAGEMENT, AND REPORTING
ETH-304 – INSTITUTIONAL CONFLICTS OF INTEREST POLICY
EMP-158 – OUTSIDE ACTIVITIES (INCLUDING OUTSIDE EMPLOYMENT OR BOARD SERVICE) POLICY
ETH-104 – CONFLICTS OF INTEREST, CONFLICTS OF COMMITMENT, AND OUTSIDE ACTIVITIES

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

6.1 APPOINTMENT AND EVALUATION OF IRB MEMBERS AND CHAIRS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: MAY 30, 2019

I. POLICY STATEMENT

- A. This policy describes the regulations and requirements for establishing, maintaining and utilizing IRBs at UT Southwestern. The UT Southwestern Medical Center has assured the Department of Health and Human Services (DHHS) of compliance with DHHS regulations (45 CFR 46.103) for the protection of human subjects, through an Office of Human Research Protection (OHRP) approved Federalwide Assurance (FWA00005087). The FWA covers the UT Southwestern Medical Center, inclusive of the Graduate School of Biomedical Sciences, Medical School, School of Allied Health Sciences, UT Southwestern Moncrief Cancer Center, Zale Lipshy University Hospital, and William P. Clements Jr. University Hospital, centers and organized research units.
- B. Each IRB individually shall meet the following membership requirements:
1. A minimum of five members.
 2. At least one member whose primary concerns are in scientific areas.
 3. At least one member whose primary concerns are in nonscientific areas.
 4. The IRB may not consist entirely of members of one profession.
 5. Every effort will be made to ensure that each IRB does not consist entirely of men or entirely of women.
 6. Each IRB shall include one or more individuals who are knowledgeable about and experienced in working with vulnerable human subject population (such as children, prisoners, pregnant women, or physically or mentally disabled persons) in which research is regularly reviewed.
 - a. Each IRB shall have at least one member not affiliated with the institution and not an immediate member of a family affiliated with the institution (such individuals should be drawn from and represent the community). Individuals with no affiliation to the institution other than by serving on the IRB are considered unaffiliated.
- C. The IRB Chairs, members (primary, alternate, and ex-officio) and the Human Research Protection Program Director (HRPPD) and staff must be familiar with the ethical principles guiding human research; the requirements of federal regulations, applicable state law, the institution's FWA; and, institutional policies and procedures established for the protection of human subjects. The IRB as a whole must also have effective knowledge of subject populations and other factors which can potentially contribute to a determination of risks and benefits to subjects and which can impact participants' informed consent.

-
- D. Evaluation of IRB Chairs and members (primary, alternate and ex-officio), membership and composition of the IRB are evaluated at least annually.

II. SCOPE

- A. This policy and procedures applies to IRB members (primary, alternate and ex-officio), IRB Chairs and vice-Chairs.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. Appointment Procedures/Terms of Membership

1. IRB Chairs, Vice Chairs, members, and alternates are responsible for providing the HRPP Office their curriculum vitae to document each member's expertise, degrees, and/or license number. The HRPP Office maintains a copy of the curriculum vitae for each member during their term on the IRB and periodically requests updates, as appropriate.
2. Alternate IRB members replace regular IRB members who are unable to attend convened meetings of the IRB. Alternate members have qualifications comparable to the applicable regular member and may be alternates for more than one IRB member. The Human Research Protection Programs Director (HRPPD) or designee maintains lists of alternate members on the official membership list approved by the Office for Human Research Protections (OHRP). The membership list specifies which members the alternate is qualified to replace. The duties are the same as those of regular IRB members.
3. Alternates attending a meeting or conducting a protocol review have all the authority of regular IRB members and receive the same training and protocol review application materials as the regular members. If the regular member and his/her alternate attend the same convened meeting, only one individual may vote depending upon roles.
4. Institutional liaisons may attend IRB meetings to ensure coordination among other research administrative units. Examples include but are not limited to: Radiation Safety Officer, Legal Counsel, and Institutional Biosafety Officer.
5. Affiliate Institutions are represented with assigned voting/alternate voting members. Examples include but are not limited to: Parkland, Children's Health, and Texas Scottish Rite.
6. The HRPPO staff recruit ad hoc and cultural consultants with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available among the IRB membership. These ad hoc and cultural consultants do not vote with the IRB and do not count toward a quorum at a convened meeting. Ad hoc or cultural consultants may provide comments or recommendations in writing to the IRB prior to the meeting or attend the convened meeting to participate in the review. The procedures for contacting consultants are described in [2.1. INITIAL REVIEW OF RESEARCH](#).

- B. When the IRB reviews research that involves prisoners, both of the following must be true:

1. A majority of the IRB (exclusive of the prisoner representative) must have no association with the prison involved, apart from their relationship on the IRB.
2. At least one voting member at the IRB meeting must be a prisoner or a prisoner representative with appropriate background and experience to serve in that capacity.

C. Filling Appointments

1. The IRB Chairs, HRPPD, or delegate solicit recommendations from a variety of sources and recruits potential members.
 - a. Potential members who are faculty at UT Southwestern Medical Center should also provide a written letter of support for appointment to the IRB from their respective Department Chair.
 - b. The HRPPD makes recommendations for appointments to the Boards. Prior to making the recommendation, the HRPPD ensures no individual from a developmental or business office is appointed as an IRB member. The HRPPO staff send a copy of the recommendations and letters of support (if applicable) to the Institutional Official for appointment of new members. The Institutional Official has been delegated the authority from the President of the University to appoint individual members and chairs to the IRBs. The President has the ultimate authority to appoint the Institutional Official and the IRB committee as one of the President's Institutional Standing Committees (see RES-151 Human Research Protection Program).
 - c. A letter from the Institutional Official to the Chair(s) or member(s) confirming appointments to the Board signifies such appointment.
 - d. IRB Chairs are appointed in the same way; however, they should have an Associate Professor title.
 - e. All IRB Chair and member appointments are for a period of 3 years and may be renewed indefinitely.
 - f. New members to the IRB shall receive orientation from the IRB Chairs, HRPPD, or designee. Members must complete required training as outlined in applicable IRB education policies. Members will also receive continuing education on current topics of human research as outlined in applicable IRB education policies. Members are educated on topics, such as ethics, applicable regulations, policies, etc. Each member shall receive continuing education information as part of the monthly IRB packets. Pertinent issues are discussed at meetings and documented in the minutes as appropriate.

D. OHRP IRB Registration/IRB Membership Roster

1. The HRPPD, HRPPAD, or his/her designee completes the Office for Human Research Protections (OHRP) IRB registration forms and updates the registration in a timely manner when membership changes are made. The OHRP registration form serves as the official IRB roster and denotes in which scientific capacity each member serves.

2. The HRPPD, HRPPAD, or his/her designee maintains membership records. HRPPO staff use the IRB Membership Roster to determine who may attend IRB meetings and count toward the quorum. It includes a list of regular members, their designated alternates and indicates the scientific status and issue specific knowledge of all members.
 3. To meet OHRP registration requirements and in order to hold convened meetings, the scientist and nonscientist member designations are as follows:
 - a. Nonscientific: The intent of the requirement for diversity of disciplines is to include members whose main concerns are not in scientific areas. Therefore, nonscientific members are individuals whose:
 - i. education, work, or interests are not solely in medical, behavioral or social science areas.
 - ii. little or no scientific or medical training or experience.
 - iii. individuals with advanced or professional training in both scientific and non-scientific areas should not be classified as non-scientists.
 - b. Scientific: members whose primary interests are scientific. These individuals generally have substantial scientific or medical training. For example:
 - i. academic degrees in science-related fields;
 - ii. Medically-related practice degrees (e.g. nursing, pharmacy, physicians assistants, etc.); or
 - iii. Other roles/positions actively engaged in medically-related research in the physical, educational, social, behavioral or biological sciences and disciplines and/or hold regular faculty appointments.
 4. After appointments and changes, IRB Membership is reported in accordance with the [8.2 REPORTING POLICY AND PROCEDURE](#).
- E. Removal of IRB Members
1. Members may be disqualified from the IRB for scientific misconduct, unethical behavior, conflict of interest, or non-compliance with the rules governing the IRB or failure to actively participate.
 2. Such concerns are forwarded to the Institutional Official (IO) for review and action, as appropriate.
- F. Evaluation of IRB Membership
1. IRB members
 - a. The HRPPD and the IRB Chairs are responsible for evaluating the IRB members on at least an annual basis.
 - b. Annual assessment of IRB members

- i. IRB Member self-evaluations are sent to IRB members annually. The HRPPD and Chairs discuss the results of the self-evaluations annually.
 - ii. The HRPPD and Chairs meet annually to discuss IRB members' understanding of the HRPP (ethical principles, policies and procedures, and regulations) and to ensure that their service on the IRB will continue to contribute to the ethical and regulatory review of research. Information about an individual member's performance (including attendance and quality of reviews) obtained during the ongoing review process listed below is also used in making decisions about continued service on the IRB.
 - iii. Results of the annual evaluation process will be provided to members at a convened IRB meeting at the end of the fiscal year (generally August). Based on the information obtained from the self-evaluation and the annual evaluation process, individual members or IRBs may be provided additional guidance or further education.
- c. The report of the annual evaluations will be shared with the IO at the end of each fiscal year. On-going assessment and evaluation of IRB members
- i. The HRPPD and Chairs meet on a regular basis. As part of the agenda, the Director and Chairs evaluate previous board meeting(s). As appropriate, issues related to a specific member's performance as a primary or secondary reviewer or other roles are discussed.
 - ii. In addition, the performance of all members during the meeting that were notable (i.e., problematic or done well) are discussed.
 - iii. The goal of this ongoing evaluation process is to promptly identify areas for improvement of individual board members. Areas of evaluation include:
 - 1. The quality of the member's pre-review and/or review for the convened meeting in identifying substantive scientific and ethical issues,
 - 2. Meeting attendance,
 - 3. Being adequately prepared for the meeting,
 - 4. Knowledge of regulatory criteria for approval,
 - 5. Knowledge of other clinical, ethical and institutional issues,
 - 6. Contributions to the board (i.e. number reviews conducted, subcommittee attendance).
 - iv. As needed, the Director and Chairs develop an informal plan to address areas for improvement (e.g., provide additional education, meet with the board member to discuss specific issues, provide feedback to board members as appropriate, etc.).
 - v. If the informal improvement plan does not result in improved performance for the members identified during this process the HRPPD may take other actions

(e.g., not reappointing the member at the next scheduled period, dismissing the member from the board).

2. Evaluation of IRB Chairs

a. Annual Evaluation

- i. IRB Member and Chair self-evaluations are sent to IRB Members and Chairs annually. The HRPPD and IO discuss the results of the self-evaluations annually.
- ii. Current Chairs are evaluated by the HRPPD and Institutional Official annually to ensure that their service as Chair will continue to contribute to the ethical and regulatory review of research. Information about a chair's performance obtained during the ongoing review process listed below is also used in making decisions about continued service on the IRB.
- iii. Results of the annual evaluation process will be provided to Chairs at an IRB Chair meeting near the end of the fiscal year (generally August). Based on the information obtained from the self-evaluation and the annual evaluation process, individual Chairs may be provided additional guidance or further education.
- iv. The report of the annual evaluations will be shared with the IO at the end of each fiscal year.

b. On-going assessment and evaluation of IRB Chairs

- i. The HRPPD and Institutional Official (IO) meet on a regular basis. As part of the agenda, the Director and IO discuss previous board meetings. As appropriate, issues related to a specific Chair's performance (e.g., notable issues with regulatory knowledge, meeting management, resolution of problems, consensus building, or other issues related to the Chair's responsibilities are discussed.
- ii. The goal of this ongoing evaluation process is to promptly identify areas for improvement of an individual Chair.
- iii. As needed, the Director and Institutional Official develop an informal plan to address areas for improvement (e.g., provide additional education, meet with the chair to discuss specific issues, provide feedback as appropriate, etc.).
- iv. If the informal improvement plan does not result in improved performance by the chair identified during this process, the IO may take other actions (e.g., not reappointing the chair at the next scheduled period, dismissing the chair from the board IRB).

G. Annual assessment of Membership

1. The HRPPD and Chairs collaborate to adjust the IRB membership to ensure ethical and regulatory review of research and appropriate representation at convened meetings.

2. University committee assignment of members generally occurs at the beginning of the fiscal year. Several months prior to this date, the university solicits faculty and staff to volunteer for service on each of the committees, including the IRB.
3. As part of this process, the HRPPD completes a comprehensive evaluation of the IRB membership and individual evaluations of each Board member including the chairs.
4. For the comprehensive evaluation the Director determines whether the membership, collectively has the appropriate:
 - i. Knowledge of applicable regulatory and legal requirements;
 - ii. Knowledge of professional standards and practices;
 - iii. Knowledge of the local research context and research sites and their capabilities;
 - iv. Knowledge of community standards and attitudes;
 - v. Scientific, scholarly, clinical, and professional expertise;
 - vi. Racial, ethnic, and cultural diversity; and
 - vii. Representation of participants' perspectives.
5. Based on these assessments and taking into consideration the nature and volume of research reviewed, the composition and membership of each IRB is adjusted by the HRPP Director, assisted by the IRB Chairs.
6. Each prospective IRB member's qualifications are reviewed during the recruitment process by a working group led by the HRPPD. Prospective members are recommended for appointment to fulfill the needs of the IRB identified during the comprehensive evaluation of the membership.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
May 2019	HRPP	Updated IRB Member and Chair Feedback process
July 2018	HRPP	Update Member appointment process
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office

HRPP@UTSouthwestern.edu

214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

6.2 IRB APPROVAL OF RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. This policy and procedure sets forth the human research approval criteria for the IRB and the procedures for the approval of research process.
- B. Review of research includes consideration of specific determinations required for approval (approval criteria) as defined in applicable federal, state and local regulations and further explained below.
- C. All UTSW IRBs may review any IRB related issues: new studies (initial review), re-approve active studies (continuation review), requests to modify previously approved research, reports of unanticipated problems involving risks to subjects or others, complaints that may indicate that a research subject's rights, safety or welfare may have been or were adversely affected, reports of possible serious or continuing noncompliance, or other issues).
- D. Approval criteria are used during initial and continuing review and as appropriate during review of modifications to previously approved research. In order to approve research, the IRB (the Full Board or Expedited Reviewer) shall determine that all required determinations of approval (45 CFR 46.111) are satisfied.
- E. The appropriate Full Board or Expedited Reviewer must consider deferral, disapproval (full board only), suspension (in part or in toto) or termination of research. These actions are considered (as appropriate) during initial and continuing review and during review of modifications to previously approved research (if necessary on an urgent basis) where evaluation of the above criteria results in unresolved controverted issues considered substantive for example but not limited to:
 1. Research not being conducted in accordance with the IRBs requirements.
 2. Research that has been associated with unexpected serious harm to participants.
- F. When study approval is suspended or terminated, the IRB or the person ordering the suspension will:
 1. Consider actions to protect the rights and welfare of currently enrolled participants.

2. Consider whether procedures for withdrawal of enrolled participants take into account their rights and welfare (e.g., making arrangements for medical care off a research study, transfer to another investigator, and continuation in the research under independent monitoring).
 3. Consider requiring the investigator to inform current participants of the termination or suspension.
 4. Consider requiring the investigator to report any adverse events or outcomes to the IRB.
- G. If IRB approval of a specific study expires, the IRB must decide whether investigators must stop all research activities involving human subjects or whether it is in the best interests of already enrolled subjects to continue to participate in the research. The IRB will consider the best interests of subjects either individually or as a group. If the IRB determines that it is not in the best interests of already enrolled subjects to continue to participate, investigators must stop all human subjects research activities related to that study, including intervening or interacting with subjects, or obtaining or analyzing identifiable private health information about human subjects.

II. SCOPE

- A. This policy and procedure applies to the IRB, which will review all non-exempt human research activities and determine the appropriate action. The review of human research activities will occur only in the context of a duly constituted and operating convened IRB or under expedited procedure in the name of a duly constituted and operating IRB consistent with the applicable requirements of HRPP Policies and Procedures ([2.1. INITIAL REVIEW OF RESEARCH](#), [2.2. CONTINUING REVIEW OF RESEARCH](#) and [2.3 MODIFICATIONS TO RESEARCH](#)). For the purpose of this policy, both the convened board and the expedited review procedure will be referred to as the “IRB”.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Procedures for review are incorporated into [2.1. INITIAL REVIEW OF RESEARCH](#), [2.2. CONTINUING REVIEW OF RESEARCH](#) and [2.3 MODIFICATIONS TO RESEARCH](#).
- B. Criteria for approval
1. Criteria 1: Risks to subjects, that may result from the research, are minimized
 - a. Initial Review The IRB uses component analysis to evaluate each new submission for risks and determines whether the probability or magnitude of each risk is the least possible for addressing the research aims and do not unnecessarily expose participants to risk by considering multiple factors, including for example:
 - 1) Whether the risks listed in the submission adequately reflect the complete list of the risks that are reasonably expected to result from the research.

- 2) Whether the study design is scientifically sound and likely to answer the research questions (purpose of the research).
- 3) Whether an alternative research design would reduce the likelihood/magnitude of harm while still achieving the purpose of the study.
- 4) Whether the rationale and details of research procedures are adequately described and acceptable.
- 5) Whether there is a clear differentiation between research-only procedures and standard of care / standard evaluation.
- 6) Whether fewer procedures would reduce the likelihood/magnitude of harm while still achieving the purpose of the study.
- 7) If the research procedures include those which may be performed for diagnostic or treatment (non-research) purposes, the IRB evaluates whether risks exist whose probability or magnitude can be reduced by using the non-research procedures rather than requiring the subjects to undergo the same procedures for both research and clinical purposes.
- 8) Whether adequate preliminary data exists to justify the research.
- 9) Whether sufficient justification exists for the research.
- 10) Whether the rationale for the proposed study population is reasonable, and whether an alternative population would reduce the likelihood/magnitude of harm while still addressing the purpose of the study.
- 11) Whether fewer participants could answer the scientific question(s).
- 12) Whether plans for data analysis are defined and justified.
- 13) Whether members of the research team are qualified to perform the research procedures.
- 14) Whether adequate staff, facilities or other provisions are available to protect the rights and welfare of research subject and to deal with possible harmful sequelae. For example: If the investigator is not a clinician, when appropriate, the protocol must have provisions for enlisting the services of a clinician with appropriate expertise and privileges to perform duties that may include, but not be limited to:
 - i. Reviewing the data, adverse events, and new study findings; and
 - ii. Making required decisions to protect the health of the subject (e.g., stopping the participant's involvement in the study or determining when to notify the subject or the subject's health care provider of information that may affect the health of the subject)
- 15) Whether criteria for enrollment and withdrawal are appropriate in relation to the anticipated risks.

b. Continuing Review -The IRB reviews each request for re-approval (progress report) to identify information related to new risks or changes to previously identified risks. The IRB determines whether the probability or magnitude of each risk continues to be the least possible for addressing the research aims and does not unnecessarily expose participants to risk by considering multiple factors, including for example:

- 1) Detailed description of the reasons for withdrawal of subjects from the study since the last IRB review.
- 2) Previously reported and new (unreported) unanticipated problems involving risks to subjects or others (UPIRSOs).
- 3) Information from an independent safety monitoring entity (e.g., medical monitor, Data Safety Monitoring Board, etc.) (if applicable).
- 4) Information from the multi-center sponsor (if applicable).
- 5) Information from the literature or other sources.
- 6) Information contained in the summary of the progress of the study in the local progress report that may address risks or problems.

c. Review of proposed modifications - The IRB evaluates whether a proposed modification includes new risks or changes to existing risks and determines whether the probability or magnitude of each risk is the least possible for addressing the research aims. Additionally, the modification shall not unnecessarily expose participants to risk by considering the factors used during Initial Review to determine that risks are minimized. In this case, the factors listed for Initial Review are used only as applicable to the changes contained in the modification.

d. In addition, the IRB may include other aspects of the research that may minimize risks and don't fit into the criteria listed above.

2. Criteria 2: Risk Level

a. The IRB evaluates all sources of risk that may result from the research and determines the appropriate risk level for the study as a whole. Depending on the research activity under review, the overall risk level may change over the course of time a study is conducted (further discussed in the Initial Review of Research Policy and Procedure). The overall risk level must be one of the following levels:

- 1) minimal risk
- 2) more than minimal risk or;
- 3) minor increase over minimal risk (only when considering children in research)

3. Criteria 3: The risks to subjects that may result from the research are reasonable in relation to anticipated benefits to subjects (if any) and the importance of the knowledge that may reasonably be expected to result.
 - a. Initial Review
 - 2) The IRB uses component analysis to evaluate each submission for benefits and determines whether the probability and magnitude of each benefit is the greatest possible, given the research aims (maximizes benefits).
 - 3) Components are divided into either:
 - i. those that offer the prospect of direct benefit to research participants, or
 - ii. those designed solely to answer the research question(s).
 - 4) The IRB confirms that each of the components that do not offer a direct benefit contributes to answering the research question(s). For each of these components, the IRB determines whether the risks are justified only by the potential benefit associated with the knowledge to be gained.
 - 5) The IRB determines whether the direct benefits listed in the submission accurately reflect the complete list of anticipated benefits to the subject from the research, or by a monitoring procedure that is likely to contribute to the subject's well-being. For each of the components that do offer the prospect of direct benefit where that benefit does not justify the risk, the IRB determines whether the risks are justified by the potential benefit associated with the knowledge to be gained, and whether the components meet the criteria for research equipoise (general uncertainty whether the study procedures or accepted practice is preferred).
 - b. Continuing Review - The IRB evaluates each request for re-approval (continuing review) for changes in the study components, risks or benefits and determines whether the changes affect the component analysis.
 - c. Review of proposed modifications - The IRB uses component analysis in the same general manner as during initial review. In this case, the factors listed for initial review are used only as applicable to the changes contained in the modification.
4. Criteria 4: The selection of participants is equitable.
 - a. Initial Review - The IRB evaluates the following to determine whether selection criteria are equitable and recruitment practices promote voluntariness:
 - 1) The purposes of the research and setting in which the research will be conducted
 - 2) That the study objectives, not the vulnerabilities or privileges of participants, guide inclusion criteria and choice of targeted populations.

- 3) That the inclusion/exclusion criteria impose fair and equitable burdens and benefits.
- 4) Limited English Proficiency (LEP).
 - i. In accord with the Belmont Report the UTSW IRB will consider if an injustice would occur when some benefit to which a person is entitled would be denied without good reason or when some burden would be imposed unduly.
 - ii. Based on federal policies and ethical considerations, the IRB should not routinely allow investigators to exclude LEP persons from research studies without acceptable justification.
 - iii. Investigators are justified in excluding LEP persons only if there is:
 - a) A sound scientific reason for excluding LEP persons,
 - b) A sound ethical reason for excluding LEP persons, or
 - c) If there are insufficient resources to include LEP persons and the proportion of LEP subjects is very low.
 - d) For example the IRB may decide to allow exclusion of LEP persons if the benefit exists outside the study (e.g., standard care is considered effective not generally declined due to toxicity and excluding LEP persons would not result in irreversible health problems or extreme suffering. Should excluding LEP persons have the potential for irreversible health problems or extreme suffering strong justification would be required to consider this to be a valid argument.)
- 6) Whether prospective participants may be vulnerable to coercion or undue influence (e.g., lack mental capacity or voluntariness) and, if so, a description of appropriate additional safeguards is included
- 7) Whether additional actions, limitations or safeguards are appropriate to protect the safety and welfare of the subjects
- 8) That participant recruitment and enrollment procedures and materials are fair and equitable
- 9) Payments made to subjects (both the amount and schedule) should be structured to reduce any possible undue influence. The IRB will take into consideration the following when determining acceptable compensation:
 - i. the schedule of payment;
 - ii. the number of hours or visits completed;
 - iii. the number of procedures completed;

- iv. the amount of discomfort, inconvenience and/or expenses to the subject that is anticipated as appropriate;
 - v. whether or not a bonus payment is offered for completing all procedures.
 - vi. The IRB may not allow compensation for participation in a trial offered by a sponsor to include a coupon good for a discount on the purchase price of the product once it has been approved for marketing.
 - b. Continuing Review - New information provided in the progress report is reviewed to determine whether the selection of subjects continues to be equitable, including for example:
 - 1) Any new information related to the actual subject recruitment information and total number of subjects enrolled by ethnicity/race that indicates an issue with equitable selection of subjects
 - 2) Any new information related to issues of coercion or undue influence
 - 3) Any new information relevant to protecting vulnerable populations (e.g., children, prisoners, pregnant women/fetuses, etc.)
 - c. Review of Proposed Modifications - The IRB evaluates whether a proposed modification includes changes that affect the equitable selection of subjects or vulnerable populations by considering the factors used during initial review. In this case, the factors are used only as applicable to the changes contained in the modification.
- 5. Criteria 5: Informed consent will be sought from each prospective subject or legally authorized representative (LAR).
 - a. Initial Review and Review of Proposed Modifications
 - 1) The IRB evaluates whether the study plan meets the requirements for full informed consent and represents legally effective informed consent of the subject or the subject's legally authorized representative, unless:
 - i. the IRB finds and documents that informed consent can be waived (45 CFR 46.116(c) or (d)); or
 - ii. the IRB finds and documents that the research meets the requirements of the HHS Secretarial waiver under 45 CFR 46.101(i) that permits a waiver of the general requirements for obtaining informed consent in a limited class of research in emergency settings. When informed consent is required, it must be sought prospectively.
 - 2) The IRB evaluates whether the plan for obtaining consent could be improved to better ensure participant understanding and voluntary decision-making.

- 3) The consent process must be presented in a manner that enables a person to voluntarily decide whether or not to participate as a research subject.
 - 4) The circumstances surrounding consent must provide sufficient opportunity for the subject or LAR to consider whether or not to participate.
 - 5) The circumstances surrounding consent must minimize the possibility of coercion or undue influence.
 - 6) Persons who conduct the consent interview, and/or obtain consent are acceptable, given the nature of the study.
 - 7) The information given to the subject/representative must be in language understandable to the subject/representative (may also be reviewed as part of Criteria 6 – consent documentation).
 - 8) The consent does not contain exculpatory language through which the subject or the representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution or its agents from liability for negligence. If the study sponsor has provisions for injury compensation, the consent information provides this information (may also be reviewed as part of Criteria 6 – consent documentation).
 - 9) Unless deemed not appropriate or waived/altered by the IRB, informed consent will provide the information described in the basic elements of informed consent (45CFR46.116(a) & (b)) (may also be reviewed as part of Criteria 6 – consent documentation).
 - 10) The assent of children, incompetent persons or those determined to have impaired decision-making capacity must be appropriate
- b. Continuing Review - The IRB evaluates whether informed consent continues to meet the requirements for full informed consent and represents legally effective informed consent by determining the circumstances that might require repeating or supplementing the informed consent process. (For example, if the protocol design or risks have changed, or if a substantial period of time has elapsed between the time consent was obtained and the study began)
6. Criteria 6: Informed consent will be appropriately documented.
- a. Initial Review and Review of Proposed Modifications (as appropriate) - The IRB reviews the written consent form(s) to be used to document informed consent (unless consent was waived). The form(s) are intended to provide a written representation of the information used in the informed consent process and are later available for the subjects' future reference.
 - 1) Except as provided in the section on waiver of a signed consent form of this section, the consent form must be one of the following:

- i. A written consent document that embodies the elements of informed consent required by the IRB under Criteria 5; Informed Consent (above) is the preferred method of documenting consent.
 - ii. IRB review of research includes the consent process to ensure that the person obtaining consent gives either the subject or the representative adequate opportunity to read it before it is signed, regardless of whether it had already been read to the subject.
 - iii. While not the preferred method of documenting consent, a short form written consent process may be used to document consent as described in the [3.4 INFORMED CONSENT OF SUBJECTS WITH LIMITED ENGLISH PROFICIENCY](#).
 - 2) Where waiver of the requirement to obtain a signed consent form is requested, the IRB must determine the following in order to approve the request:
 - i. The IRB agrees that:
 - a) For non-FDA regulated studies, the only record linking the subject and the research and the principal risk would be the potential harm resulting from a breach of confidentiality (the PI must include provision for asking each subject whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern), or
 - b) The research procedure(s) for which the waiver is being requested presents no more than minimal risk and involves no procedures for which written consent is normally required outside the research context.
 - ii. The IRB determines whether the waiver of consent documentation applies to some or all subjects.
 - iii. The IRB determines whether the investigator must provide subjects with a written statement regarding the research.
- b. Continuing Review - New information is reviewed to determine if the study continues to meet this requirement, for example:
 - 1) New information in the progress report related to whether the consent document remains accurate, complete and up-to-date.
 - 2) New information in the progress report related to whether the consent document attached to the progress report is the current approved consent.
 - 3) Significant new findings in the progress report related to the subject's willingness to participate are added to the consent document process.

- 4) New information in the progress report related to any identified problems related to consent are adequately resolved.
- 5) New information in the progress report related to the consent process in general.
7. Criteria 7: The research plan makes adequate provisions for monitoring the data collected to ensure the safety of subjects.
 - a. Initial Review and Review of Proposed Modifications (as appropriate)
 - 1) The IRB determines whether Data and Safety Monitoring is required because:
 - i. The study is more than minimal risk or;
 - ii. Data and Safety Monitoring is required by NIH or FDA or;
 - iii. The IRB/IRB Expedited Reviewer decides that a plan to monitor collected data is required to ensure the safety of subjects.
 - 2) The IRB determines whether the local plan for collecting, monitoring, analyzing and reporting safety data is acceptable, given the nature of the study and the anticipated risks of the research.
 - 3) The IRB determines whether the local plan for reviewing the data to ensure accuracy is acceptable, given the nature of the study.
 - b. Continuing Review - The IRB reviews new information to determine if the study continues to meet this requirement, for example:
 - 1) Any new information that indicates the need to revise the local plan for continuously collecting and monitoring the safety data of subjects
 - 2) Any new information that indicates the need to revise the DSMP to reflect the required prompt reporting of UPIRSOs
 - 3) When a history of not following prompt reporting procedures is noted, any new information concerning why prompt reporting procedures were not followed
8. Criteria 8: There are adequate provisions to protect privacy and maintain confidentiality of data (if required).
 - a. Initial Review and Review of Proposed Modifications (as appropriate)
 - 1) Privacy
 - i. The recruitment plan and consent process address protections of the privacy of the individual.
 - ii. The IRB reviews plans to ensure subjects privacy rights are protected during visits and procedures.

- iii. Examples for both considerations above include: self-determination of access to their person, whether they will be seen in a setting in which they will not be overheard particularly if the visit involves sensitive discussions and whether the subject will be comfortable in the setting in which the procedures are taking place.
- 2) Confidentiality
 - i. The study procedures minimize the possibility of a breach of confidentiality.
 - ii. Whether the research data constitutes a significant risk if placed in the medical record.
- b. Continuing Review, new information is reviewed to determine if the study meets this requirement, for example, any new information that indicates the need to revise the plan to protect privacy and assure confidentiality
- 9. Criteria 9: Other criteria as determined by the IRB
 - a. The IRB shall ensure additional appropriate protections are in place for subjects determined to be vulnerable as applicable (see [2.6 RESEARCH INVOLVING INDIVIDUALS WITH DIMINISHED AUTONOMOUS DECISION-MAKING CAPACITY](#)).
 - b. During Initial and Continuing Review, or Review of Proposed Modifications, the IRB must determine whether the research should be reviewed by a consultant to supplement the IRB expertise.
- C. After appropriate review, results are reported in accordance with the [8.2 REPORTING POLICY AND PROCEDURE](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

6.3 CONDUCT OF FULL BOARD MEETINGS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. The UTSW IRB conducts convened meetings in accordance with applicable federal requirements for full review. IRBs meet regularly to review and act on initial and continuing review, as well as review of requests for modification of approved research, reports on non-compliance or unanticipated problems for all non-exempt human research. The Human Research Protection Program Director (HRPPD) establishes the schedule for meetings. The HRPPD, Chair, or Institutional Official may direct or convene additional meetings at any time.

II. SCOPE

- A. This policy and procedures applies to all human subject research reviewed by a convened Board.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Meeting Preparation and Materials
 1. Following the completed Human Research Protection Program Office (HRPPO) pre-review (See HRPPO Policy: [1.1. RECEIVING, ROUTING, AND ADMINISTRATIVE REVIEW OF IRB SUBMISSIONS](#)), the HRPPO staff will document unresolved issues and notes to be forwarded to the Primary Reviewers
 2. The HRPPO staff develops, maintains, and revises the IRB meeting schedule, as appropriate. The dates are available on the IRB website or by request.
 3. For each meeting, the HRPPO staff generates the agenda. The HRPPO staff review the agenda for accuracy and completeness before distributing it to the IRB. The agenda serves as a guideline for the conduct of the meeting. The agenda for the meeting may include additional discussion items at the discretion of the IRB Chair, the HRPPO staff, or Institutional Official (IO).
 4. After the agenda has been completed, HRPPO staff notifies the IRB Members and other appropriate individuals scheduled to attend the convened meeting (including alternate members as appropriate) that the materials are available in the electronic IRB system for review. IRB members are assigned studies to review, and in turn receive access to all appropriate study materials, agendas and reviewer assignments with sufficient time for their review at least 5 calendar days prior to scheduled IRB meetings to be prepared to participate in deliberations and voting.
 5. If special circumstances require adding a submission to the agenda, the HRPPO staff prepares a revised agenda, assigns a primary reviewer and distributes it and the applicable application information to IRB members and appropriate individuals prior to

the meeting. In addition, the member assigned as the primary reviewer of the study receives the additional materials.

B. Quorum Requirements

1. Quorum Members are those members that count towards a quorum. Quorum Members are all the IRB voting members. The Chair counts towards a quorum.
2. A quorum is defined as a majority of the quorum members present (attendance by teleconference is acceptable in order to be counted towards a quorum). Examples of how to calculate the majority of the Quorum members is as follows: e.g., If the number of Members that count towards a Quorum (Quorum Members) = 16, a Majority = 9; if Quorum Members = 15, a Majority = 8; if Quorum Members = 14, a Majority = 8)
3. At the convened meeting, at least one member whose primary concerns are in nonscientific areas, and represent the general prospective of the participants must be in attendance.
4. When FDA-regulated research is reviewed, there must be at least one member in attendance who is a licensed physician.
5. When prisoner research is reviewed, there must be at least one prisoner representative in attendance. For DHHS-funded research, the organization certifies to OHRP that the duties of the IRB have been fulfilled as outlined in the [8.2 REPORTING POLICY AND PROCEDURE](#). Additionally, a majority of the Board (exclusive of member(s) representing prisoners) will have no association with any prison(s) involved in the research being reviewed, apart from their membership on the Board.
6. When Research involving individuals vulnerable to coercion or undue influence or sensitive types of research/procedures is reviewed there must be at least one knowledgeable IRB member or consultant attending the IRB Meeting.
7. Alternate members may attend in the place of absent regular members in order to meet the quorum requirements. (See [6.1 APPOINTMENT AND EVALUATION OF IRB MEMBERS AND CHAIRS](#))
8. The IRB does not consider ad hoc and cultural consultants to establish a quorum.
9. At least one un-affiliated member must attend 75% of the scheduled meetings per year. This member need not serve one role on the IRB (i.e., the unaffiliated member may also represent the general perspective of participants). The IRB does not consider this member to establish a quorum.
10. Members must excuse themselves from the meeting prior to discussion and during a vote when they have a conflict of interest (See [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#)). In such cases, they do not count as a part of the members necessary to constitute a vote or majority.
11. If the quorum is lost during a meeting (e.g., loss of a majority through excused members with conflicting interests or early departure or absence of a non-scientist member, members who leave for any reason at any time do not count towards the quorum), the

IRB does not take further protocol actions that require a vote unless the quorum is restored.

C. Meeting Process

1. The IRB Chair, Vice Chair, Director of Human Research Protection Program, HRPP Associate Director or any voting IRB member may chair the convened meeting.
2. For review of research at a convened meeting, the IRB may request that PIs (or another knowledgeable party) attend the convened meeting when deemed appropriate.
3. To the extent possible, the proceedings of the meetings are confidential. Individuals such as prospective board members or representatives from non-UTSW IRBs attend as observers if approved by the HRPPO staff or Chair. The HRPPO staff obtains a statement of confidentiality from observers who have permission to attend and they excuse themselves from meetings prior to discussion and during a vote when they have a conflict of interest concerning any protocol (See [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#)). Observers do not receive a copy of application materials.
4. IRB members, consultants, observers do not participate in the review of any component of a project in which the member has a conflict of interest, except to provide information requested by the IRB. (See [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#))
5. See [2.1. INITIAL REVIEW OF RESEARCH](#), [2.2. CONTINUING REVIEW OF RESEARCH](#), [2.3 MODIFICATIONS TO RESEARCH](#), [9.2 UPIRSO and UADE](#), and [9.3 NONCOMPLIANCE REVIEW](#) for discussion of review outcomes and controverted issues.
6. The HRPPO staff is responsible for preparing meeting minutes. (See [8.1 IRB MINUTES](#))

D. Tele/Videoconference Participation

1. The IRB may conduct convened meetings by telephone or video conferencing as long as IRB members have received a copy of all of the documents under review at the meeting (as described in I.4. above), a quorum as defined above is present, and discussion occurs in real time.
2. Such members count as part of the quorum and may vote. "Telephone polling" (where the HRPPO staff or others contact IRB members individually by telephone) does not qualify as a convened meeting. To allow for appropriate discussion, all members must be connected simultaneously for a teleconference to take place.
3. If the member has a conflict of interest, that member may not be present during the vote or discussion (see [6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST](#)) and prior to the review must have terminated the connection, not just be placed on "hold."

E. Voting

1. IRB members may not vote by proxy (i.e., members not present at the convened meeting or not participating in the tele/videoconference call may not vote on an issue discussed during a convened meeting). However, members can provide written comments for IRB consideration.

2. The voting may include a show of hands or voice count at the discretion of the chair.
3. At the time of voting, the chair asks members to vote separately for each item with the following choices: for, against or abstain.
4. Voters against or abstaining may be offered the opportunity to comment either verbally or in writing and have their comments added to the minutes.
5. Voting at a convened meeting takes place under the following conditions:
 - a. A quorum of the members for a specific IRB must attend (for waivers of authorization under HIPAA an additional quorum requirement includes a non-affiliated member be in attendance) for each review/action voted on at a convened meeting;
 - b. A passing vote must consist of a majority of members in attendance voting in favor of the motion;
 - c. An individual who is not listed on the official IRB roster provided to the Office for Human Research Protections (OHRP) prior to the meeting may not vote with the IRB;
 - d. Ad hoc and cultural consultants may not participate in the vote;
 - e. A non-scientific member must always be in attendance for a vote;
 - f. A licensed physician must be in attendance to vote on FDA-regulated research;
 - g. If the outcome of the IRB vote is to approve pending submission of minor revisions:
 - i. the IRB Chair, HRPP Director or designated Expedited Reviewer may review and approve the PI's response on behalf of the IRB under an expedited review procedure, or
 - ii. the response will be reviewed as specified by the Board during the vote if the Board determines the PI response requires review by a specific member (i.e., primary reviewer or IRB Chair) or by the Board.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM POLICY AND PROCEDURE

6.4 IRB MEMBER AND CONSULTANT CONFLICT OF INTEREST

RESPONSIBLE OFFICE: Human Research Protection Program OFFICE (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. In the environment of research, openness and honesty are indicators of integrity and responsibility, characteristics that promote quality research and can only strengthen the research process. Therefore, conflicts of interest should be eliminated when possible and effectively managed and disclosed when they cannot be eliminated
- B. Individual Conflicts of Interest are declared by all new IRB members on the Member Information Sheet Form and then updated as necessary. Financial Conflicts of Interest are collected annually on all UT Southwestern faculty by the Conflict of Interest Office in compliance with institutional policy. Non-UT Southwestern Board members are required to complete the same declaration with the Conflict of Interest Office. If the Conflict of Interest status of an IRB member changes during the course of a study, the IRB member is required to declare this to the IRB Chair and/or HRPP Director.
- C. No regular or alternate IRB member may participate in review of any research in which the member has a conflict of interest (either financial or non-financial), except to provide information as requested by the IRB Designated Reviewer or IRB Chair. Such review includes review by a convened IRB, review using expedited procedure, initial review, continuation review, review of modifications, review of unanticipated problems involving risk to participants or others, review of noncompliance with the regulations or the requirements of the IRB and any other ad hoc reviews requested by the IRB.
- D. A consultant may not participate in the review or provide information to the IRB for any research project in which the consultant has a conflict of interest (either financial or non-financial). Such review includes review by a convened IRB, review using expedited procedure, initial review, continuation review, review of modifications, review of unanticipated problems involving risk to participants or others, and review of noncompliance with the regulations or the requirements of the IRB and any other ad hoc reviews requested by the IRB.
- E. Due to institutional conflict of interest, no individual from a developmental or business office may be appointed as an IRB member.

II. SCOPE

- A. This policy and procedures applies to all IRB members and consultants to UT Southwestern

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. The HRPPO staff confirms that no conflict of interest exists:
 - 1. When contacting an IRB Member to serve as a reviewer by reviewing eCOI and other materials as well as querying the member at the time of assignment to review (if necessary); and

2. When contacting an individual to serve as a consultant by reviewing eCOI and other materials as well as querying the individual at the time of assignment to review. Once the HRPPO staff has this confirmation, they distribute the confidentiality agreement to the consultant.
- B. It is the responsibility of each voting member or alternate member of the IRB to disclose any conflict of interest when conducting a review and to excuse him or herself from deliberations and voting.
 - C. The procedure for excusing a consultant, or IRB member, including the IRB Chair, from deliberating/voting on all full board review protocols for which there is a conflict of interest is detailed in [6.3 CONDUCT OF FULL BOARD MEETINGS](#). The HRPPO staff document all conflict of interest disclosures in the IRB meeting minutes for those members who are present at meetings. The absent IRB member is not counted toward quorum and his/her absence during the discussion and vote on the protocol will be noted in the IRB meeting minutes.
 - D. Expedited reviewers confirm that a conflict of interest does not exist prior to making any Expedited determinations for initial review, continuing review, modification review, and reportable events.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

7.1 DRUG RESEARCH POLICY AND PROCEDURE

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The IRB reviews projects that involve drugs or biologics (referred to in this policy as drugs) to protect the rights and welfare of human subjects involved in such research/investigations as directed by the Department of Health and Human Services (DHHS) and by the Food and Drug Administration (FDA).
- B. The IRB is responsible for evaluating the use of a drug in research involving human subjects (DHHS) or a clinical investigation (FDA) to determine if prior submission to the FDA is required or if the use of the drug is exempt from such prior submission to the FDA. If prior submission is required, the IRB must determine whether an Investigational New Drug application (IND) has been obtained.
- C. It is the policy of the UT Southwestern that research involving a drug, other than the use of a marketed drug in the course of medical practice, must have an investigational new drug (IND) number provided by the FDA, unless the drug meets the FDA IND Exemption criteria described in the procedure below.
- D. This policy does not apply to Emergency use and use under a Treatment IND as both are covered in the [7.4 EXPANDED ACCESS TREATMENT USE OF AN UNAPPROVED DRUG/BIOLOGIC](#)

II. SCOPE

- B. This policy and procedures applies to all human subjects' research of drugs or biologics that constitute research involving human subjects (DHHS) or clinical investigations (FDA).

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. The IRB evaluates:
 - a. Whether use of the drug is considered research and involves human subjects (DHHS – 45 CFR 46.101), and;
 - b. Whether a drug used is considered an investigational drug and involves human subjects (FDA – 21 CFR 56.102)
- A. If the IRB determines neither A.a nor A.b. above are true, the activity that includes a drug may still be reviewed. In this case, if the activity is not considered to be research (non-research) or research not involving human participants under DHHS rules the activity is reviewed following

guidance in the [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#).

- B. If the activity is considered Exempt research (DHHS) not constituting a clinical investigation (FDA) then it is reviewed following guidance in the [1.3. EXEMPT REVIEW OF RESEARCH](#).
- C. All research (DHHS) involving human participants (whether or not determined not to be a clinical investigation (FDA)) is evaluated following guidance in [2.1. INITIAL REVIEW OF RESEARCH](#).
- D. Clinical investigations are evaluated by the IRB to determine whether:
 - a. Submission to the FDA for an IND is required, and if required has been completed (as indicated by documentation provided by the sponsor) or;
 - b. The use of the drug is exempt from prior submission to the FDA.
- E. IND Exemption Categories. Research which meets one or more of the following exemptions categories does not require prior submission to the FDA for an IND.
 - a. Exemption 1 - The clinical investigation is for a drug product that is lawfully marketed in the United States and all of the following apply:
 - i. The investigation is not intended to be reported to FDA as a well-controlled study in support of a new indication for use nor intended to be used to support any other significant change in the labeling for the drug.
 - ii. If the drug that is undergoing investigation is lawfully marketed as a prescription drug product, the investigation is not intended to support a significant change in the advertising for the product.
 - iii. The investigation does not involve a route of administration or dosage level or use in a patient population or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product.
 - iv. The investigation will be conducted in compliance with 21 CFR 50 and 56.
 - v. The investigation will be conducted in compliance with the requirements of 21 CFR 312.7.
 - b. Exemption 2 - The clinical investigation is for an in vitro diagnostic biological product that involves one or more of the following:
 - i. Blood grouping serum, reagent red blood cells, and/or anti-human globulin; AND
 - ii. The diagnostic test was intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure, AND
 - iii. The diagnostic test will be shipped in compliance with 21 CFR 312.160.
 - c. Exemption 3 – The clinical investigation is for a drug intended solely for tests in vitro or in laboratory research animals if shipped in accordance with 21 CFR 312.160.

- d. Exemption 4 – The clinical investigation involves the use of a placebo and the investigation does not otherwise require submission of an IND
- e. Exemption 5 – Dietary supplements, botanicals, or other substances designated as generally recognized as safe (GRAS) for use in food if study does NOT evaluate product’s ability to diagnose, cure, mitigate, treat or prevent disease (see [FDA guidance](#) for required conditions)
- f. Exemption 6 – Radioactive drug or biological product (see [FDA guidance](#)) if:
 - i. It involves basic research not intended for immediate therapeutic, diagnostic, or similar purposes, or otherwise to determine the safety and efficacy of the product,
 - ii. The use in humans is approved by a Radioactive Drug Research Committee (RDRC) that is composed and approved by FDA,
 - iii. The dose to be administered is known not to cause any clinically detectable pharmacological effect in humans, and
 - iv. The total amount of radiation to be administered as part of the study is the smallest radiation dose practical to perform the study without jeopardizing the benefits of the study and is within specified limits.
- F. When a Clinical Investigation (i.e., research proposal) is received involving a drug with an IND number the HRPPO documents a valid IND has been received as evidenced by:
 - a. A document from the sponsor indicating the IND number or;
 - b. A letter from the FDA indicating the IND number or;
 - c. Other IRB approved method of validation.
- G. When a study involving an investigational drug is submitted to the IRB for review without an IND number:
 - a. The HRPPO staff pre-reviewer considers the justification for exemption provided by the investigator/sponsor in the eIRB application. Based on this review, the HRPPO staff pre-reviewer determines whether an IND is needed or whether the use in the clinical investigation can be exempt from the IND requirements.
 - b. If the IRB agrees with the justification for exemption, then this decision is documented in the IRB files and the research is reviewed in accordance with [2.1. INITIAL REVIEW OF RESEARCH](#). The IRB agreement with this determination is documented in the minutes (See [8.1 IRB MINUTES](#)).
 - c. If the HRPPO staff pre-reviewer determines that an IND is required and the IRB agrees with this determination, the HRPPO staff will communicate this decision to the investigator/sponsor and approval will not be granted until an IND number is submitted to the IRB or the FDA determines that an IND is unneeded for the study.
- H. When prior submission to the FDA is required but has not yet been received

1. The IRB may contingently approve the study under the condition that valid proof of receipt of an IND has been obtained prior to starting the study.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
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214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

7.2 DEVICE RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. The IRB reviews projects that involve medical devices to protect the rights and welfare of human subjects involved in such research/investigations as directed by the Department of Health and Human Services (DHHS) and the Food and Drug Administration (FDA).
- B. The IRB is responsible for evaluating the use of a device in research involving human subjects (DHHS) or a clinical investigation (FDA) to determine if prior submission to the FDA is required or if the use of the device is exempt from such prior submission to the FDA. If prior submission is required, the IRB must determine whether an Investigational Device Exemption (IDE) has been obtained.
- C. It is the policy of UT Southwestern that when research is conducted to determine the safety or effectiveness of a device, the device must have an IDE issued by the FDA, unless the device 1) meets one of the four exemptions from the requirement to have an IDE or 2) meets the requirements for an abbreviated IDE

II. SCOPE

- A. This policy and procedures applies to all human subjects' research of medical devices that constitute research involving human subjects (DHHS) or clinical investigations (FDA).

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. The IRB evaluates:
 - a. Whether use of the device is considered research and involves human subjects (DHHS - 45 CFR 46.101), and;
 - b. Whether a device used is considered an investigational device (unapproved device or the object of an investigation) and involves human subjects (FDA - 21 CFR 56.102)
- B. If the IRB determines neither A.a nor A.b. above are true, the activity that includes a device may still be reviewed. If the activity is not considered to be research (non-research) or research not involving human participants under DHHS rules the activity is reviewed following guidance in the [1.2. DETERMINING WHETHER AN ACTIVITY IS RESEARCH INVOLVING HUMAN SUBJECTS](#).

- C. If the activity is considered exempt research (DHHS) not constituting a clinical investigation (FDA) is reviewed following guidance in the [1.3. EXEMPT REVIEW OF RESEARCH](#).
- D. All research (DHHS) involving human participants (whether or not determined to be a clinical investigation (FDA)) is evaluated following guidance in [2.1. INITIAL REVIEW OF RESEARCH](#).
- E. Clinical investigations are evaluated by the IRB to determine whether:
 - a. Submission to the FDA is required, and if required has been completed (as indicated by documentation from the sponsor that a valid IDE has been received) or;
 - b. The use of the device is exempt from prior submission to the FDA, or;
 - c. If the use of device may be approved under abbreviated requirements.
- F. Clinical investigations with an IDE (approved under Sec. 812.30) or approved by the IRB under “Abbreviated Requirements” (21 CFR 812.2(b)) exempts the device from sections 502, 510, 514, 551, 516, 519, 520(e) and 520(f). All other sections of the FDA regulations and Federal Food, Drug and Cosmetic Act remain in effect (including Sec. 820.30 (if applicable) and 721 of the Act).
- G. Review under “Abbreviated Requirements” and a nonsignificant risk determination alone does not ensure a study will meet criteria for Expedited Review. The study must be minimal risk and involve only procedures listed in one or more of the specific nine categories published in the Federal Register, further explained in [6.2 IRB APPROVAL OF RESEARCH](#).
- H. IDE Exemption Categories:
 - a. Approved/Cleared Devices
 - i. A device, other than a transitional device, in commercial distribution immediately before May 28, 1976, and will be used or investigated in accordance with the indications in labeling in effect at that time.
 - ii. A device, other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent (510k) to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of part 807 in determining substantial equivalence.
 - b. A diagnostic device, if the sponsor complies with applicable requirements in 21 CFR 809.10(c) and if the testing:
 - i. Is noninvasive.
 - ii. Does not require an invasive sampling procedure that presents significant risk.
 - iii. Does not by design or intention introduce energy into a participant.
 - iv. Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure.
 - c. A device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution, if the testing:
 - i. Is not for the purpose of determining safety or effectiveness, and

- ii. Does not put participants at risk.
 - d. A custom device as defined in 21 CFR 812.3(b), unless the device is being used to determine safety or effectiveness for commercial distribution.
- I. Abbreviated IDE Requirements:
 - a. The IRB may approve the study as a nonsignificant risk device study if the following are met:
 - i. The device does not present a potential for serious risk to the health, safety, or welfare of subjects and:
 - ii. The device will not be used in this study as an implant, and
 - iii. It will not be used to support or sustain human life in this study, and
 - iv. It will not be of substantial importance in diagnosing, curing, mitigating, or treating disease or otherwise preventing impairment of human health in this study
 - b. The FDA considers the study to have an approved IDE if the IRB approved it as a nonsignificant risk device study. The PI (or sponsor of the study) must then comply with the abbreviated requirements under 21 CFR 812.2(b):
 - i. The sponsor labels the device in accordance with 21 CFR §812.5 and must bear the statement "CAUTION - Investigational Device. Limited by Federal (or United States) law to investigational use."
 - ii. The sponsor obtains IRB approval of the investigation after presenting the reviewing IRB with a brief explanation of why the device was not a significant risk device, and maintains such approval.
 - iii. The sponsor ensures that investigators participating in an investigation obtain and document informed consent from each subject under the investigator's care (under 21 CFR 50), unless documentation was waived.
 - iv. The sponsor complies with the requirements of 21 CFR 812.46 with respect to monitoring investigations.
 - v. The sponsor maintains the records required under 21 CFR 812.140(b) (4) and (5) and makes the reports required under 21 CFR 812.150(b) (1) through (3) and (5) through (10).
 - vi. The sponsor ensures that participating investigator (if different from the sponsor) maintain the records required by 21 CFR 812.140(a)(3)(i) and make the reports required under §812.150(a) (1), (2), (5), and (7).
 - vii. The sponsor complies with the prohibitions in 21 CFR 812.7 against promotion and other practices.
- J. When a Clinical Investigation (i.e., research proposal) is received where the device has an IDE number the HRPPO documents a valid IDE has been received as evidenced by:

- a. A document from the sponsor indicating the IDE number or;
 - b. A letter from the FDA indicating the IDE number or;
 - c. Other HRPPO-approved method of validation.
- K. When a [Clinical Investigation](#) (i.e., research proposal) is received where the device does not have an IDE number
- a. The HRPPO staff pre-reviewer considers the investigator's rationale for exemption as provided in the eIRB application. Based on this review, the HRPPO staff pre-reviewer determines whether the device could be exempt from the requirements to have an IDE and forwards this recommendation to the IRB for consideration.
 - b. If the IRB agrees with the rationale for the exemption determination, the investigator will be notified of the IRB's decision (see [8.2 REPORTING POLICY AND PROCEDURE](#))
 - c. If the HRPPO staff pre-reviewer determines that the use of the device is not eligible for exemption under the categories described above, then the protocol will be examined for approval under the abbreviated IDE requirements. If the protocol is either not eligible for abbreviated IDE requirements, or not eligible for expedited review it will be assigned for review by the convened IRB. A significant/non-significant risk device determination will be made and documented in the IRB minutes.
- L. Significant/Non-Significant Risk Determination
- a. A significant risk/non-significant risk (NSR) determination is typically made by the sponsor.
 - b. During the initial review of the protocol, the IRB will consider the sponsor's rationale for the device risk determination.
 - c. If the sponsor makes an initial NSR determination, and the IRB agrees with this determination, then the IRB confirms that the study will be conducted in accordance with the abbreviated IDE requirements as described above. For NSR determinations, the study may be initiated without an IDE number. This determination will be documented in the IRB minutes (for Convened Review) and the expedited approval documentation in eIRB (for Expedited Review).
 - d. If the IRB disagrees with the sponsor's NSR determination and determines that the device represents significant risk, then the investigator and sponsor will be informed of this decision. The IRB's significant risk device determination will be documented in the IRB minutes. For such determinations, the sponsor must submit an IDE application to the FDA before the IRB will review the study. When the application is reviewed, the IDE number will be verified as described previously.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
21 CFR 812 – INVESTIGATIONAL DEVICE EXEMPTIONS (FDA)
21 CFR 809 – IN VITRO DIAGNOSTIC PRODUCTS FOR HUMAN USE (FDA)

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

7.3 HUMANITARIAN USE DEVICE (HUD)

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. A HUD is a device that is intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or are manifested in less than 4,000 individuals in the United States per year. The U.S. Office of Orphan Products Development (OOPD) determines if a device meets specific requirements, including scientific rationale and population prevalence, for designation as an HUD.
- B. UT Southwestern IRB recognizes humanitarian device exemption (HDE) approval by the FDA is based on safety and probable benefit of a designated Humanitarian Use Device (HUD). All uses of a HUD require IRB approval.
- C. This policy applies to the following HUD uses that are not considered to be Clinical Investigations (research):
 - a) When a HUD is used according to its approved labeling and indication(s) and does not involve collection of safety and effectiveness data.
 - b) When a HUD is used for an indication not approved under the existing HDE and the IRB has determined there is no intention or plan to collect safety or effectiveness data to support a PMA for that new indication.
 - c) Uses that do not meet the regulatory definition of a clinical investigation are not subject to 21 CFR Parts 50 & 56.
- D. **Exception to this policy:** The following uses meet the regulatory definition of a clinical investigation are subject to 21 CFR Parts 50 & 56. As such, this policy does not apply in the following situations. Instead, the following uses will be reviewed under [2.1. INITIAL REVIEW OF RESEARCH](#):
 - a) When a HUD is used according to its approved labeling and indication(s) and involves the collection of safety and effectiveness data. As such, the device is legally marketed and an IDE is not required.
 - b) When a HUD is used for an indication not approved under the existing HDE and the plan is to collect safety or effectiveness data to support a PMA. As such, requires prior submission to the FDA for an IDE.

II. SCOPE

This policy applies to the IRB and all research personnel involved with the use of a Humanitarian Use Device

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Initial Submission to HRPPO

- a) All requests for use of an HUD under an HDE must be initially reviewed and approved by the convened IRB unless used in an emergency as follows:
 - i. A physician in an emergency situation determines that IRB approval for the use of the HUD at the facility cannot be obtained in time to prevent serious harm or death to a patient
 - ii. The physician must report the emergency use within five days; provide written notification of the use to the IRB chairperson including identification of the patient involved, the date of the use, and the reason for the use. See section 520(m)(4) of the Act; 21 CFR 814.124.
- b) The Health Care Provider must submit the request for use of an HUD in eIRB. The submission must include:
 - (1) A copy of the HDE approval order;
 - (2) A description of the device;
 - (3) The product labeling;
 - (4) The patient information packet that may accompany the HUD;
 - (5) A sample consent form for the use of the HUD if required by the IRB or sponsor; and
 - (6) A summary of how the physician proposes to use the device, including:
 - i. A description of any screening procedures,
 - ii. The HUD procedure, and
 - iii. Any patient follow-up visits, tests or procedures.
- c) Upon receipt of the application, HRPPO staff designated to pre-review HUD requests, screen the application including any informed consent process and documentation for completeness and accuracy and forwarded for review by the convened IRB (see [1.1. RECEIVING, ROUTING, AND ADMINISTRATIVE REVIEW OF IRB SUBMISSIONS](#))

B. IRB Initial Review – the Board members:

- a) Receive access to a copy of the submitted materials in eIRB. A list of approved HDEs may be found at "CDRH Humanitarian Device Exemption Summaries of Safety and Possible Benefit".
- b) Ensure that health care providers are qualified through training and expertise to use the device. For many HDEs, the HDE holder is required to provide training on the use of the device prior to the health care provider using the device. Such requirements would be specified in the HDE approval order, available at "CDRH Humanitarian Device Exemption Summaries of Safety and Possible Benefit" (select the HDE number).
- c) Where the plan is to use the device beyond the scope of the FDA HDE-approved indications, ensure the rationale for the off-label use is reasonable with regards to safety and probable benefit.

C. IRB Review Outcomes:

- a) The IRB considers the following as applicable:
 - i. Additional information needed to determine HUD or HDE status;
 - ii. Required revisions needed to qualify for approval;
 - iii. How the HUD may be used (within approved labeling, outside approved labeling where there is no intention or plan to collect safety or effectiveness data to support a PMA for that new indication);
 - iv. Where the use of the HUD may take place;
 - v. Who may use the HUD (Individuals, departments, hospitals, etc.);
 - vi. Whether or not IRB approval is needed prior to use on each patient;
 - vii. Determination that the activity does not qualify for approval with rationale for the determination and recommendations for submission of full review human research application where applicable;
 - viii. Approved for implementation (general comments or suggestions may be included but not required for approval).
 - b) The HRPPO records all determinations concerning the use of an HUD under an HDE as described in [8.1 IRB MINUTES](#).
 - c) The Health Care Provider requesting the use of the HUD under an HDE is notified as described in [8.2 REPORTING POLICY AND PROCEDURE](#).
- D. Informed Consent:
- a) Use of a consent form is not required by the federal regulations, however, it is permitted.
 - b) When the HUD is used according to the approved labeling, the IRB may or may not require that consent be obtained. It is generally advisable to obtain consent for the use of a HUD, if the Health Care Provider would obtain consent for other similar clinical procedures, if the need for the HUD can be anticipated, and the clinical situation will permit obtaining consent.
 - i. When a HUD is used for an indication not approved under the existing HDE, the Health Care Provider will obtain informed consent from the patient (21 CFR Part 803).
- E. Modifications in ongoing HUD use
- a) All requests for alterations to the IRB approved use of an HUD under an HDE must be reviewed and approved by the IRB and may be reviewed by expedited procedure (except where necessary to eliminate apparent immediate hazards to the patient).
 - b) The PI must submit the proposed changes to the HRPPO by submitting a modification request in eIRB.
 - c) The designated IRB reviewer (either expedited or convened IRB) will determine whether the change alters the determination that the device may be used under the HDE in place.

- d) If the changes do not affect the HDE determination and are acceptable, the IRB reviewer documents the determination in the eIRB record and notifies the local Health Care Provider that requested the use of the HUD is approved according to [8.2 REPORTING POLICY AND PROCEDURE](#).
- e) If the changes do affect the determination such that the study will no longer be eligible for use of an HUD under an HDE, the reviewer contacts the local Health Care Provider that requested the use of the HUD and develops a plan to either withdraw the change or submit the study as human research under the appropriate review process (expedited or full review).

F. Annual Continuing Review of the use of an HUD

- a) Continuing review of the use of an HUD under an HDE must be reviewed and approved at least annually by the IRB.
- b) Health care providers must to submit a Progress Report in eIRB and any applicable attachments for continuing review.
- c) Continuing Review may be completed by Expedited procedure. [FDA recommends the use of an expedited procedure because a HUD is a legally marketed device and no safety and effectiveness information is being collected systematically, as is required for a research protocol.]
- d) At Continuing Review, the Chair or the Chair's designated member(s) will consider the risk and benefit information available and any Medical Device Reporting (MDR) reports

G. Review of HDE Medical Device Reports

- a) 21 CFR 814.126(a) requires HDE medical device reports (MDRs) that are submitted to FDA in compliance with the requirements of part 803 of this chapter also be submitted to the IRB of record.
- b) The HRPP Director or HRPP Associate Director will review all MDRs submitted directly to the IRB from manufacturers.
 - i. MDRs requiring immediate action are forwarded to the IRB Chair or HRPP Director for consideration of suspension or termination.
 - ii. MDRs not requiring immediate action
 - 1. Filing MDR reports does not necessarily mean that the product caused or contributed to the event. Many reports are incomplete and do not provide enough information to rule in or out a relationship between the event and the device.
 - 2. The IRB designated reviewer will send a letter advising the PI that the IRB has received the MDRs and that further evaluation by the local Health Care Provider that requested the use of the HUD is required.
 - a. If the events are determined to require immediate local action the Health Care Provider will submit a modification.

- b. If the events do not require immediate local action the Health Care Provider will submit a list and summary of all MDRs, adverse events and unanticipated problems with the next continuing review.
- H. The Health Care Provider requesting the use of the HUD under an HDE is notified of any IRB determinations for initial review, continuing review or modifications of use as described in [8.2 REPORTING POLICY AND PROCEDURE](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

7.4 EXPANDED ACCESS TREATMENT USE OF AN UNAPPROVED DRUG/BIOLOGIC

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. **Nothing in this policy is intended to prevent a physician from preserving life.** If in the investigator's opinion, immediate use of the test article is required to preserve the patient's life, and time is not sufficient to obtain IRB Approval or notify the IRB, the clinical investigator should make the determination and then follow the procedures outlined in the [Emergency Use of an Unapproved Investigational Drug Policy and Procedure](#) [21 CFR 50.23(c)].
- B. This policy describes the procedures for utilizing the Food and Drug Administration (FDA) Expanded Access Program (EAP) including individual patient and intermediate or large population treatment investigational new drug (IND) applications
- C. Expanded access, sometimes called "compassionate use," is the use of an investigational test article outside of a clinical trial to treat a patient with a serious or immediately life-threatening disease or condition who has no comparable or satisfactory alternative treatment options.
- D. The compassionate use provision allows access for patients who do not meet the requirements for inclusion in the clinical investigation but for whom the treating physician believes the test article may provide a benefit in treating and/or diagnosing their disease or condition.

II. SCOPE

- A. This policy and procedures applies to Investigators requesting approval for one of the following categories of EAP:
 - a Individual patient IND, including emergency use IND (21 CFR 312.310) commonly held by treating physician or investigator for treatment of an individual patient.
 - b Intermediate population treatment IND (21 CFR 312.315) commonly held by the sponsor (manufacturer) for use in a population smaller than a typical treatment IND or treatment protocol. The investigational drug for intermediate population treatment INDs may be in active development or may be an FDA approved drug that is unavailable or in limited supply.
 - c Large population treatment IND or treatment protocol (21 CFR 312.320) commonly held by the sponsor for widespread treatment use. For a large population treatment INDs, the sponsor must be pursuing marketing approval.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Before submitting an Individual Patient IND to FDA, a physician or PI must confirm the manufacturer will provide the drug. If a large or intermediate scale EAP is available through the manufacturer, the PI may coordinate access to the drug through the manufacturer's approved Treatment IND rather than filing a separate Individual Patient IND.

- B. FDA regulations require prospective review by the convened IRB.
- C. FDA policy specifies that "the provision for emergency use would rarely apply to a treatment protocol or treatment IND because these are planned uses of the test article and sufficient time is available to obtain IRB review and approval." In rare cases in which emergency use does apply for individual patients, administration takes place according to emergency use federal regulations (21 CFR 56.104) following procedures in the [Emergency Use of an Unapproved Investigational Drug Policy and Procedure](#).
- D. The FDA identifies special considerations when a patient is to be treated under an EAP:
 - a. **Drug Development:** In considering EAP use, individual needs must be balanced against societal needs. The FDA stipulates that expanded access use should not compromise enrollment or interfere with active clinical investigations that could support approval of the drug.
 - b. **Informed Consent:** Informed consent is especially important in expanded access use situations because the subjects are desperately ill and particularly vulnerable. They will receive medications which have not been proven either safe or effective in a clinical setting. Both the setting and their desperation may work against their ability to make an informed assessment of the risk involved. Therefore, the PI must ensure that potential subjects are fully aware of the risks involved in the participation.
 - c. **Charging for Treatment INDs:** The FDA permits charging for the drug, agent, or biologic when used in an EAP when regulatory criteria are met. Therefore, the IRB must pay particular attention to EAPs in which the subjects will be charged for the cost of the drugs. If subjects will be charged for use of the test article, economically disadvantaged persons may inadvertently be excluded from participation. Charging for participation may preclude economically disadvantaged persons as a class from receiving access to test articles. The IRB must balance this interest against the possibility that unless the sponsor can charge for the drug, it will not be available for treatment use until it receives full FDA approval.
 - d. **Regulatory Responsibilities:** Per FDA a licensed physician under whose immediate direction an investigational drug is administered for an expanded access use is considered an investigator assuming applicable regulatory responsibilities. An individual who submits an IND for expanded access use is considered a sponsor-investigator, assuming applicable responsibilities for sponsors and investigators (21 CFR 312.305(c)).
- E. Individual Patient IND
 - a. The physician or PI submits the following for review by the convened IRB:
 - i. a completed eIRB application;
 - ii. individual patient IND approval letter from FDA;
 - iii. investigator's brochure if applicable;
 - iv. brief description of patient situation and treatment plan; and

- v. copy of the informed consent form.
 - b. HRPPO staff screen the IRB submission and verify the IND number according to procedures described in the [7.1 DRUG RESEARCH POLICY AND PROCEDURE](#).
 - c. The IRB reviews the submission as outlined in [2.1. INITIAL REVIEW OF RESEARCH](#) and according to federal regulations.
 - d. At the conclusion of treatment, the physician or PI reports a written summary of the results of the expanded access use, including any safety related information, to the IND sponsor or FDA and the IRB.
- F. Individual Patient IND in an Emergency Situation
- a. In the rare cases in which an emergency requires that the patient be treated before a written IND submission can be made, the PI obtains authorization for individual use from FDA by telephone or electronic communication with subsequent submission of IND paperwork (21 CFR 312.310).
 - b. The PI follows procedures described in the [7.5 EMERGENCY USE OF AN INVESTIGATIONAL DRUG OR DEVICE](#).
 - c. The IRB Chair, HRPPO staff, and the IRB follow review procedures as described in the [7.5 EMERGENCY USE OF AN INVESTIGATIONAL DRUG OR DEVICEe](#).
- G. Intermediate or Large Population Treatment IND
- a. The PI follows procedures described in [2.1. INITIAL REVIEW OF RESEARCH](#) with the following additions and provisions:
 - i. a completed eIRB application;
 - ii. documentation of FDA treatment IND approval (i.e., correspondence from FDA or commercial sponsor, IND number printed on sponsor protocol); and
 - iii. related materials including the treatment protocol, investigator's brochure, informed consent form, and potential investigational drug costs.
 - b. HRPPO staff screen the IRB submission following procedures described in [2.1. INITIAL REVIEW OF RESEARCH](#).
 - c. The convened IRB reviews the protocol as outlined in [2.1. INITIAL REVIEW OF RESEARCH](#) and according to federal regulations.
 - d. At the conclusion of treatment, the physician or PI reports a written summary of the results of the expanded access use, including any safety related information, to the IND sponsor or FDA and the IRB.
- H. See [8.1 IRB MINUTES](#) for details concerning documenting Treatment Use Protocols.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

7.5 EMERGENCY USE OF AN INVESTIGATIONAL DRUG OR DEVICE

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: August 1, 2017

I. POLICY STATEMENT

- A. The emergency use provision in the Food and Drug Administration (FDA) regulations [[21 CFR 56.104\(c\)](#)] allows physicians a onetime use of an **unapproved** investigational drug, biologic, or device (referenced hereafter as “test article”). This policy is intended to assist physicians by outlining the FDA emergency use requirements and the necessary procedures to ensure both the treatment of seriously ill patients in a life-threatening situation and compliance with FDA regulatory requirements.
- B. The FDA expects the physician to assess the potential benefits from the use of an unapproved device and to have substantial reason to believe that the benefits will exist in addition to determining whether the patient meets the qualifying criteria for emergency use.
- C. FDA and Department of Health and Human Services (DHHS) regulations differ as follows:
 - a. Under **FDA regulations** although an emergency use is considered a “clinical investigation, it allows an exemption from IRB review. However, patients who receive a test article in an emergency use may not be considered research participants
 - b. **DHHS regulations** do not permit data obtained from patients who receive a test article in an emergency use to be classified as human participants’ research, nor do they permit the outcome of such care to be included in any report of a research activity subject to DHHS regulations.
- D. Sufficient time to obtain IRB approval prior to use
 - a. For the purposes of this policy, there is sufficient time to obtain IRB approval if the physician decides that the test article is not needed prior to the next scheduled IRB meeting and the application for the use of the test article can be submitted at least one week prior to that meeting.
 - b. On the other hand, if there is insufficient time to prepare the application and to get it reviewed at Full Board before its use is needed to treat the condition, then the emergency use without IRB approval criteria may be met. The clinician should not delay treatment if waiting for Full Board review would jeopardize the patient’s health or safety.

II. SCOPE

- A. This policy and procedures applies to any physician who identifies the need for the emergency use of an unapproved drug or device to treat a life-threatening or severely debilitating condition for a patient who does not meet criteria for treatment on an existing IRB approved protocol.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. When reviewing a request for Emergency Use of a test article, the IRB or IRB Chair considers the following specific protections:
- a. An IND/IDE is required for emergency use of test articles as follows:
 - i. Drugs: the IND may be either:
 - 1. Previously existing, or
 - 2. An emergency IND (eIND) obtained from the FDA
 - ii. Devices: the IDE may be either:
 - 1. Previously existing, or
 - 2. Non-existent – the FDA has stated, using its enforcement discretion, it has not objected if a physician chooses to use an unapproved device in such an emergency, provided that the physician later justifies to FDA that an emergency actually existed, UT Southwestern policy allows for this circumstance in the following situations:
 - a when an IDE for an unapproved device does not exist, or
 - b the proposed use is not approved under an existing IDE, or
 - c the physician or institution is not approved under the IDE,
 - b. Whether exemption from prior IRB approval may be allowed, and
 - c. Whether Exception from informed consent may be allowed or whether informed consent must be obtained
- B. The process for Emergency Use can be broken down into three categories: Prior-Use Requirements, Use, and Post-Use Requirements.
- a. **Prior-Use Requirements.**
 - i. Qualifying Criteria for Emergency Use – Physicians who wish to use a test article for Emergency Use must complete and submit an Emergency Use Request Notification (Emergency Use of an Investigational Drug, Biological, Device for Patient Care) provided by the HRPP to document the following criteria are met in order to comply with federal regulations and University policy
 - 1. The patient has a condition that is life-threatening or severely debilitating,
 - 2. No standard treatment is available,
 - 3. There is not sufficient time to obtain IRB review and approval for an unapproved investigational drug, biologic, or device.

4. Understanding that Emergency Use permission may be granted only one time to treat a single patient
- ii. Specific information for Emergency Use of Drugs/Biologics:
 1. Contact the Sponsor/Manufacturer: Determine whether the test article can be made available for the emergency use under the sponsor/manufacturer's IND.
 - a. NOTE: If the sponsor/manufacturer of the test article requires a letter from the IRB before shipping the test article, an acknowledgement letter of the emergency use can be provided (which should not be construed as IRB approval).
 2. Contact the FDA: If the manufacturer of a drug or biologic declines permission to use its IND, the physician may contact the FDA to obtain an IND. The physician may also contact the FDA for additional information and guidance, and for notification about the emergency use.
 3. Contact the appropriate Investigational Drug Pharmacy: If the emergency use involves a drug or biologic, you must comply with institutional policies regarding the receipt, storage, and dispensation of the drug/biologic.
- iii. Specific information for Emergency Use of Devices:
 1. The emergency use of any unapproved device may occur:
 - a. When a physician wants to use the device in a way not approved under the IDE,
 - b. When a physician is not an investigator under the IDE, or
 - c. When an IDE for the device does not exist.
 2. Contact the Sponsor/Manufacturer: Obtain authorization from the IDE sponsor, if an IDE exists (if possible).
 3. IMPORTANT NOTE: Contacting the FDA for prior use notification or approval is not required for shipment or emergency use of the unapproved device. The FDA does not need to be notified prior to the emergency use of a device when a patient meets the criteria for emergency use.
 4. Contact the appropriate Institutional Research office and/or Investigational Pharmacy (if applicable)

5. If possible, seek an independent assessment (written) of an uninvolved physician regarding the emergency use of the unapproved device.
 - iv. Contact the Human Research Protection Program Office (HRPPO)
 1. Contact the UT Southwestern HRPP Director or IRB Chair as soon as possible. Calls regarding emergency use are handled as expeditiously as possible. The treating physician should discuss the case to determine if it meets the FDA criteria for emergency use and, if relevant, whether the use meets FDA criteria for waiving consent. If contact with an IRB Chair, HRPP Director is not possible, the physician should proceed with the emergency use if the patient meets the qualifying criteria.
 2. IMPORTANT NOTE: Contacting the HRPPO or concurrence by a UT Southwestern IRB Chair or Vice Chair **should not be construed as IRB approval.**
 - v. Whenever possible, the HRPPO/IRB will respond to physician inquiries prior to the emergency use of a test article, and will provide contact information for the appropriate IRB Chair/Vice Chair. In addition, if needed, an acknowledgment letter of the emergency use can be provided after concurrence with the IRB Chair (**which should not be construed as IRB approval**).
- b. **Use of the Test Article**
- i. Obtain informed consent or determine whether Exception from informed consent may be allowed.
 1. Written informed consent is required, and must be obtained from the patient or the patient's legally authorized representative unless the criteria for an exception from the informed consent requirement is met.
 2. Exception from the informed consent requirement may occur if both the treating physician and a physician not otherwise involved in the emergency use, certify in writing that all of the following criteria are met ([21 CFR 50.23\(a\)](#)):
 - a. The prospective recipient is confronted by a life- threatening situation necessitating the use of the test article.
 - b. Informed consent cannot be obtained from the recipient because of an inability to communicate with, or obtain legally effective consent from, the recipient.

- c. Time is not sufficient to obtain consent from the recipient's legal representative.
- d. There is no available alternative method of approved or generally recognized therapy that provides an equal or greater likelihood of saving the life of the recipient.
- e. If there is not sufficient time to obtain an independent written certification of the criteria for an exception from informed consent prior to the use of the test article, the determinations of the treating physician must be made, reviewed and evaluated in writing by a physician who is not involved in the emergency use, and submitted to the IRB within 5 working days after the emergency use of the test article ([21 CFR 50.23\(b\)](#) and [21 CFR 50.23\(c\)](#)).

C. Post-Use Requirements

- i. The PI must submit the following to the HRPPO within 5 working days after the test article use:
 - 1. Copy of the completed Notification of Emergency Use of a Test Article Form
 - 2. Copy of the signed informed consent form *or* certification of informed consent waiver
 - 3. Copy of the completed Emergency Use Request Notification for Drug/Biologic or Device
- ii. Notify the FDA and Sponsor/Manufacturer
 - 1. The physician must provide outcomes or safety information as required by the FDA.
 - 2. For Drugs/Biologics: If the treating physician is the IND holder, any follow-up information should be reported to the FDA.
 - 3. For Devices: The FDA requires the following post-use reporting:
 - 4. If an IDE exists, the physician must provide the IDE sponsor a report. The sponsor is required to submit a report to the FDA within 5 working days the sponsor is aware of the emergency use.
 - 5. If an IDE does not exist, the physician must submit a report to the FDA within 5 working days of device use.

6. The report should include a summary of the conditions constituting the emergency, the patient protections measures taken, and patient outcome information
 - iii. The physician should consider possible future use of the test article at UT Southwestern and, if necessary, initiate efforts to obtain IRB approval and regulatory clearance (IND or IDE) for such future uses.
 - iv. The HRPPO staff will review the Notification of Emergency Use and make a preliminary determination of whether the treating physician met FDA regulations and guidance.
 1. The HRPPO staff will forward the Notification of Emergency Use to the IRB Chair or designee who will review the Report Form and determine whether the treating physician met FDA regulations and guidance.
 2. If there are any questions or concerns regarding the report from the IRB Chair or designee, questions or concerns to the treating physician may be communicated with the assistance from the HRPPO staff.
 3. HRPPO staff will prepare and schedule the report for discussion at a convened IRB meeting.
 - v. The HRPPO will maintain documentation of all emergency use reports submitted to the IRB.
- d. **IRB Review**
 - i. The convened IRB will review the documents submitted by the PI and determine either:
 1. The regulatory criteria for emergency use **were met**, or
 2. The regulatory criteria for emergency use **were not met** and will be reviewed as possible noncompliance.
 - ii. Noncompliance with emergency use requirements will be processed as described in the [9.3 NONCOMPLIANCE REVIEW](#)
 - iii. See [8.1 IRB MINUTES](#) for details concerning documenting emergency use of a test article
 - iv. After the IRB meeting, the use is reported in accordance with [8.2 REPORTING POLICY AND PROCEDURE](#) and the [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	
August 2017	New Policy Development
March 2012	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

8.1 IRB MINUTES

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: January 21, 2019

[0.1 POLICY AND PROCEDURE ADDENDUM for the 2018 REQUIREMENTS](#) describes the variations in policies and procedures that the UT Southwestern HRPPO, IRB, investigators, and all study staff will adhere to for all research subject to the revised Common Rule that is IRB approved, determined to be exempt, or evaluated regarding project status as human subjects research on or after January 21, 2019 or to studies transitioned to these new requirements by the UT Southwestern HRPP and IRB. Please refer to this Policy and Procedure Addendum for any changes.

I. POLICY STATEMENT

- A. This procedure outlines the responsibilities of the Human Research Protection Program Office (HRPPO) and the IRB for documentation of convened IRB proceedings according to applicable regulations such as:
- 45 CFR 46.115, §46.116(c), §46.116(d), §46.117(c);
 - 21 CFR 56.115, §56.109(c)(1);
 - 21 CFR 50.24;
 - 32 CFR 219.115, §219.116(c), §219.116(d), §219.117(c);
 - 45 CFR 164.512(i)(2)

II. SCOPE

- A. This policy and procedures applies to the Human Research Protection Program Office (HRPPO) Staff, IRB, and the Institutional Official
- B. Summary of Responsibilities include:
1. HRPPO staff records the discussion, deliberations and decisions of the convened IRB in minutes in accordance with applicable federal, state and local regulations.
 2. HRPPO staff are responsible for documentation of minutes and reports to the convened Board of IRB decisions that occur outside a convened meeting under the rules and regulations applicable to IRB review of human subjects' research.
 3. All IRB minutes are reviewed and approved by the IRB Chair where recommendations for changes are allowed. Once the minutes are accepted by the Board at a subsequent IRB meeting they may not be altered by anyone, including any higher authority. If comments or clarifications are required to be added to minutes after approval by the IRB Chair, an addendum will be attached.
 4. Minutes are accessible to review by the Institutional Official in eIRB.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. The HRPPO maintains electronic agendas based on the requests, reports, and studies that will be reviewed by the convened IRB.
- B. The HRPPO maintains minutes of all convened IRB meetings documenting when applicable:
1. That the meeting was convened with members appropriately representing regulatory requirements (i.e., quorum) and the general perspective of participants.

2. Attendance at the meeting. Including:
 - a. The name of the members present and whether the member is serving as a primary or alternate. For alternates, the name of the member being represented is included.
 - b. The names of members not present or represented
 - c. Members and Consultants with a conflict are documented in the minutes as being absent with an indication that a conflicting interest was the reason for the absence.
 - d. The names of members or alternate members attending via videoconference or teleconference. Those members will have received all pertinent material before the meeting to ensure they are able to actively and equally participate in all discussions
 - e. The name of any consultants, guests, or other non-member in attendance.
3. The result of the IRB vote for approval or changes to the previous meeting minutes.
4. Separate deliberations with pertinent discussions of each action/protocol.
5. Record of votes: Votes for, against and abstentions for protocol approval are documented in the meeting minutes. Abstentions are counted as votes against the motion, as a majority is required for a motion to pass.
6. Additional comments to include thorough documentation of unique questions or concerns, recusal of investigators/members/consultants from discussion and vote, or other unique information that may be deemed valuable.
7. IRB determinations (e.g., approved as submitted, approved contingent upon revisions or clarifications, deferred, disapproved) and decisions. Where appropriate, protocol-specific findings are documented supporting determinations. Other required determinations and protocol-specific findings justifying those determinations include:
 - a. Whether requests for waiver or alteration of the consent process meet applicable regulatory criteria.
 - b. Whether requests to involve pregnant women, fetuses, and neonates meet applicable regulatory criteria
 - c. Whether requests to involve prisoners meet applicable regulatory criteria
 - d. Whether requests to involve children meet applicable regulatory criteria
 - e. Significant risk/non-significant risk device determinations - The rationale for determining that risk associated with using a medical device in a study significant or non-significant.
8. Summary of discussion on controverted issues and their resolution
9. For initial and continuing review, the approval period. For modifications, if the Board voted to shorten the approval period, it should be noted.

10. The basis for requiring changes in or disapproving research
 11. Justification of any deletion or substantive modification of information concerning risks or alternative procedures contained in the DHHS approved sample consent document.
 12. The level of risk determined by the IRB.
 13. The IRB considers written comments and/or information provided by ad hoc or cultural consultants in the review process. Ad hoc or cultural consultants may provide comments or recommendations in writing to the IRB prior to the meeting or attend the convened meeting at the request of the IRB. In cases where the consultant participates in the meeting, the minutes of the meeting document the information provided by the consultant.
- C. The HRPPO Staff creates an Expedited Report which is an electronic record of all IRB decisions that occur outside a convened meeting documenting, when applicable:
1. The report demonstrates that determinations were made as required by the regulations and that protocol-specific findings, where applicable, are documented justifying those determinations (including for example that modifications are minor or that study is eligible for expedited review and the applicable expedited review category depending on the reason for review outside a convened meeting);
 2. Description of actions taken by the designated reviewer should be reported to the next convened IRB.
- D. After review, record keeping is in accordance with the [8.3 RECORDKEEPING](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
32 CFR 219 - PROTECTION OF HUMAN SUBJECTS (DOD)

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
January 2019	HRPP	Revision to reference 2019 common rule
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office

HRPP@UTSouthwestern.edu

214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM POLICY AND PROCEDURE

8.2 REPORTING POLICY AND PROCEDURE

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

I. POLICY STATEMENT

- A. This policy and procedures outlines specific actions and responsibilities of the Principal Investigator, HRPPO and convened IRB's for ensuring prompt reporting of required activities, circumstances and results involving the conduct and monitoring of research involving human subjects.

II. SCOPE

- A. This policy and procedure applies to the convened IRB or the HRPPO making a determination that requires reporting in accordance with this policy
- B. Summary of responsibilities
 - 1. HRPPO staff are responsible for collecting or recording determinations of the IRB in accordance with UT Southwestern (UTSW) policy, creating appropriate reporting documents, obtaining appropriate signatures and sending reports/making reports available to applicable individuals, institutions, departments or agencies.
 - 2. Appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children's, Parkland, etc.).
 - a. If the research is also regulated by other involved institutions, HRPPO staff also send specific reports to the appropriate institutional officials at involved institutions. Each of the Institutional Officials is responsible for sending those reports throughout their institution, as they consider appropriate (e.g., if an unauthorized use, loss, or disclosure of individually identifiable patient information resulted, the institution's Privacy Officer would be notified).

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. Problem Reports
 - 1. The IRB reports unanticipated problems involving risks to participants or others (UPIRSOs), unanticipated adverse device effects (UADEs) (and if appropriate, depending upon the outcome of the review, external sponsor reviews for UADE's), serious or continuing noncompliance, and suspensions or terminations, of research to internal entities (such as Principal Investigators and other appropriate UTSW officials) and external entities (such as department or agency heads, OHRP, and the FDA) as required by federal regulations. For FDA-regulated research, any reported events that the IRB determines to be internal unanticipated problems involving risks to subjects or others will be reported to the FDA by the HRPPO will be reported to the FDA by the HRPPO.
 - 2. IRB determinations of serious or continuing non-compliance in accordance with the non-compliance policy will be reported to the following entities. Please note that additional notifications of serious or continuing noncompliance will occur according to specific local institutional requirements (e.g., UTSW, Parkland, Children's) as soon as possible:

- a. Principal Investigator;
 - b. Person(s) involved in the noncompliance;
 - c. Department Chair (or equivalent);
 - d. Dean or unit Director, if appropriate;
 - e. Institutional Official;
 - f. Compliance Office, Sponsored Program Administration (SPA), and other institutional entities as appropriate;
 - g. OHRP (incident report) (if federally funded);
 - h. FDA, if applicable;
 - i. DoD funding agency, if applicable, when research is funded by the Department of Defense
 - j. Sponsor coordinated through Sponsored Program Administration (SPA), if appropriate;
 - k. Other appropriate institutional officials at involved institutions (e.g., Children's, Parkland, etc.) for which the UTSW IRB is serving as the IRB of record.
 - l. The person raising the allegation (if the identity of the person is known and the feedback is deemed appropriate) (This notification is communicated by the HRPP Director/HRPP Associate Director).
3. The determinations of UPIRSO, UADE (and if appropriate, depending upon the outcome of the review, external sponsor reviews for UADE) in accordance with the unanticipated problems policy will be reported to the following entities following the IRB's determination. Please note that additional notifications of UPIRSO, UADE (depending upon the outcome of the review, external sponsor reviews for UADE) will occur according to specific local institutional requirements (e.g., UTSW, Parkland, Children's):
- a. Principal Investigator;
 - b. The Department Chair;
 - c. Dean or unit Director, if appropriate;
 - d. Institutional Official;
 - e. Compliance Office, Sponsored Program Administration (SPA), and other institutional entities as appropriate;
 - f. OHRP (incident report); federally funded studies in which a UPIRSO occurred that was based on an internal UPIRSO and/or based on an external UPIRSO only if the local PI identified the problem, the HRPPO promptly submits an incident report to Applicable Federal Department or Agency head if funded by a department or agency including OHRP.
 - g. FDA, if applicable; when research is FDA regulated and the UPIRSO is an internal UPIRSO and/or based on an external UPIRSO only if the local PI identified the problem: The IRB requires that the PI reports the UPIRSO to the sponsor (as

applicable), who must report to the FDA. If the PI is also the sponsor, then the IRB requires that the sponsor- investigator report to the FDA. Regardless of whether such reporting has occurred as indicated by the PI for Initial determination or resolution of UPIRSOs the HRPPO will report to the FDA.

- h. DoD funding agency, if applicable, when research is funded by the Department of Defense
 - i. Sponsor coordinated through Sponsored Program Administration (SPA), if appropriate;
 - j. Other appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children's, Parkland, etc.)
4. The IRB's decision to suspend or terminate research in accordance with the Suspensions and Terminations Policy and/or notification to the IRB of the IO's decision to suspend or terminate research will be reported to the following entities after the IRB's determination. Please note that additional notifications of the IRB's decision to suspend or terminate research will occur according to specific local institutional requirements (e.g., UTSW, Parkland, Children's):
- a. Principal Investigator;
 - b. Department Chair (or equivalent);
 - c. Dean or unit Director, if appropriate;
 - d. Institutional Official;
 - e. Compliance Office, Sponsored Program Administration (SPA), and other institutional entities as appropriate;
 - f. OHRP (incident report) (if federally funded);
 - g. DoD funding agency, if applicable, when research is funded by the Department of Defense
 - h. FDA, if applicable;
 - i. Sponsor coordinated through Sponsored Program Administration (SPA), if appropriate;
 - j. Other appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children's, Parkland, etc.).

If the IRB decides to suspend or terminate a research activity, it will include in its written notification a statement of the reasons for the IRB's action.

5. Appeals to reports
- a. The PI may appeal the IRB's decision regarding determinations of unanticipated problems involving risks to participants or others, serious or continuing non-compliance, and suspensions or terminations of research. The PI specifies the nature of any claimed procedural error or the perceived unfairness of action taken by the IRB.

- b. The appeal will go before the convened IRB for review and consideration.
- c. The IRB determination following a review of an appeal is considered final.
- 6. Responses or reports from federal departments
 - a. HRPPO presents responses or other reports from federal departments or agency heads (generally OHRP or FDA) to:
 - i. UT Southwestern Institutional Official (IO)
 - ii. the IRB,
 - iii. appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children's, Parkland, etc.)
 - iv. the PI, and
 - v. AAHRPP
 - 1. UTSW will report to AAHRPP within 24 hours of becoming aware of any sanctions taken by a government oversight office, including, but not limited to, OHRP Determination Letters, FDA Warning Letters, and FDA Restrictions placed on an IRB or investigator or any lawsuits related to human research protection.
 - 2. UTSW will consult the AAHRPP office for further advice if in doubt about whether a particular item is immediately reportable.

B. Other Reports

- 1. The HRPP reports to internal entities (such as Principal Investigators and other appropriate UTSW officials) and as appropriate external entities (such as department or agency heads, OHRP and the FDA) as required by federal regulations:
 - a. inclusion of certain vulnerable populations,
 - b. IRB Membership and Certification changes,
 - c. Emergency Medical Research requesting Exception to Informed Consent, and
 - d. determinations made by the IRB following initial and continuing review and as appropriate during review of modifications to previously approved research.
- 2. Determinations made by the IRB/HRPPO following review (initial and continuing review, review of modifications to previously approved research, and responses to contingencies for research which was conditionally approved) by the convened IRB, expedited review, or administrative HRPPO review will be reported by the HRPPO to the PI and the appropriate officials at affiliated institutions of the following:
 - a. For each research item reviewed by the convened IRB, the HRPPO will report the following determinations to the appropriate institutions for which the UTSW IRB is serving as the IRB of record:
 - i. Approve the research activities as written,
 - ii. Require minor modifications to secure IRB approval (conditional approval),

- iii. Defer review to another convened meeting pending resolution of major issues/modifications (tabled item), or
 - iv. Inactivate.
 - v. Disapproval: In the case that research is disapproved (for convened meetings only) by the IRB during initial or continuing review, a written notification containing a statement of the reasons for the decision, and a list of the required modifications or clarifications for re-consideration of the item for approval by a subsequent convened IRB is forwarded to the Principal Investigator and the appropriate officials at affiliated institutions. If the disapproval leads to a suspension of research activities or lapse in IRB approval, the IRB follows the appropriate guidance in either Suspension or Termination of Research Policy and Procedure or Continuation Review Policy and Procedure.
 - b. For each research item reviewed under an expedited review procedure the HRPPO will report the determinations to the following:
 - i. The PI
 - ii. Affiliated institutions relying on the UTSW IRB
 - iii. The convened IRB. The Expedited Actions report constitutes documentation of approval and is available to members of all convened IRBs prior to and during each IRB meeting.
 - c. For each item reviewed under HRPPO Administrative review (not requiring IRB review), the HRPPO will report the results of the action to:
 - i. The PI
 - ii. Appropriate institutions engaged in the research for which the UTSW IRB is serving as the IRB of record
- 3. Reporting research involving Pregnant Women, Fetuses, and Neonates where the IRB finds that the research is not otherwise approvable for pregnant women, nonviable neonates, or neonates of uncertain viability under 45 CFR 46 Subpart B and 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 - the HRPPO reports to:
 - a. PI
 - b. OHRP
- 4. Reporting research involving Prisoners where the PI has submitted the protocol to the State, County or DHHS or where the research is DHHS funded and includes prisoners - the HRPPO reports to:
 - a. PI
 - b. OHRP

5. Reporting research involving Children, if the IRB finds that the research is not otherwise approvable but presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children under the applicable FDA, DHHS, or U.S. Department of Education subpart - the HRPPO reports to:
 - a. The PI
 - b. With a copy to the applicable federal agency (e.g., Secretary of DHHS through OHRP, Secretary of U.S. Department of Education, or Commissioner of FDA).
 6. Reporting changes in IRB membership - the HRPPO reports to: OHRP.
 7. Reporting Certification of IRB Approval - the HRPPO reports upon request to: The funding agency either directly or through the PI.
 8. Reporting Emergency Medical Research requesting Exception to Informed Consent when the IRB does not approve an exception from the general informed consent requirements for emergency research under FDA and DHHS requirements - the HRPPO reports to:
 - a. The PI
 - b. The sponsor
- C. Serious or Continuing Noncompliance – Reporting Procedure
1. HRPPO Staff reports determinations of Serious or Continuing Noncompliance via informal means and formal official notices
 - a. Informal notification is made via telephone or encrypted email, as necessary to satisfy specific institutional requirements.
 - b. The HRPPO prepares official notifications of serious or continuing noncompliance within the timeframe required from the date an event is determined to be serious and/or continuing noncompliance by the IRB, if the event is a more serious incident, this may mean reporting to OHRP within days. In all cases, incident reporting will occur within the timeframe required above of determining the event is a serious and/or continuing noncompliance.
 - i. The IRB Chair or designee , reviews the determination letter (report), which the HRPPO sends to the PI with a copy to the appropriate federal agency, department chair, and appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children’s, Parkland, etc.)
 - ii. If the DHHS conducts or funds the research, the HRPPO sends the report to OHRP in accordance with current OHRP guidance on incident reporting http://www.hhs.gov/ohrp/policy/incidreport_ohrp.html.
 - iii. If an agency that is subject to the “Common Rule,” other than the DHHS, conducts or funds the research, the HRPPO sends the report to the agency as required by the agency and OHRP.

- iv. For FDA-regulated research, any IRB determinations of serious or continuing non-compliance will be reported to the FDA by the HRPPO as outlined in "when reporting to the FDA" (below).
 2. The report includes the title of the research protocol and/or grant proposal; name of the PI on the protocol; IRB number assigned to the research protocol; the grant/award number of any applicable federal award(s) (grant, contract, or cooperative agreement); the nature of the event; and the findings of UTSW or the IRB; actions taken by the PI, UTSW, and/or the IRB to address the issue.
 3. The HRPPO files a copy of the federal report(s) and any final IRB actions in the IRB study file.
 4. All reports made by the HRPPO to federal agencies pertaining to serious or continuing non-compliance will be made available to the convened IRBs.
- D. Unanticipated Problems Involving Risks to Subjects (UPIRSO), Unanticipated Adverse Device Effects (UADE) – Reporting Procedure after a UPIRSO/UADE determination is made by designated reviewers or the convened IRB
 1. HRPPO Staff reports UPIRSO/UADE determinations and the specified resolution via informal means (initial notification) and formal official notifications (notices of determination and notices of resolution)
 - a. Informal notification is made via telephone or encrypted email, as necessary to satisfy specific local institutional requirements. Generally, initial notices are sent locally pending IRB review.
 - i. The initial notification will identify:
 1. Name of the institution (e.g., university, hospital, foundation, school, etc.) conducting the research;
 2. Title of the research project and/or grant proposal in which the problem occurred;
 3. Name of the principal investigator on the protocol;
 4. The grant/award number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
 5. A description of the problem; and
 - ii. If substantive issues remain (e.g., additions to the action plan to account for issue(s) identified as conditions of continued approval to conduct research at any of the involved institutions) a follow-up notice requesting further input from the appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record, PI's department chair or PI may be necessary or an appointment may be set to meet with the PI to determine the status of the UPIRSO/UADE.
 - b. Official notifications are made as determination notices. Determination notices are sent following IRB/designated reviewer review. However, if the event is a more

serious incident, this may mean reporting to applicable federal department or agency head including OHRP days prior to an IRB determination. In all cases, incident reporting of IRB determinations to the applicable federal department or agency heads including OHRP will occur within the timeframe required above.

- i. The Determination notice will identify:
 1. Name of the institution(s) (e.g., university, hospital, foundation, school, etc.) conducting the research;
 2. Title of the research project and/or grant proposal in which the problem occurred;
 3. Name of the principal investigator on the protocol;
 4. The grant/award number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
 5. IND or IDE number (if applicable)
 6. A detailed description of the problem;
 7. Actions the IRB, PI, sponsor and institution(s) are taking or plan to take to address the problem (e.g., educate the investigator, educate all research staff, suspend the protocol, suspend the investigator, conduct random audits of the investigator or all investigators, revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.); and
 8. Any additional actions requested of the PI by the IRB to resolve the problem (if applicable).
 - ii. Concerning follow-up reports (if required by the IRB).
 1. If the follow-up report has not been received within approximately 30 days following the meeting, HRPPO Staff prepare follow-up correspondence to the PI and coordinator requesting any information necessary for resolution
 - iii. The HRPP Director, HRPP Associate Director, or IRB Chair approves all official notices.
2. HRPPO Staff reports determinations to all required entities as indicated below:
 - a. Appropriate officials at UTSW including:
 - i. Compliance Officer (for all reports involving privacy issues),
 - ii. Institutional Official
 1. for UPIRSO based on Internal Adverse Events
 2. UPIRSO based on non-adverse events where:

- a. a local incident, experience or outcome or
 - b. where external incident, experience or outcome was identified by local PI
 - 3. UADE reports
 - iii. IRB Chair (as appropriate, e.g., for designated reviewer determinations)
 - 1. for UPIRSO based on External Adverse Events, and
 - 2. UPIRSO based on non-adverse events where:
 - c. A determination of incident, experience or outcome was not made by local PI (e.g., sponsor or DSMC via sponsor identified the external information that was determined to represent a possible UPIRSO).
 - iv. IRB (as appropriate, e.g., for determinations)
 - 3. Each IRB reviews UPIRSO related documents placed on the meeting agenda.
- b. Appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children’s, Parkland, etc.). Appropriate organizational representatives then disseminate as needed within their organization and gather any additional institutional requirements and forward any such requirements to the PI to be incorporated into the action plan if necessary.
- c. Applicable Federal Department or Agency head if funded by a department or agency including OHRP
- i. OHRP is only notified for:
 - 1. UPIRSO based on Internal Adverse Events
 - a. UADE reports may meet this criteria
 - 2. And when deemed appropriate by the HRPP Director, HRPP Associate Director or IO any UPIRSO based on non-adverse events where OHRP would not otherwise be notified by another entity:
 - a. a local incident, experience or outcome or
 - b. external incident, experience or outcome identified by local PI
 - ii. If the DHHS conducts or funds the research, the HRPPO sends the report to the Office for Human Research Protections (OHRP) in accordance with current OHRP guidance on incident reporting
 - iii. If an agency that is subject to the “Common Rule”, other than the DHHS, conducts or funds the research, the HRPPO sends the report to the agency as required by the agency and OHRP.
- d. For FDA-regulated research, any reported event that the IRB determines to be a UPIRSO (UPIRSOs based on an internal event and/or based on an external event in

which the local PI identified the issue) will be reported to the FDA by the HRPPO as outlined in "when reporting to the FDA" (below).

3. The HRPPO files a copy of the notices, federal reports and reports of any final IRB actions in the IRB study file.

E. Suspension or Termination of Research – Reporting Procedure

1. HRPPO Staff reports determinations of suspension and termination via informal means and formal official notices
 - a. Informal notification is made via email or telephone, as necessary to satisfy specific local institutional requirements.
 - b. The HRPPO prepares official notification, a summary report of suspension and termination, within the timeframe required above. However, if the event is a more serious incident, this may mean reporting to appropriate federal agencies (e.g., OHRP) within days. In all cases, incident reporting will occur within the timeframe required above.
 - i. The HRPP Director or HRPP Associate Director, in consultation with the IRB Chair, approves the report, which the HRPPO sends to the PI with a copy to the appropriate federal agency, department chair, and appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children’s, Parkland, etc.)
 - ii. If the DHHS conducts or funds the research, the HRPPO sends the report to OHRP in accordance with current OHRP guidance on incident reporting http://www.hhs.gov/ohrp/policy/incidreport_ohrp.html.
 - iii. If an agency that is subject to the “Common Rule,” other than the DHHS, conducts or funds the research, the HRPPO sends the report to the agency as required by the agency and OHRP.
 - iv. For FDA-regulated research, any suspensions or terminations of IRB approval will be reported to the FDA by the HRPPO as outlined in "when reporting to the FDA" (below).
2. The report includes:
 - a. the title of the research protocol and/or grant proposal;
 - b. name of the PI on the protocol;
 - c. IRB number assigned to the research protocol;
 - d. the number of any applicable federal award(s) (grant, contract, or cooperative agreement);
 - e. the nature of the event; and
 - f. the findings of UTSW, IO, or the IRB;
 - g. actions taken by the PI, UTSW, IO, and/or the IRB to address the issue.

3. The HRPPO files a copy of the federal report(s) and any final IO or IRB actions in the IRB study file.
 4. All reports made by the HRPPO to federal agencies pertaining to suspensions or terminations of research will be made available to the convened IRBs.
- F. Determinations of the IRB/HRPPO – Reporting Procedure. Following review of the following items by either the HRPPO or IRB: initial review, continuing review, review of modifications to previously approved research, inactivation requests, response to IRB stipulations and administrative changes. HRPPO staff:
1. Draft convened IRB minutes. See IRB Minutes Policy and Procedures.
 2. Draft notification letters or emails for all levels of review – HRPPO, Expedited Review, Convened IRB review. These letters indicate the following actions:
 - a. Approved,
 - b. Conditionally Approved,
 - c. Deferred,
 - d. Disapproved, or
 - e. Inactivated
 3. Send the notification to the Principal Investigator and any officials at other institutions engaged in research for which the UTSW IRB is serving as the IRB of record (e.g., Children’s, Parkland, etc.). It is the PIs responsibility to report to any institutions where research activities are being performed and UTSW is not the reviewing IRB.
 - a. If conditionally approved, the notification details the reasons for conditional approval and actions necessary to resolve the non-substantive issues and that research may not start until receipt of final approval.
 - b. If deferred, the notification details the substantive reasons for deferral and actions necessary to resolve the substantive issues as well as detailing other non-substantive issues. Generally investigators are given the opportunity to respond to the IRB at a subsequent convened meeting of the same IRB panel if the PI disagrees with the actions outlined by the IRB.
 - c. If disapproved, the notification details the substantive reasons for disapproval and details other non-substantive issues. This notification includes a statement that provides the PI an opportunity to respond to the IRB decision in person or in writing.
 - d. The letter will include the following:
 - i. the title of the research protocol and/or grant proposal;
 - ii. name of the PI on the protocol;
 - iii. IRB number assigned to the research protocol;
 - iv. Expiration date (for initial and continuing review notifications)

- v. The grant/award number of any applicable federal award(s) (grant, contract, or cooperative agreement), if available;
 - vi. the findings of HRPPO or the IRB including:
 - 1. Date of approval
 - 2. Expedited review categories for new studies that were not reviewed by the convened IRB.
 - 3. Exempt review categories for new studies determined exempt from IRB review
 - 4. Determination of non-human research or non-regulated research for those studies determined not to meet the definition of human subjects' research.
 - 5. Approval of the inclusion of any vulnerable populations
 - 6. Approval of any waivers or alterations of informed consent or HIPAA authorizations.
 - e. Research proposals/activities that have been approved under an expedited review procedure (initial review, continuing review, modifications to existing studies and responses to contingencies for research which was conditionally approved) will be reported to the IRB within one month following the date the determinations were made. This report will contain the following information and will be organized according to the types of items reviewed:
 - i. eIRB tracking number (STU number);
 - ii. PI;
 - iii. Study/project title;
 - iv. Sites engaged in research;
 - v. IRB documents reviewed;
 - vi. Date of review;
 - vii. Description of the modification(s) to the study (if modification(s) requested).
- G. Pregnant Women, Fetuses, and Neonates – Reporting Procedure**
- 1. Upon receipt of an IRB application or request, HRPPO staff screen protocols for any inclusion of pregnant women, fetuses, or nonviable neonates, or neonates of uncertain viability in research submitted to or funded by the DHHS as part of Administrative/Regulatory Pre-review (See Receiving, Routing, and Administrative Review of Submissions Policy and Procedure).
 - 2. When required under this policy, HRPPO staff, with input from the IRB and the PI, prepares a report to the DHHS based on the current guidance from OHRP. The IRB, in consultation with the HRPP Director or HRPP Associate Director, approves the report, which HRPPO staff sends through the IO, with a copy to the PI and to OHRP per OHRP guidance following IRB approval of the report.

3. HRPPO staff file a copy of all correspondence in the IRB protocol file and database, if applicable.
4. If the OHRP disagrees with the IRB findings on the research involving pregnant women, fetuses, nonviable neonates, or neonates of uncertain viability, HRPPO staff present the information from OHRP to the IRB and the PI.

H. Prisoners – Reporting Procedure

1. Upon receipt of an IRB application or request, HRPPO staff screen protocols for any inclusion of prisoners in research submitted to or funded by DHHS as part of Administrative/Regulatory Pre-review (See Receiving, Routing, and Administrative Review of Submissions Policy and Procedure).
2. HRPPO staff notifies the PI of the State, County or DHHS reporting requirements.
3. With input from the IRB and the PI, for DHHS-funded research, HRPPO staff prepares a prisoner certification report certifying to OHRP that the duties of the IRB have been fulfilled to the DHHS based on the current guidance from OHRP on research which includes prisoners. The HRPP Director or HRPP Associate Director approves the report and HRPPO sends it through the IO to OHRP following approval of the report. HRPPO staff file a copy of all correspondence in the IRB protocol file.
4. If the OHRP disagrees with the UTSW IRB classification of the research involving prisoner(s), HRPPO staff present the information from OHRP to the IRB and the PI.

I. Children – Reporting Procedure

1. Upon receipt of an IRB application or request, HRPPO staff screen protocols for inclusion of children in research submitted to or funded by DHHS or the U.S. Department of Education; or regulated by FDA as part of Administrative/Regulatory Pre-review (See [1.1. RECEIVING, ROUTING, AND ADMINISTRATIVE REVIEW OF IRB SUBMISSIONS](#)).
2. The HRPPO staff, with input from the IRB and the PI, prepares a report summarizing the research that is not otherwise approvable but presents an opportunity to understand, prevent, or alleviate serious problems to the DHHS based on the current guidance from the applicable agency. The IRB, in consultation with the HRPP Director or HRPP Associate Director, approves the report and sends it through the IO with a copy to the PI. HRPPO staff forward the report to the institutional official of the applicable federal agency (e.g., Secretary of DHHS through OHRP, Secretary of U.S. Department of Education, or Commissioner of FDA) based on current guidance from the agency. The HRPPO staff place a copy of all correspondence in the IRB protocol file and database, if applicable.
3. If the applicable federal agency disagrees with the IRB findings on the research involving children, the HRPPO staff present the information from the agency to the IRB and the PI.

J. Changes in IRB Membership – Reporting Procedure

1. When a change in IRB membership occurs, HRPPO staff notifies OHRP. The HRPP Director, HRPP Associate Director or designee enters the required information regarding the changes in membership and submits the data to OHRP according to OHRP's policy

requirements following receipt of approval of the membership in accordance with IRB Membership Policy and Procedure

K. Certification of IRB Approval – Reporting Procedure

1. When a funding agency requires certification of IRB approval, the PI contacts the HRPPO to request that HRPPO staff prepare the certification document. The PI is responsible for requesting HRPPO documentation of IRB approval in accordance with the funding agency requirements.
2. The PI may provide HRPPO staff with a copy of the agency certification form. HRPPO staff prepares the required agency form(s) and obtain the signature of the UTSW authorized organizational representative for sponsored research, or authorized IRB member.
3. The HRPPO staff files a copy of the certification form in the IRB protocol file and forwards the original certification form to the investigator.
4. The PI transmits the certification of IRB approval to the funding agency within the time period specified by the agency and provides a copy to appropriate organizational representatives at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., the Sponsored Program Administration (SPA)).
5. To prepare a certification form for grants/contracts that fund more than one IRB protocol, the PI provides the HRPPO with a list of pertinent IRB protocol numbers. HRPPO staff verifies the IRB numbers and IRB approval prior to preparing and issuing the certification document. The PI transmits the certification to the agency and provides appropriate institutional officials at involved institutions (e.g., the Sponsored Program Administration (SPA)) with a copy.

L. Exception to Informed Consent in Planned Emergency Research – Reporting Procedure

1. When the IRB approves an exception from the general informed consent requirements for planned emergency research under FDA and DHHS regulations, the PI provides the sponsor with a copy of the information publicly disclosed prior to the initiation and at the completion of the study. The PI is responsible for maintaining a copy of the report.
2. If the IRB does not approve a request for exception to informed consent for planned emergency research under FDA and DHHS regulations, the HRPPO staff, with input from the IRB, prepares a report of the reasons why the IRB did not approve the exception. The IRB Chair, in consultation with the HRPP Director or HRPP Associate Director, approves the report. The HRPPO staff submits the report to the sponsor and the PI.
3. When the IRB approves an exception from the general informed consent requirements for planned emergency research under DHHS regulations and not under FDA regulations (21 CFR part 50), the HRPPO provides the Office for Human Research Protections (OHRP) with a report that the conditions of approval have been met in accordance with the HHS Secretarial waiver under (45 CFR 46.101(i) that permits a waiver of the general requirements for obtaining informed consent in a limited class of research in emergency settings [Federal Register: Oct 2, 1996 (Vol. 61, Num. 192)].
4. HRPPO staff file a copy of the reports in the IRB files.

5. Agency-Requested Reports

- a. A federal agency may periodically ask the IRB or the UTSW for a specific report on a variety of issues (e.g., alleged noncompliance submitted to a federal agency). The HRPP Director or designee will review the request and designate an HRPPO staff member to assist the IRB/UTSW with preparation of the report
- b. The designated HRPPO staff member prepares the report in accordance with the agency's request relative to content and timing.
- c. The HRPP Director or HRPP Associate Director approves the report. The HRPP Director, HRPP Associate Director and/or IRB Chair or IO determines who receives a copy of the report depending on the nature of the request.

M. Procedure for Determining Which UTSW Officials Will Receive Copy of IRB Reports

1. The HRPP Director or designee recommends the UTSW and affiliated institutional officials or offices that should be included in reporting notifications to a federal agency for any of the federally mandated reports contained in this policy. The IO makes the final determination on a case-by-case basis. The determination is in accordance with applicable federal requirements and in accordance with the policies outlined in the applicable institutional policies and memorandums of understanding/agreement (e.g., Parkland)
2. Appropriate institutional officials then disseminate as needed within their organization and gather any additional institutional requirements and forward any such requirements to the PI to be incorporated into the action plan if necessary
3. Examples of organizational representatives who may receive copies of a report include, but are not limited to, the following:
 - a. Institutional Official;
 - b. Dean of a University School;
 - c. Associate Dean;
 - d. Department or Division Chair;
 - e. Legal Counsel;
 - f. Assistant Vice President of Sponsored Programs Administration;
 - g. Privacy Officer;
 - h. Compliance Officer;
 - i. Other appropriate institutional officials at involved institutions for which the UTSW IRB is serving as the IRB of record (e.g., Children's, Parkland, etc.)

N. When reporting to the FDA:

1. For suspensions or terminations of IRB approval, include the IND or IDE number, the full name of the research protocol, the name(s) of the clinical investigators, and the reason(s) for the suspension or termination.

2. These reports may be submitted via e-mail or in hard copy by FAX or mail. Information will be submitted to the following locations/contacts:
3. Report suspension or termination of IRB approval; serious or continuing noncompliance with the regulations or the requirements or determinations of the IRB; or internal unanticipated problems involving risks to human subjects (if not already reported by PI) to appropriate officials.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Updated reference to AAHRPP accreditation
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM POLICY AND PROCEDURE

8.3 RECORDKEEPING

RESPONSIBLE OFFICE: Human Research Protections Program Office (HRPPO)

EFFECTIVE DATE JULY 1, 2018

I. POLICY RATIONALE AND TEXT

- A. This policy describes documentation requirements, storage and maintenance of records for the Human Research Protection Program Office HRPPO.
- B. The HRPPO maintains a physical and electronic filing system (hybrid) for protocol and other IRB records.

II. SCOPE

- A. This policy and procedures applies to HRPPO who maintains IRB records in accordance with applicable federal, state and local regulations with regard to access, storage and retention.

III. PROCEDURES FOR POLICY IMPLEMENTATION

A. Access to Records

- 1. The HRPPO secures all paper and electronic IRB records and limits access to the IRB Chair, IRB members, HRPP Director or designee, HRPPO staff, Institutional Official (IO), and other authorized affiliated institution representatives, and officials of federal and state regulatory agencies, the Office for Human Research Protections (OHRP), the Food and Drug Administration (FDA), and accrediting bodies. IRB records are accessible for inspection and copying by authorized representatives of federal agencies or departments in reasonable times and in a reasonable manner.
 - a. HRPPO staff may grant other UTSW employees access to the records on an as-needed basis for official UTSW business. Investigators or their authorized study personnel have reasonable access to files related to their research activities. HRPPO staff limits all other access to IRB records to those who have legitimate need for them, as determined by the HRPP Director or designee, and/or when submitted through state open records statutes UTSW Legal Counsel).
 - b. Individual permissions to access electronic files are submitted to Academic Information Systems (AIS)
 - c. Individuals with access to electronic HRPP files will submit a signed Acknowledgement of Confidentiality Policy Related to Human Research to the HRPPO
- 2. Access Security
 - a. The electronic IRB system is a closed, centrally managed system that utilizes unique user IDs, passwords, and system authentication. Additionally, the electronic IRB system utilizes role-based access to authorized users only and maintains an activity history and audit trail.

- b. When the HRPPO receives a request for IRB records, HRPPO staff checks to see whether the request is from a PI or his/her authorized personnel. If the person requesting the record is listed as study personnel contact on the record requested, the HRPPO staff may copy record for that person to pick up or may fax, mail, or e-mail the pertinent parts of the record.
- c. If the individual requests a substantial amount of material, HRPPO staff allows access to the record and a scanner or computer in the HRPPO for use by the person requesting the material.
 - i. If the person requesting the record is not listed as study personnel on the record requested, the HRPP Director or designee makes a determination before releasing any records as to whether the request is from appropriate accreditation bodies, institutional officials, administrators, or regulatory agencies that should have access. Unless the individual states a reason for not informing the PI of the request for a record, HRPPO staff informs the PI that HRPPO has received a request for access to the applicable protocol.

B. Storage of protocol records

1. At the time of conversion in May 2010 the legacy IRB number was recorded in the electronic system for historical purposes. The active protocol legacy paper records for each protocol prior to electronic conversion are maintained in secure but physically accessible access restricted storage until the study is closed in the electronic system. These records are stored at the Bass Center Storage, level D.
2. Records must be identifiable, concise, accurate, timely, complete, relevant, organized and secured.
3. Records should not be corrected after they are written. If modification is necessary because of error, the original must be legible, the reasons for the modification should be clear and the modification must be signed/initialed and dated as appropriate by the person who made the correction. (Substantive changes must be communicated to the IRB and the PI.)
4. The official protocol record as of May 1, 2010 is the electronic file. Prior to that date, the paper record is the official record and the electronic files represent a hybrid shadow file plus current status. The paper record for electronically converted legacy protocols should not be the sole reference.
5. The electronic IRB system has a server-based filing system that allows electronic storage of individual protocol documents.
6. The electronic files are secured, maintained and backed up by Academic Information Systems (AIS)
7. The records must be identifiable by using the PI name and the IRB tracking number
8. The records must be concise, by containing all essential information and when possible, avoiding duplication of documents

9. The records must be accurate, by ensuring all applicable information is located within the documents and all items are verifiable
10. The records must be timely, by being completed and filed in an appropriate time frame
11. The records must be complete, by all applicable documentation within the files. The following documents will be filed in the IRB record (paper and/or electronic record):
 - a. Protocol Files
 - i. The protocol and any request to revise or amend the protocol;
 - ii. Any scientific evaluations provided to the IRB;
 - iii. Consent documents including DHHS-approved sample consent documents (as applicable);
 - iv. Progress reports and records of continuing review activities (including DSMB report summaries);
 - v. Reports of unanticipated problems (e.g., unexpected serious adverse events that are possibly related to the research or other injuries that meet the UPIRSO criteria);
 - vi. All correspondence between the IRB and investigators;
 - vii. Significant correspondence between the HRPPO and investigators;
 - viii. All correspondence between the IRB and institutional officials;
 - ix. Statements of significant new findings provided to participants;
 - x. Reports of noncompliance;
 - xi. Complaints;
 - xii. Requests to inactivate IRB approval (Notice of Study Closure);
 - xiii. Notices or approval letters from other committees (e.g., Radiation Safety Committee);
 - xiv. Drug or device information (including Investigator's Brochures, as applicable)
 - xv. Recruitment materials
 - b. Other HRPPO Records – In addition to protocol files, the HRPPO maintains the following information and records: HRPPO staff organizes and stores records in files or binders or in electronic documents as appropriate, which include, but are not limited to, the following categories:
 - i. Policies and procedures
 - ii. IRB membership rosters (including resumes or CVs for each member)
 - iii. Documentation of IRB Actions (See [8.1 IRB MINUTES](#))
 - iv. Federalwide Assurance

- v. Memorandums of Understanding where applicable, with Affiliated Institutions (e.g., Parkland, Children's, etc.)
- vi. Other IRB correspondence
- vii. Alleged noncompliance case records
- viii. Federally mandated reports and, where responses to those reports require IRB review for potential determinations, results of review of such responses by the convened IRB
- ix. Electronic records documenting completion of mandatory IRB training for study personnel, IRB members, and HRPPO staff
- x. Communications to and from the IRB
- xi. Budget/Accounting information for the department of the HRPP
- xii. The records must be relevant, by including only information needed
- xiii. The records must be organized, by filing documents within the appropriate categories

C. Retention

1. The HRPPO retains all records (with or without participant enrollment) for six years after closure or cancellation, which is sufficient to meet federal, state, and local regulations, sponsor requirements, and organizational policies and procedures
2. Physical Files
 - a. Quarterly, physical files of inactivated protocols are sent to the University X-Building for long term storage
 - b. The files to be archived are logged into an electronic database (which tracks the box number for each file) and the boxes containing the files are sealed.
 - c. A request to store the files is generated with a destruction date (six years after the inactivation date of the last study in the box which was inactivated).
 - d. The request is sent to the X-Building, whose staff transports the files and stores them.
 - e. Files are destroyed after 6 years per the request of the HRPPO. Destruction eligibility is confirmed by HRPPO and communicated to the X-Building caretaker who then proceeds with the destruction.
3. Electronic Files
 - a. Electronic files of inactivated protocols are stored indefinitely in the electronic system. The electronic system study status will display "closed."
 - b. The electronic record remains intact in the "closed" state and viewable to authorized individuals as described above.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
July 2018	HRPP	Reference changed to RSO from SHUR
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

9.1 COMPLAINTS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: July 1, 2018

I. POLICY STATEMENT

- A. The purpose of this policy and procedure is to document the responsibilities of the Human Research Protection Program Office (HRPPO), the Institutional Official, the convened IRBs, principal investigators and UT Southwestern employees for handling complaints regarding research.
- B. Complaints that are reported are considered sensitive issues and the relative information and identities of individuals named in a complaint will be handled appropriately until a final determination is made by the appropriate reviewer.
- C. Complaints that may indicate that a research subject's rights, safety or welfare may have been or were at risk of being adversely affected shall be promptly reported to the HRPP Office and are forwarded to the convened IRB if substantiated.
- D. Complaints that are substantiated may be further investigated through a directed compliance review, and actions will be taken as deemed appropriate by the IRB.
- E. A complaint that is determined to also involve serious and/or continuing noncompliance, or an unanticipated problem involving risk to subjects or others (UPIRSO) must be promptly reported to the appropriate institutional officials, the Office for Human Research Protections (OHRP) and the Food and Drug Administration (if applicable) following applicable policy.

II. SCOPE

- A. This policy and procedure applies to all complaints regarding human subjects' research conducted under the jurisdiction of UT Southwestern HRPP.
- B. Summary of responsibilities include:
 - 1. Investigators are responsible for addressing all complaints they receive. Investigators should attempt to find a suitable resolution and respond to the complainant in a timely manner.
 - 2. The Office of the IRB staff is responsible for documenting any complaints that are received and promptly forwarding the information to the HRPP Director, IRB Chair or designee.
 - 3. The Office of Compliance is responsible for reporting complaints identified during compliance reviews or human research concerns from the hotline.
 - 4. Other institutional committees and offices that oversee research activities are responsible for reporting complaints (further details are provided in the [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#)).

5. HRPP Director, Chair or designee is responsible for reviewing any complaint, collecting necessary information and resolving the issue, if possible, or forwarding the complaint for review by the convened IRB.
6. The IRB reviews complaints and determines whether the complaint is justified and recommends appropriate action.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. This procedure starts upon initial notification of a complaint. Complaints may be identified in a number of ways including the following:
 1. A complaint by an individual can be made directly to the HRPP Office,
 2. The IRB may learn of a complaint through its continuing review of ongoing research
 3. During compliance reviews (audits) conducted by the Office of Compliance or one of the UT Southwestern affiliated institutional compliance offices
 4. A complaint by an individual can be made directly to the Office of Compliance (Hotline)
 5. A complaint by or to another committee, department or official
 6. A complaint from the study sponsor's monitoring entity
- B. This procedure ends when a final determination is made by the IRB or appropriate reviewer and final determination has been communicated to the Principal Investigator.
 - A. Receipt and Screening of Complaints
 - a. The Principal Investigator (PI) is responsible for reviewing all complaints from research participants or others associated with the participant (i.e., family, care givers). The PI will attempt to resolve the complaint and will respond to the complainant in a timely manner
 2. All complaints are summarized in the next progress report submitted as part of continuation review or in the final report submitted to inactivate the study
 - a. Complaints that may indicate that a research subject's rights, safety or welfare may have been or were at risk of being adversely affected shall be promptly reported to the IRB (see [9.2 UPIRSO and UADE](#) and [9.3 NONCOMPLIANCE REVIEW](#)).
 3. Complaints from research participants or family members of research participants, members of the research team, or individuals not otherwise affiliated with the institution are accepted as verbal reports; however, persons recording a complaint are encouraged to provide their concerns in writing.
 4. The HRPP Director (HRPPD) and Associate Director (HRPPAD) are designated as the administrative reviewers for this process. Given their positions in the HRPP Office, these individuals are readily available to promptly review complaints. The reviewers are expected to communicate with the appropriate IRB Chair. The reviewers screen the complaint to determine whether the protocol has issues pertinent to other research review offices or committees, i.e., Institutional Research Offices at affiliate hospitals, the Protocol Review Monitoring Committee (PRMC), Institutional Biosafety Committee (IBC),

Radiation Safety Office (RSO), Sponsored Programs Administration (SPA), Conflict of Interest Committee (COIC) and other affiliated groups. If it is determined that the complaint is pertinent to other research review entities, appropriate coordination will be planned (see [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#)).

- B. Review of a Complaint. The HRPPD or HRPPAD reviews all complaints to determine whether they can be resolved or whether further inquiry is necessary
1. If the reviewer is able to resolve the complaint, the reviewer may:
 - a) decide to take no action, or
 - b) communicate the complaint to the principal investigator to develop an appropriate response or corrective action
 2. If the reviewer determines further inquiry is necessary, the reviewer may:
 - a) require the PI to submit documentation following the applicable policy (if the complaint involves possible noncompliance or unanticipated problems)
 - b) Otherwise, the reviewer will continue to collect information related to the complaint to determine whether the issue should be forwarded to the convened IRB. The reviewer:
 - (1) will initiate data gathering, interview, and summary report with opportunity to comment, as applicable;
 - (2) may request a compliance review (audit) be conducted by the Office of Compliance or one of UT Southwestern affiliated institutional compliance offices;
 - (3) communicate with the IRB Chair and request assistance from the Board members as needed;
 - (4) will communicate (by email, or letter, contact may be made by phone but will be followed up with an email or letter) the decision to take further action in writing to the complainant (if the identity of the person is known) and to the PI of the research against whom the complaint was made or from whom the report was received. If the complaint involves a co-investigator or a research assistant, these individuals may also be notified in writing.
 3. If the complaint involves allegations of research misconduct defined as fabrication, falsification, plagiarism in proposing, performing, or reviewing research, or in reporting research results, the Designated Reviewer notifies the Institutional Official.

4. If the complaint suggests that a research subject's rights, safety or welfare may have been or were at risk of being adversely affected
 - a) The reviewer advises the convened IRB regarding the applicable institutional policy and federal regulations, assists the IRB in documenting the review, answers questions about the review process, maintains the records as required by state and federal laws, and serves as a liaison with the funding agency or agencies.
 - b) The IRB reviews the material presented by the reviewer at a convened meeting at which a quorum is present. The convened IRB determines whether to request additional information or whether to interview additional persons of interest. The IRB may give the respondent the opportunity to meet with the convened IRB before it takes final action.

C. Review Outcomes and IRB Actions

1. The convened IRB makes the final determination whether the research subject's rights, safety or welfare may have been or were at risk of being adversely affected, and if so, the IRB, with the assistance of the HRPPO, reports the incident(s) to the applicable agency following procedures outlined in [8.2 REPORTING POLICY AND PROCEDURE](#).
2. The convened IRB may take a variety of actions, depending on the outcome of the review, including, but not limited to, the following:
 - a) No action
 - b) Approve continuation of research without changes with a cautionary reminder to the PI. If the event is a UPIRSO/UADE, this will include clarification to the PI explaining why no changes are necessary;
 - c) Require formal educational intervention;
 - d) Require minor or major changes in the research procedures and /or consent documents;
 - e) Modify the current approval period;
 - f) Require monitoring of research;
 - g) Require monitoring of the consent process;
 - h) Require audits of other active protocols of the individual(s) involved;
 - i) Recommend disqualification of the individual(s) from conducting research involving human subjects at the institution;

- j) Determine that the data collected cannot be used for publication;
 - k) Require that subjects previously enrolled in the study be contacted and provided with additional information and/or re-consented;
 - l) Request that publishers and editors be informed if manuscripts emanating from the research have been submitted or published;
 - m) Recommend to the appropriate officials of the institutions engaged in the research that further administrative or disciplinary action be taken.
3. The IRB considers Suspension, Termination, notification of participants and/or modification to the study procedures/protocol if the complaint results in a determination of serious and/or continuing noncompliance (See [9.3 NONCOMPLIANCE REVIEW](#) and [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#)).
 4. The HRPPO will communicate (see [8.2 REPORTING POLICY AND PROCEDURE](#)) the IRB decision in writing to the PI of the research against whom the complaint was made or from whom the report was received. If the complaint involves a co-investigator or a research assistant, these individuals may also be notified in writing.
 5. The HRPPO communicates as with other institutions and offices following the guidance provided in the [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#).
 6. The HRPPD or HRPPAD may communicate (by email, or letter, contact may be made by phone but will be followed up with an email or letter) the IRB decision to the person(s) who submitted the complaint, if appropriate and if the identity of the person is known.
 7. The IRB resolves questions or concerns raised by the individuals involved regarding the outcome of a specific IRB complaint review through direct communication with the individual.
 8. Appeals
 - a) If the PI or complainant disagrees with the IRB's decision, the individual(s) submits response to IRB concerns in writing within thirty days of the date the IRB issues the final decision. The IRB limits concerns to a review of the procedures employed to reach the decision (i.e., claims that the process was faulty in a way that creates a considerable risk that the outcome was incorrect) or grievances of sanctions imposed. The PI specifies the nature of any claimed procedural error or the perceived unfairness of sanctions issued.
 - b) The HRPPD or HRPPAD review the response and determine whether the concern is valid and attempt to resolve the issue with the individual. If unable to resolve the concern, the issue will be processed as a new complaint.

- c) If the IRB votes to uphold its original decision once an appeal has been processed through the complaints process the decision may not be appealed again. Nor may it be reversed by any administrator, other officer or agent of UT Southwestern Medical Center, state government or Federal government.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
July 2018	HRPP	Revision to RSO (dissolved SHUR)
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

9.2 UNANTICIPATED PROBLEMS INVOLVING RISK TO SUBJECTS OR OTHERS (UPIRSO) AND UNANTICIPATED ADVERSE DEVICE EFFECTS (UADE)

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

I. POLICY STATEMENT

- A. Prompt reporting to the reviewing IRB (and UTSW HRPP for reliance studies) is required for any unanticipated problems involving risks to subjects or others (UPIRSO) or unanticipated adverse device effects (UADE). For the purposes of this policy, UPIRSOs include UADEs and death or serious injury related to a HUD unless otherwise specified.
- B. Adverse events and UPIRSOs are also summarized in the study progress report submitted during continuing review.
- C. Investigators must report a UADE to the sponsor and reviewing IRB (and UTSW HRPP for reliance studies) within 10 working days after first learning of the UADE.
- D. Sponsor-investigators must report the results of an evaluation of a UADE to FDA and all reviewing IRBs (and UTSW HRPP for reliance studies) and participating investigators within 10 working days after first receiving notice of the UADE.
- E. In addition to prompt UADE reporting, investigators or sponsors are required to report all UADEs to the reviewing IRB (and UTSW HRPP for reliance studies) after evaluation by the sponsor. This requirement is in addition to required UADE reporting.
- F. Investigators must terminate all investigations or parts of investigations as soon as possible when an UADE presents unreasonable risk to subjects and the investigator shall report such a risk (as a UPIRSO) to the IRB.
 - a. In addition, termination must occur not later than 5 working days after a sponsor makes this determination and not later than 15 working days after the sponsor first received notice of the effect.
 - b. An investigator may not resume a terminated investigation without FDA and IRB approval.
- G. Investigators are required to follow-up on all reports until issues are considered resolved.

II. SCOPE

- A. This policy and procedures applies to all Principal Investigators involved with human research.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. This procedure starts upon the investigator becoming aware of an adverse event or other non-AE unanticipated problem (e.g., UPIRSO or UADE).
- B. This procedure ends when either the:
 - 1. PI determines the event does not meet criteria of either a UPIRSO or UADE, or;
 - 2. HRPPO notifies the investigator that the:

- a) Report of an apparent UPIRSO was determined not to meet UPIRSO criteria;, or
 - b) Report of an apparent UADE was determined not to meet UADE criteria; or
 - c) IRB or IO agreed that the event was either a UPIRSO or UADE, the appropriate actions have been completed, and the issue has been resolved.
- C. The Principal Investigator is responsible for:
- 1. **Reviewing** all incidents, experiences, and outcomes that may represent UPIRSO or UADE:
 - 2. **Determining** whether any reviewed incidents, experiences, and outcomes represents a possible UPIRSO or UADE
 - 3. Promptly reporting all possible UPIRSOs and UADEs to the reviewing IRB (and UTSW HRPP for reliance studies) using the Reportable Event Smart Form in eIRB
 - a) Prompt reporting timeframe - report is made to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 business days for the following:
 - a) UPIRSOs based on internal information (e.g., experienced by subjects enrolled by the investigator(s) at an institution affiliated with the UT Southwestern IRB)
 - b) UPIRSOs based on external information (e.g., experienced by subjects enrolled by the investigator(s) at an institution not affiliated with the UT Southwestern IRB)
 - c) UPIRSOs based on internal information that are either life threatening or fatal (if the study is sponsored by the National Cancer Institutes, the shortened reporting timeframe is only applicable to UPIRSOs based on internal adverse events that are “fatal toxicities”)
 - 4. **Contacting institutions** involved with the UPIRSO/UADE for recommendations or additional requirements to secure continued institutional approval of the research;
 - 5. **Implementing actions necessary to eliminate immediate hazard**, (if necessary, without IRB approval). Report any actions to eliminate an immediate hazard with the Reportable Event Smart Form in eIRB. Immediate actions that will also result in permanent modification to the research plan must be submitted for IRB approval using an amendment request;
 - 6. **Submitting follow-up reports** to update the information related to the event to the reviewing IRB (and UTSW HRPP for reliance studies). Follow-up reports (to correct/clarify/reassess/ or report resolution) should be submitted within approximately 30 days of receipt of request for further information/corrections or of the date the PI makes a reassessment or an action plan is fully implemented. Follow-up reports should clarify whether previous determinations made by the investigator and recorded on the initial report form have changed. In the situation where new information may affect the answers to the items on the report form, the investigator should revise the report form and address each item in the order they appear on the form;
 - 7. **Submitting modification(s)** to the reviewing IRB (and UTSW HRPP for reliance studies), as necessary, to report any actions taken without prior IRB approval to eliminate an immediate hazard and to modify the research (e.g., protocol, consent form, or consent process)

regardless of the source of the request for changes (i.e., external sponsor, affiliated institution, etc.).

- B. All of the above actions must be taken and are ultimately the responsibility of the PI, regardless of who observed or became aware of the event.
 - 1. In the absence of the PI, a co-investigator can fulfill these requirements to meet the reporting timeline.
 - 2. In the absence of either the PI or a co-investigator, a sub-investigator, coordinator, or any member of the research team must contact the HRPPO for direction.
 - 3. In instances where a student (graduate or undergraduate) suspects an unanticipated problem or serious adverse event, it is expected that the faculty advisor will be immediately made aware of any suspicious event that occurs during the study. After consultation with the HRPPO, a determination should be made as to prompt reporting to the IRB.
 - 4. In all instances, the report must state that the reporting individual has notified or will notify the PI. If the PI has been notified, the report must include a description of the PI's analysis as well. If the PI cannot be notified prior to submission of the report, a follow-up report must be submitted identifying how and when the PI was made aware of the issue and the result of analysis by the PI.
- C. In multi-site trials, one site may also take on reporting responsibilities. Local investigators at those sites would report UPIRSOs to their reviewing IRB (and UTSW HRPP for reliance studies) and to the Study Coordinating Center. The coordinating site must then also report to other participating sites, who will then report to their respective IRBs. The coordinating center will also report to FDA/OHRP as applicable.
- D. The HRPP Office is responsible for:
 - 1. Receiving the Reportable Event.
 - 2. Sending a summary of the initial report to the offices/officials as described in the [8.2 REPORTING POLICY AND PROCEDURE](#).
 - 3. Routing the report to the designated reviewer
- E. Designated Reviewer is responsible for:
 - 1. Screening Reports of Possible UPIRSO
 - a) The HRPP Director (HRPPD), HRPP Associate Director (HRPPAD), or designee are designated reviewers for this process. Given their positions in the HRPP Office, these individuals are readily available to promptly review these reports and are expected to communicate with the appropriate IRB Chair, as necessary. The reviewers screen the report to determine whether they represent an apparent UPIRSO and determine whether it involves other research review offices or committees (e.g., Office of Compliance, Privacy Office, and other affiliated groups).

- b) If it is determined that the issues are pertinent to other research review entities, appropriate coordination will occur as specified in [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#).
 - c) The reviewer utilizes the following items when reviewing the report
 - (1) Telephonic information
 - (2) Memos
 - (3) Amendments
 - (4) Progress Reports
 - (5) Reportable Event Smart Form in eIRB
 - d) The reviewer determines whether the report should be reviewed as an initial report of possible UPIRSO/UADE or as a follow-up to a previously reported possible UPIRSO/UADE.
2. Determining whether an Event meets Apparent UPIRSO or UADE criteria
- a) The HRPPD, HRPPAD, or designee reviews the report and makes one of three possible decisions:
 - (1) The event or events **meet UPIRSO criteria** (i.e., finds no supporting documents or statements that contradict the defined criteria or indicate information is inadequate to determine whether any of the criteria are met). The reviewer:
 - (a) Considers whether the action plan provided in the report is adequate regarding:
 - (i) Actions taken to eliminate an immediate hazard without prior IRB approval including
 - (a) PI or sponsor decision to halt all or part of the study
 - (b) PI or sponsor decision to halt enrollment
 - (c) Notification of currently enrolled or completed subjects
 - (ii) Other Actions taken or planned by the PI
 - (a) Changes to the consent form or process (plan for re-consenting if applicable)
 - (b) Changes to the protocol (additional monitoring, changes in the DSMP, additional safeguards)
 - (c) Notification of other agencies/appropriate institutional officials (e.g., FDA, HHS, DoD).
 - (b) Considers whether additional actions or safeguards should be taken by the investigator(s), sponsor, study coordinating center, or DSMB/DMC to protect subjects so that the study still satisfies the requirements for continued approval by the IRB.

- (c) Considers whether the affected research protocol still satisfies the requirements for IRB approval under [6.2 IRB APPROVAL OF RESEARCH](#) and HHS regulations at 45 CFR 46.111. In particular, the reviewer considers whether risks to subjects continue to be minimized; whether risks continue to be reasonable in relation to the anticipated benefits to the subjects; and whether the risks are reasonable in relation to the importance of the knowledge that may reasonably be expected to result.
 - (d) Initiates [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#) if the reviewer determines the report indicates the affected research protocol no longer satisfies the requirements for IRB approval under [6.2 IRB APPROVAL OF RESEARCH](#) and HHS regulations at 45 CFR 46.111.
 - (e) Places the issue on the agenda for review by the convened IRB. The IRB is provided with a copy of the Reportable Event as well as the reviewer's recommendations concerning the PI's plan for managing the UPIRSO prior to the meeting. (See [1.1. RECEIVING, ROUTING, AND ADMINISTRATIVE REVIEW OF IRB SUBMISSIONS](#))
- (2) There is **insufficient information** to determine an event is either a UPIRSO or UADE. In this case the investigator/coordinator is contacted to provide additional details or clarify the information provided. If no further information is available and there continues to be insufficient information to determine that the event meets the criteria, it will not be classified as a UPIRSO or UADE.
 - (3) The event **does not constitute** a UPIRSO/UADE. The decision will be communicated in writing to the PI describing the reasons why the report did not meet the criteria for either a UPIRSO or UADE. The PI will be given the opportunity to provide additional justification if necessary.
- 3. Reviewing the report to consider whether the UPIRSO or UADE also represents Serious or Continuing Noncompliance (See [9.3 NONCOMPLIANCE REVIEW](#))
 - 4. Considers sending the report to a subcommittee for further inquiry (as described in the [9.3 NONCOMPLIANCE REVIEW](#)).
- F. Responsibilities of Institutional officials (UTSW or Affiliates) who are notified of the event (See [8.2 REPORTING POLICY AND PROCEDURE](#)) include:
- 1. Reviewing the notices of UPIRSO / UADE;
 - 2. Communicating with other institutional officials, as appropriate;
 - 3. Communicating with the PI to convey any additional institutional requirements necessary to resolve the event (specifying which requirements represent conditions of continued approval to conduct research at that institution and which only represent suggestions).

G. IRB responsibilities:

1. The convened IRB considers the initial reviewer's or subcommittee's recommendation(s) and suggested management plan, determines whether the event meets criteria as an UPIRSO or UADE, and determines whether they concur with the suggested management plan.
 - a) The IRB will receive access to the same items the designated reviewer reviewed as well as any notes from the designated reviewer and the entire protocol (if necessary).
 - b) In making this determination the IRB considers whether the action plan provided in the report is adequate regarding:
 - (1) Actions taken to eliminate an immediate hazard without prior IRB approval including
 - (a) PI or sponsor decision to halt all or part of the study
 - (b) PI or sponsor decision to halt enrollment,
 - (c) Notification of currently enrolled or completed subjects
 - (2) Other Actions
 - (a) Changes to the consent form or process (plan for re-consenting if applicable)
 - (b) Changes to the protocol (additional monitoring, changes in the DSMP, additional safeguards)
 - (c) Notification of other agencies/appropriate institutional officials (e.g., FDA, HHS, DoD).
 - (3) Other actions as deemed appropriate.
 - (4) Considers whether additional actions or safeguards should be taken by the investigator(s), the sponsor, the study coordinating center, or DSMB/DMC to protect subjects so that the study still satisfies the requirements for continued approval by the IRB.
2. The convened IRB considers whether the affected research protocol still satisfies the requirements for IRB approval under [6.2 IRB APPROVAL OF RESEARCH](#) and HHS regulations at 45 CFR 46.111. In particular, the reviewer considers whether risks to subjects continue to be minimized; whether risks continue to be reasonable in relation to the anticipated benefits to the subjects; and whether the risks are reasonable in relation to the importance of the knowledge that may reasonably be expected to result.
3. The convened IRB initiates [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#) if the Board determines the report indicates the affected research protocol no longer satisfies the requirements for IRB approval under [6.2 IRB APPROVAL OF RESEARCH](#) and HHS regulations at 45 CFR 46.111.
4. The convened IRB may take a variety of additional actions, depending on the outcome of the review, including, but not limited to, the list of actions outlined in [9.1 COMPLAINTS](#).

- H. The Human Research Protection Program Office is responsible for reporting determinations made by designated reviewers and those made by the convened IRBs as noted in the [8.2 REPORTING POLICY AND PROCEDURE](#).
- I. Determinations concerning follow-up reports
 - 1. Reports submitted as Follow-up reports may be considered new initial reports if new information warrants (e.g., new risk, risk changed category from Non-AE to AE or an AE UPIRSO with “greater risk” was changed to “serious”). Such reports will be processed as a new UPIRSO/UADE report as described above.
 - 2. Reports will be considered “follow-up” reports if submitted:
 - a) To identify how and when a PI was notified of a report submitted by another member of the research team so long as the PI did not disagree with the analysis in a manner that requires IRB review
 - b) To file the corrected report in the protocol record.
 - c) In response to request for further input from the appropriate UT Southwestern officials, the IRB or the Reviewer.
 - d) To report on actions taken by PI and research staff in response to event
 - e) To report implementation of action plan
 - f) To report on completion of action plan
 - g) To report additional action requirements of affiliated institutions.
 - 3. Follow up reports will be processed in the same manner as other Responsive Materials as described in [2.1. INITIAL REVIEW OF RESEARCH](#).
 - 4. A final follow-up notice to involved institutions of internal (or external) UPIRSO determination” will be sent as described in [8.2 REPORTING POLICY AND PROCEDURE](#).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

21 CFR 50 – [PROTECTION OF HUMAN SUBJECTS](#)

45 CFR 46 – [PROTECTION OF HUMAN SUBJECTS](#)

45 CFR 164 – [SECURITY AND PRIVACY \(HIPAA PRIVACY RULE\)](#)

21 CFR 56 – [INSTITUTIONAL REVIEW BOARDS](#)

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Expanded UADE, clarified review for external IRB studies, changed possible to apparent.
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
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214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

9.3 NONCOMPLIANCE REVIEW

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

I. POLICY STATEMENT

- A. This policy outlines responsibilities for managing issues of noncompliance with human subjects regulations or IRB requirements or determinations.
- B. Noncompliance with the regulations, institutional human research policies, or with the requirements or determinations of the Institutional Review Board (IRB) must be reported to the UTSW IRB (or HRPP for reliance studies) (See [9.5 REPORTABLE EVENTS GUIDANCE](#) for UT Southwestern reporting requirements).
- C. Issues or events that are reported are considered apparent noncompliance until a final determination is made by the convened IRB, Institutional Official (IO), or designated HRPP reviewer.
- D. Noncompliance that is determined to be serious or continuing must be promptly reported by the IRB or IO to the appropriate institutional officials, Federal Funding Agencies (if applicable), and the U.S. Food and Drug Administration (FDA) (if applicable).
- E. Results of any internal or external audits that identify issues that appear to constitute serious or continuing noncompliance must be promptly reported to the reviewing IRB (and UTSW HRPP for reliance studies) according to [9.5 REPORTABLE EVENTS GUIDANCE](#).
- F. Noncompliance (e.g., deviation) that does not meet the UTSW definition of either [serious noncompliance](#) or continuing noncompliance does not require prompt reporting to the IRB (or UTSW HRPP for reliance studies). Instead, these events should be reported at continuing review or notice of study closure, whichever comes first. Although, when patterns emerge, these patterns may appear to constitute continuing noncompliance, which may or may not also be serious noncompliance, and therefore may require prompt reporting.
- G. If the noncompliance issue also involves an unanticipated problem involving risks to subjects or others (UPIRSO), investigators and research staff are responsible for taking appropriate action to protect the rights, safety, and welfare of subjects or others. The IRB will review such events according to [9.2 UPIRSO and UADE](#).

II. SCOPE

- A. This policy and procedures applies to the following:
 - 1. **Investigators and research staff** who are responsible for promptly reporting apparent serious and continuing noncompliance to the reviewing IRB (and UTSW HRPP for reliance studies).
 - 2. **The HRPPO staff, IRB Chair, or designated HRPP reviewer** who are responsible for initially reviewing allegations of apparent serious or continuing noncompliance and taking appropriate action (including no action).

3. **The Office of Compliance** (at UTSW or its affiliates) who are responsible for reporting to the HRPP: 1) results of compliance reviews, 2) concerns from any other source, such as audits, that may indicate noncompliance, or 3) any complaint, concern, comment, or question that may indicate noncompliance.
4. **Members of the UTSW Institutional Review Boards or Institutional Official (IO)** who are responsible for reviewing apparent serious and continuing noncompliance and making determinations regarding corrective action plans.
5. **The HRPPO** staff who are responsible for documenting the process to include communications, determinations, reporting, and actions taken.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. For the purpose of this policy, all sources of apparent noncompliance will be referred to as allegations until a determination is made by the IRB, IO, or designated HRPP reviewer.
- B. Identifying Noncompliance. Noncompliance may be identified in a number of ways, including, for example:
 - a) A report by an individual can be made directly to the HRPPO.
 - b) Through IRB continuing reviews of ongoing research.
 - c) Compliance reviews (audits) conducted by the Office of Compliance or one of the UTSW-affiliated institutional compliance offices.
 - d) A report by an individual can be made directly to the Office of Compliance (e.g., the Compliance Hotline) or one of the UTSW-affiliated institutional compliance offices.
 - e) Comments, concerns, or complaints from research participants or family members of research participants, members of the research team, or individuals not otherwise affiliated with the institution
 - f) A report by another committee, department, institution, or official.
 - g) A report from the study sponsor or sponsor's monitoring entity.
 - h) Collective evaluations of all noncompliance (i.e., deviations, violations, departures) could contain instances of apparent serious or continuing noncompliance, which require prompt reporting to the IRB.
- C. Prompt Reporting and Screening of Allegations of Apparent Serious or Continuing Noncompliance
 1. Allegations of noncompliance by UTSW employees or affiliated personnel may be initially provided as verbal reports, but must later be submitted in writing.
 2. Allegations of noncompliance by non-affiliated individuals are accepted as verbal reports; however, persons recording a complaint are encouraged to provide their concerns in writing.
 3. Investigators are required to promptly submit events that appear to constitute serious or continuing noncompliance using the applicable eIRB Reportable Event Form.

4. Complaints that are not apparent serious or continuing noncompliance are reviewed in accordance with [9.1 COMPLAINTS](#).
5. The PI must report apparent serious or continuing noncompliance to the reviewing IRB (and UTSW HRPP for reliance studies) according to the timeframe in the [9.5 REPORTABLE EVENTS GUIDANCE](#).
6. The HRPP Director (HRPPD), HRPP Associate Director (HRPPAD), or designee will determine whether allegations of apparent serious or continuing noncompliance are pertinent to other research review offices (e.g., affiliated institutions) or ancillary and safety committees. If it is determined that the allegations of apparent serious or continuing noncompliance are pertinent to other research review entities, appropriate coordination will occur according to the [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#).

D. Evaluating Allegations of Apparent Serious or Continuing Noncompliance

1. The HRPPD, HRPPAD, or designee are designated HRPP reviewers. Given their positions in HRPP, they are readily available to promptly screen and review allegations of noncompliance. The reviewers are expected to communicate with the IRB Chair or IO as appropriate.
2. The HRPP designated reviewer evaluates all allegations to determine whether they are substantiated (i.e., there are supporting documents or statements).
3. If the issue possibly involves research misconduct defined as fabrication, falsification, or plagiarism in proposing, performing, reviewing, or reporting results of research, or other material deviations from accepted scientific practices such as obstruction of another's research, deliberate violations of confidentiality, and willful deception or omission, the HRPP designated reviewer will notify the IO. The issue will be reviewed according to the institutional policy [RES-101 MISCONDUCT OR FRAUD IN RESEARCH](#)
4. If the HRPP designated reviewer evaluates an allegation as unsubstantiated (i.e., finds no supporting documents or statements):
 - a) the reviewer may dismiss the allegation as unjustified, and may
 - (1) decide to take no action, or
 - (2) continue the review as a complaint or UPIRSO (following other HRPP policies as applicable).
 - b) If the reviewer takes no action, the decision will be communicated in writing to the complainant (if the identity of the person is known) and to the investigator against whom the allegation was raised (respondent) or from whom the report was received.
5. If the HRPP designated reviewer determines that an allegation is not serious or continuing noncompliance, the reviewer may:
 - a) withdraw the item and require submission at continuing review
 - b) process the concern as a complaint or UPIRSO (following other [HRPP policies](#) as applicable)

- c) manage the concern through communications with the investigator (management decisions and recommendations are based on the investigator's stated plan to correct issues and prevent future occurrence), and/or
 - d) acknowledge the event as noncompliance that is neither serious nor continuing
6. If the HRPP designated reviewer determines that an allegation appears to constitute serious or continuing noncompliance, the reviewer may:
- a. pursue further inquiry (data gathering, interviews, etc.),
 - b. acknowledge the event as noncompliance that is neither serious nor continuing after further inquiry is completed, or
 - c. forward the issue to the reportable event subcommittee, IRB, and/or the IO if the event appears to constitute serious or continuing noncompliance.
- E. Subcommittee Review of an Allegation of Apparent Serious or Continuing Noncompliance
1. If an allegation or report of noncompliance appears to constitute serious or continuing noncompliance, the IRB designated reviewer may forward the allegation to an IRB subcommittee for further review. The IRB subcommittee will consist of members of the UTSW IRBs and will be selected by the HRPP Director and/or the IRB Chair(s) with consultation from the IO.
 2. When the subcommittee of the IRB conducts the inquiry, the process includes the following:
 - a) If the allegation suggests subjects are at immediate risk, the IRB subcommittee may contact the IRB Chair who has the authority to immediately suspend IRB approval or take other actions as appropriate to protect the rights, safety, and welfare of subjects or integrity of the research. If research is suspended (either partially or completely), the applicable IRB policy on [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#) will be followed.
 - b) If the issue possibly involves research misconduct, the inquiry may await the resolution of the assessment phase of the applicable institutional misconduct procedures such that they can occur in conjunction with each other if both procedures call for an inquiry and no immediate risk is present.
 - c) The HRPPD, HRPPAD, or IRB Chair may invite one or more members of the subcommittee to gather information pertaining to the nature of the allegation, the procedures approved in the IRB protocol, and the procedures followed in conducting the study. The HRPP designated reviewer, may conduct the inquiry alone or with the assistance of other subcommittee members. In more serious cases, the IRB Chair, designated reviewer(s), or subcommittee (collectively referred to as *inquiry members*) may work together to gather the information for the IRB.
 - d) The inquiry members may elect to interview the complainant(s), if applicable.
 - (1) In cases where the complainant requests anonymity, the individual who received the original allegation may interview the complainant.

- (2) The interviewer prepares a summary of the interview and gives the complainant the opportunity to comment on the written summary.
 - (3) In some cases, the complainant may have already submitted a written complaint, which the inquiry member then verifies.
 - (4) An inquiry member may also request additional information from the complainant.
 - e) The inquiry member(s) may request a compliance review (audit) be conducted and provided with a written report of the audit by:
 - (1) The Office of Compliance,
 - (2) HRPPO, or
 - (3) One of the UTSW-affiliated institutional compliance offices.
 - f) The inquiry members may interview the subject of the allegation (respondent) or PI from whom the report was received and may provide the opportunity to comment on the allegation and provide additional information.
 - (1) A summary of the interview is prepared, given to the respondent who may comment on the summary.
 - (2) In some cases, the respondent may have submitted a written rebuttal to the complaint or report of noncompliance, which the reviewer verifies.
 - (3) The inquiry members may also request additional information from the respondent.
 - g) Depending on the nature of the allegation and the information collected during the interviews, the inquiry members may interview other individuals, examine research data (both published and unpublished), informed consent/assent forms, medical records, inclusion/exclusion criteria, applicable approved IRB protocol(s), and any other pertinent information.
3. The subcommittee inquiry process is complete when the inquiry members conclude that there is sufficient information related to the event to determine whether apparent serious or continuing noncompliance occurred.
 - a) If inquiry members determine that the event was not noncompliance (i.e., dismissal of the allegation), the issue will be closed according to actions provided in the evaluation section (above) of this policy.
 - b) If inquiry members determine that the event was noncompliance (finding of noncompliance) that is not serious or continuing, the issue will be closed according to actions provided in the evaluation section (above) of this policy.
 - c) If inquiry members determine that the event was noncompliance (finding of noncompliance) that appears to be serious or continuing, the issue is forwarded to the convened IRB for final determination.
4. When appropriate, inquiry members prepare, with the assistance of HRPPO staff, a written summary report. The report may consist of a summary of the allegations of noncompliance, interview summaries, and copies of pertinent information (e.g., correspondence such as

emails). The report may or may not include recommendations for IRB action. In some cases, the inquiry members simply provide the IRB with a summary of the allegations, the interview summaries, and copies of pertinent information without an accompanying written summary report.

F. IRB/IO Review Procedures

1. Following the initial review by the HRPP designated reviewer and/or reportable event subcommittee, the IRB reviews the allegation at a convened meeting at which a quorum is present. If the study is relying on an external IRB, the allegation will be reviewed by the IO.
2. The IRB/IO is provided with the report of noncompliance (if applicable), written summary report from the inquiry members (if applicable), corrective and preventative action (CAPA) plan, and any other documents deemed relevant. The IRB/IO determines whether to request additional information or whether to interview additional persons of interest. The IRB/IO may give the respondent the opportunity to meet with the convened IRB before it takes final action.
3. The HRPP Designated Reviewer or delegate advises the IRB/IO regarding the applicable institutional policies and federal regulations, assists the IRB/IO in documenting the review, answers questions about the review process, maintains the records as required by state and federal laws, and serves as a liaison with the funding agency or agencies.

G. IRB/IO Review Outcomes and Actions

1. The IRB/IO makes the final determination whether the noncompliance is serious or continuing based on the materials compiled during the inquiry.
2. The IRB/IO approves a CAPA plan that may include a variety of actions, depending on the outcome of the review, including, but not limited to, the list of actions outlined in [9.1 COMPLAINTS](#).
3. If the noncompliance is serious or continuing, the IRB/IO, with the assistance of HRPP, reports the incident(s) to the applicable agency or agencies following procedures outlined in the [8.2 REPORTING POLICY AND PROCEDURE](#).
4. The IRB/IO must consider the following actions in a determination of serious and/or continuing noncompliance:
 - a) Suspend (temporary cessation of IRB approval of some or all research activities) (see [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#));
 - b) Terminate IRB approval/disapprove continuation of the study (permanent withdrawal of IRB approval) (see [9.4 SUSPENSION OR TERMINATION OF RESEARCH](#));
 - c) Require notification of current participants when such information might relate to participant's willingness to continue to take part in the research
5. In the review of the CAPA plan, the IRB/IO may approve (or require additional changes to) the following:
 - a) Modification of the protocol
 - b) Modification of the information disclosed during the consent process

- c) Providing additional information to past participants
 - d) Requiring current participants to re-consent to participation
 - e) Modification of the continuing review schedule
 - f) Monitoring of the research
 - g) Referral to other organizational entities
6. In cases of serious and continuing noncompliance, the IRB/IO may recommend additional sanctions. Possible sanction recommendations include:
 - a) Reclassification as possible scientific misconduct
 - b) Research privilege probation
 - c) Suspension of research privileges
 - d) Termination of research privileges
 - e) Embargo of publications
 7. The HRPPO communicates by email or letter (contact may initially be made by phone, but will be followed up with an email or letter) the IRB/IO decision to the person raising the allegation (if the identity of the person is known) and in writing to the respondent or person making the report of noncompliance.
 8. The HRPPO informs appropriate individuals or entities of the allegation, the review process, and the findings of the review, if appropriate, depending upon the outcome of the review (this may include the external sponsor or applicable regulatory agencies). See [8.2 REPORTING POLICY AND PROCEDURE](#) for details.
 9. The IRB/IO resolves questions or concerns raised by an investigator regarding the outcome of a specific IRB/IO noncompliance review through direct communication with the investigator.
 10. If the IRB/IO requires additional remedial actions to be taken by the investigator (for a specific study or research team), the investigator should submit a response to IRB/IO concerns within 30 days of the date the IRB/IO issues the final decision. The HRPP should close the issue within 120 days of the IRB decision.
 11. Remedial actions involving programmatic noncompliance should be completed within 180 days after the IRB's/IO's determination, unless remediation requires substantial renovation, fiscal expenditure, hiring, or legal negotiations.

H. Appeals

1. If an investigator or complainant disagrees with the IRB/IO's decision, an appeal must be submitted to the HRPP in writing within 30 days of the date the IRB/IO issues the final decision. The HRPP limits appeals to a review of the procedures employed to reach the decision (i.e., claims that the process was faulty in a way that creates a considerable risk that the outcome was incorrect) or grievances of sanctions imposed. The appeal should specify the nature of any claimed procedural error or the perceived unfairness of sanctions imposed.

2. The HRPPD, HRPPAD, or delegate reviews the response and determines whether the appeal is valid and attempts to resolve the issue with the individual. If unable to resolve the concern, the issue will be processed as a new complaint.

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Updated references to serious/continuing noncompliance, included IO in determination process
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

9.4 SUSPENSION OR TERMINATION OF RESEARCH

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: NOVEMBER 18, 2019

I. POLICY STATEMENT

- A. The convened IRB or Institutional Official (IO) may suspend or terminate approval of research that is not being conducted in accordance with the IRB requirements or that has been associated with unexpected serious harm to participants.
- B. The IRB Chair or designated IRB reviewer may suspend approval of research that is not being conducted in accordance with the IRB requirements or that has been associated with unexpected serious harm to participants.
 - 1. The IRB Chair or designated IRB reviewer may only suspend the research; authority to terminate the research is limited to the convened IRB or the Institutional Official.
 - 2. The IRB Chair or designated IRB reviewer may suspend approval of some or all of the research when the continuation of the research may adversely affect the rights and welfare of research subjects or when continuation may represent an immediate threat of harm to the subjects.

II. SCOPE

- A. This policy and procedure applies to all non-exempt human subject research.
- B. Summary of Responsibilities
 - 1. The IO, convened IRB, IRB Chair, or designated IRB reviewer are responsible for actions taken in this policy.
 - 2. The HRPP Director (HRPPD) will be designated IRB reviewer for this process. Given the position in the HRPPO, this individual is readily available to promptly review issues such as allegations of noncompliance, unanticipated problems, progress reports, compliance reviews, and complaints that may indicate research is not conducted in accordance with IRB requirements or associated with unexpected serious harm to participants requiring consideration of suspension.

III. PROCEDURES FOR POLICY IMPLEMENTATION

- A. This procedure starts with the IO, convened IRB, IRB Chair, or designated IRB reviewer becoming aware of apparent serious or continuing noncompliance, or an issue has been associated with harm to the rights and welfare of human subjects in which suspension or termination may be appropriate or when continuation may represent an immediate threat of harm to the subjects. The process of considering suspension or termination of research may be prompted for several reasons, for example:
 - 1. During the review of reports of apparent serious or continuing noncompliance or unanticipated problems

2. During the review of progress reports submitted for annual updates or continuation review
 3. Based upon results of compliance reviews, audits, or other institutional processes
 4. Based upon complaints from participants, family members, or others
- B. This procedure ends when the convened IRB, the Institutional Official, IRB Chair or designated IRB reviewer determines:
1. Suspension is not an appropriate action, or
 2. These officials suspend the research and the convened IRB or IO makes a final determination whether to continue or alter the suspension or terminate the research.
- C. Suspension of IRB Approval:
1. The IO, IRB Chair or designated IRB reviewer will consider suspension as an action pending review of the issue by the convened IRB.
 2. For issues of a more serious nature, if there is insufficient time to have the next scheduled convened IRB review the situation, the IRB Chair or designated IRB reviewer may call a special meeting of the IRB to review the issue.
 3. When making the determination of suspension, which may involve the withdrawal of current subjects from a research protocol or interruption of research procedures, the convened IRB, IO, IRB Chair, or designated IRB reviewer will consider alternative actions to protect subjects from harm that could result from withdrawal of research procedures that could affect their health or well-being. For example:
 - a) Transfer of subjects to another investigator that would allow continuation of research (i.e., assign a new PI),
 - b) Arrangement of clinical care outside the research,
 - c) Continuation of some research activities under the supervision of an independent monitor,
 - d) Permitting follow-up of subjects for safety reasons,
 - e) Requiring reporting of adverse events or outcomes to the IRB and the sponsor,
 - f) Re-consent participants.
 4. If the IO, IRB designated reviewer, or IRB Chair suspends IRB approval:
 - a) The reason for suspension is documented and the PI is notified as described in [8.2 REPORTING POLICY AND PROCEDURE](#).
 - b) The HRPPO staff adds the issue to the agenda of the next scheduled IRB meeting and the convened IRB discusses the suspension.
 - c) IRB members attending the convened meeting are provided access to the protocol, consent, information relevant to the suspension, and who ordered the suspension.
 5. When the HRPPO staff notifies the PI of the suspension, the correspondence may include, but is not limited to, the following:

- a) An explanation of the extent of the suspension in terms of enrollment, recruitment, interventions, interactions, and data analysis;
 - b) The reasons for the suspension, an explanation of the reasons for the decision, and an offer to the investigator to respond to the convened IRB;
 - c) A request for a description of any procedures needed to protect the rights and welfare of current subjects if the suspension involves currently enrolled subjects;
 - d) A description of whether follow-up of subjects for safety reasons is permitted or required.
6. The PI notifies enrolled subjects (active and/or former) of the suspended research protocol, and the PI considers the appropriate procedures for withdrawal of enrolled subjects, taking into account their rights and welfare.
- D. Termination of IRB Approval
1. The convened IRB may consider alternatives to termination as an approach to protect currently enrolled participants who may be harmed if the research is terminated. The IRB may require modification of the study to allow continuation including the following changes:
 - a) Add, remove or limit the responsibilities of investigator(s),
 - b) Arrangement of clinical care outside the research,
 - c) Add or modify the local safety monitoring plan (e.g., addition of an independent monitor, addition of safety monitoring procedures or data),
 - d) Re-consent participants,
 - e) Requiring reporting of adverse events or outcomes to the IRB and the sponsor,
 - f) Shortening the current approval period.
 2. When a termination involves the withdrawal of current subjects from a research protocol, the convened IRB considers alternatives to termination that will result in protection of subjects from harm that could result from withdrawal of research procedures that could affect their health or well-being. For example:
 - g) Immediately provide the IRB of list of current and/or former participants,
 - h) Possible transfer of subjects to another research study,
 - i) Arrangement of clinical care outside the research,
 - j) Permitting follow-up of subjects for safety reasons,
 - k) Requiring reporting of adverse events or outcomes to the IRB and the sponsor.
 3. HRPPO staff notifies the PI of the termination. The notification may include, but is not limited to, the following:
 - a) An explanation of the extent of the termination in terms of enrollment, recruitment, interventions, interactions, and data analysis;

- b) The reasons for the termination, an explanation of the reasons for the decision, and an offer to the investigator to respond to the convened IRB;
 - c) A request for a description of any procedures that need to be followed to protect the rights and welfare of current subjects if the termination involves currently enrolled subjects;
 - d) A description of whether follow-up of subjects for safety reasons is permitted or required;
 - e) An explanation that any request for the IRB to reconsider the termination should be made within 30 days from date of the notification.
4. The PI notifies enrolled subjects of any termination of the research protocol and considers the appropriate procedures for withdrawal of enrolled subjects taking into account their rights and welfare.
- E. Any suspension or termination of approval shall include a statement of the reason for the action.
- F. See [8.1 IRB MINUTES](#) for details concerning documenting suspensions and terminations.
- G. After review, suspension or termination is reported in accordance with the [8.2 REPORTING POLICY AND PROCEDURE](#). In addition, the HRPP staff sends copies of the termination notification to other UT Southwestern administrative units in accordance with [1.5. COMMUNICATION WITH OTHER COMMITTEES AND OFFICES](#) (e.g., Institutional Biosafety Committee, Subcommittee for Human Use Radiation, Sponsored Programs Administration).

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Clarifications of noncompliance, clarify procedures for all studies (including sIRB studies)
August 2017	HRPP	New Policy Development
March 2012	IRB Office	IRB Written Procedures

VII. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL GUIDANCE

9.5 REPORTABLE EVENTS GUIDANCE

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: November 18, 2019

This reportable event guidance applies to all non-exempt research conducted by or on behalf of UT Southwestern (UTSW), its affiliates, and investigators, sites, or institutions relying on the UTSW IRB. See Section V for additional reporting requirements for research relying on a non-UTSW (external, central, or single) IRB.

I. INVESTIGATOR RESPONSIBILITY

Principal Investigators (PIs) (or their designees) are responsible for:

- monitoring their studies in real-time for adherence to the IRB-approved investigational plan (e.g., protocol, Smartform, ICD);
- obtaining prior IRB approval for non-emergency exceptions/waivers;
- tracking and assessing instances of noncompliance (e.g., deviations, violations, departures);
- promptly reporting apparent serious noncompliance, continuing noncompliance, and UPIRSOs to the reviewing IRB (and UTSW HRPP for reliance studies); and
- knowing and complying with all other reporting requirements (e.g., sponsor, FDA, external IRB) for their studies

II. NONCOMPLIANCE

Noncompliance is any failure to follow:

- Applicable federal regulations, state and local laws, or institutional policies governing human subjects protections, or
- The requirements or determinations of the IRB, including the requirements of the approved investigational plan (e.g., protocol, Smartform, ICD)
 - Noncompliance can result from performing an act that violates these requirements or failing to act when required

To limit noncompliance, sponsors and sponsor-investigators should build flexibility into their protocols and investigators should strictly adhere to the written IRB-approved protocol and investigational plan to avoid adversely affecting subject safety or science. Nevertheless, noncompliance does and will occur in human research. Regulatory guidance recognizes the need to balance the protection of human subjects and scientific integrity with investigator and IRB/HRPP burden. The noncompliance policy at UTSW aims to achieve that delicate balance. Therefore, the following definitions and reporting requirements apply:

- A. **Exceptions** (also called single-subject exceptions or single-subject waivers) include any changes to the IRB-approved investigational plan that is ***not due to an emergency*** and is:
- intentional on part of the investigator;
 - in the investigator's control;
 - not intended as a systemic change (e.g., single-subject exceptions to eligibility [inclusion/exclusion] criteria); or

- in rare instances, intended as a systemic change, but the change has not yet been IRB-approved
 - **Reporting requirement for studies relying on the UTSW IRB:** Exceptions require *prospective* IRB approval before being implemented. Call the HRPPO at 214-648-3060 if your request is urgent. **NOTE:** Failure to obtain prior IRB approval for exceptions is considered [noncompliance](#). If the noncompliance meets the definition of [serious noncompliance](#) and/or [continuing noncompliance](#), promptly report it to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 working days of discovery. Otherwise, report the noncompliance at the next continuing review or notice of study closure, whichever comes first.
 - **Reporting requirement for studies relying on non-UTSW IRBs:**
The UTSW HRPP cannot approve exceptions for studies relying on non-UTSW IRBs. Study teams should contact their reviewing IRBs for exception/waiver requests and approval. Exceptions/waivers approved by non-UTSW IRBs should be reported to the UTSW HRPP at the next continuing review or notice of study closure, whichever comes first.
- B. **Emergency deviations** include any changes to the IRB-approved investigational plan that is necessary to:
- avoid immediate apparent harm, or
 - protect the life or physical well-being of subjects or others
 - **Reporting requirement:** Promptly report emergency deviations to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 working days of occurrence.
- C. **Serious noncompliance** includes any noncompliance that:
- increases risk of harm to subjects; and/or
 - adversely affects the rights, safety, or welfare of subjects (any of which may also be an unanticipated problem); and/or adversely affects the integrity of the data and research (i.e., substantially compromises the integrity, reliability, or validity of the research)
 - **Reporting requirement:** Promptly report apparent serious noncompliance to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 working days of discovery.
- D. **Continuing noncompliance** includes:
- A pattern of repeated noncompliance (in one or more protocols simultaneously or over a period of time) which continues **after** initial discovery, including inadequate efforts to take or implement corrective or preventive actions within a reasonable timeframe, which may or may not also constitute [Serious Noncompliance](#).
 - **Reporting requirement:** Promptly report apparent continuing noncompliance to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 working days of discovery.
- E. **Noncompliance that is neither serious nor continuing** includes:
- Events, incidents, outcomes, etc. that do not meet the definitions of either [serious noncompliance](#) or [continuing noncompliance](#).

- **Reporting requirement:** Noncompliance that is *neither* serious nor continuing should be tracked and summarized in the progress report at the next continuing review or notice of study closure, whichever comes first.

III. UNANTICIPATED PROBLEMS

A. Unanticipated problems involving risks to subjects or others (UPIRSOs) are incidents, experiences, outcomes, etc. that meet **ALL three (3)** of the following criteria:

1. Unexpected in nature, frequency, or severity (i.e., generally not expected in a subject's underlying condition or not expected as a risk of the study; therefore, not included in the investigator's brochure (IB), protocol, or informed consent document),
AND
2. Probably or definitely related to participation in the research,
AND
3. Suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic/financial, legal, or social harm) than was previously known or recognized.

For purposes of this policy, UPIRSOs include unanticipated adverse device effects (UADEs) and death or serious injury related to a humanitarian use device (HUD).

NOTE: UPIRSOs require changes to the research documents/investigational plan (e.g., protocol, IB, and/or informed consent document/process) or corrective actions to protect the integrity of the research or the rights, safety, or welfare of subjects or others. Therefore, if no changes to the research or corrective actions are being made as a result of the event, it is *probably not* a UPIRSO.

- **Reporting requirement:** Promptly report apparent UPIRSOs to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 working days of discovery.

NOTE: Some instances of noncompliance may also be UPIRSOs, and vice versa. For example, administering a subject 100 mg of study drug vs. the protocol-required dosage of 10 mg, even if the subject experiences no adverse effects, is both noncompliance and a UPIRSO.

B. Research-related complaints can be made by a subject, subject's family, or others.

- **Reporting requirement:** Promptly report research-related complaints affecting subjects' rights, safety, or welfare to the reviewing IRB (and UTSW HRPP for reliance studies) within 5 working days of receiving the complaint.

IV. OTHER RESEARCH-RELATED INCIDENTS AND REPORTS

A. The following other research-related incidents or reports should **NOT** be promptly reported to the UTSW IRB (or HRPP for reliance studies) unless they contain events, incidents, or outcomes that appear to constitute serious noncompliance, continuing noncompliance, or UPIRSOs:

- Events, problems, or reports that are required by the sponsor to be submitted to the UTSW IRB/HRPP

- Data safety monitoring (DSMB/DMC/DSC) reports
 - Safety (i.e., IND/IDE, MedWatch/Form FDA 3500, CIOMS) reports
 - Monitoring reports
 - Audit reports
 - Instances of noncompliance (e.g., deviations) that do not meet the UTSW HRPP definition of either [serious noncompliance](#) or [continuing noncompliance](#)
 - AEs/SAEs that do not meet **ALL 3** UPIRSO criteria
 - Any new information since the last IRB review
- **Reporting requirement:** Other research-related incidents and reports that do NOT appear to constitute serious noncompliance, continuing noncompliance, or UPIRSOs should be tracked, evaluated, and submitted to the IRB (and UTSW HRPP for reliance studies) in summary form at the next continuing review or notice of study closure, whichever comes first.

A. Progress Report at Continuing Review

The progress report should include a summarization (not a listing) of the investigator's overall assessment of any adverse events, noncompliance, UPIRSOs, and any other new information that has become available in order for the IRB to determine if the risk/benefit ratio has changed. Examples of appropriate summaries:

- "There were several out-of-window visits due to the participants' schedules and two participants failed to bring their medication diary to their follow-up visits. No systemic issues were identified."
- "We obtained prior IRB approval for exceptions on two subjects who were taking the same excluded medication, XYZ. After reviewing the safety profile of the medication, the sponsor decided to modify the eligibility criteria to allow subjects to use XYZ at its lowest dose while participating in the study. We submitted the revised protocol documents to the IRB/HRPP in MOD #4, which was approved on 1/15/2017."
- "Since the last reporting period, 5 SAEs and 35 AEs occurred. All were expected or not related to the study interventions or procedures."

V. RESEARCH RELYING ON A NON-UTSW (EXTERNAL, CENTRAL, OR SINGLE) IRB

Investigators relying on a non-UTSW IRB who are conducting research on behalf of UTSW or its affiliates are responsible for submitting the following **LOCAL** events to the UTSW HRPP:

- **LOCAL** emergency deviations
 - **LOCAL** events that appear to constitute serious or continuing noncompliance
 - **LOCAL** UPIRSOs
 - **LOCAL** research-related complaints affecting subjects' rights, safety, or welfare
- **Reporting requirement:** Promptly report the **LOCAL** events listed above to the UTSW HRPP within 5 working days of discovery. In addition, submit the external IRB's responses or determinations on these local events to the UTSW HRPP within 10 working days of receipt.

VI. QUESTIONS

For questions on how to classify an event or whether an event should be reported promptly, at continuing review, or at all, please contact the HRPP at 214-648-3060 (select the option for Reportable Events) or HRPP@utsouthwestern.edu.

VII. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

VIII. REFERENCES

Resource
21 CFR 50 – PROTECTION OF HUMAN SUBJECTS
45 CFR 46 – PROTECTION OF HUMAN SUBJECTS
45 CFR 164 – SECURITY AND PRIVACY (HIPAA PRIVACY RULE)
21 CFR 56 – INSTITUTIONAL REVIEW BOARDS
Food and Drug Administration (FDA) ADVERSE EVENT REPORTING TO IRBS – IMPROVING HUMAN SUBJECT PROTECTION
NIH Office of Biotechnology Activities (OBA) - REPORTING OF INCIDENTS RELATED TO RESEARCH SUBJECT TO THE NIH GUIDELINES FOR RESEARCH INVOLVING RECOMBINANT OR SYNTHETIC NUCLEIC ACIDS TO THE NATIONAL INSTITUTES OF HEALTH (NIH) OFFICE OF BIOTECHNOLOGY ACTIVITIES (OBA)
Office of Human Research Protections (OHRP) REVIEWING AND REPORTING UNANTICIPATED PROBLEMS INVOLVING RISKS TO SUBJECTS OR OTHERS AND ADVERSE EVENTS

IX. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Updated definitions and reporting requirements for serious/continuing noncompliance
August 2017	HRPP	New Policy Development, standardized reporting timeframes
August 2016	HRPP Office	Revised reporting requirements to be consistent with Federal Requirements
March 2012	IRB Office	IRB Written Procedures

X. CONTACT FOR FURTHER INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTION PROGRAM DEPARTMENTAL POLICY AND PROCEDURE

9.6 CLINICALTRIALS.GOV REQUIREMENTS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: NOVEMBER 18, 2019

I. POLICY STATEMENT

- A. UT Southwestern Medical Center is committed to fostering compliance with requirements concerning the public availability of clinical trial data on ClinicalTrials.gov. This policy is in support of requirements from the Food and Drug Administration, National Institutes of Health, International Committee of Medical Journal Editors and Centers for Medicare and Medicaid Services (CMS).
- B. The Human Research Protection Program Office (HRPPO) in collaboration with the Office of Compliance provides administration, monitoring, auditing, training and oversight to foster compliance with FDAAA and NIH.
- C. The research community has the responsibility to create and maintain records in ClinicalTrials.gov while making determinations about registrations required to comply with ICMJE and CMS. Additionally, the research community must notify HRPP when there is an external agency notification and when a Principal Investigator/Responsible Party personnel change on a ClinicalTrials.gov record has occurred.
- D. Applicable Clinical Trials and National Institutes of Health clinical trials are required to include a word-for-word statement regarding ClinicalTrials.gov registration in the informed consent documentation.
- E. Researchers who fail to comply with the requirements may be subject to enforcement actions.
 - 1. Failure to comply with FDAAA requirements may result in financial penalties, withholding of funds and sanctions imposed by the FDA.
 - 2. Failure to comply with NIH may result in withholding of cash payments, disallowing cost for an activity, suspending or terminating either in part or whole the current award, withholding a future award and having a non-compliance notice publically available.
 - 3. Failure to comply with ICMJE requirements may result in an inability to publish in an ICMJE affiliated journal.
 - 4. Failure to comply with CMS requirements can result in a lack of payment for a qualified research billing service and a need to refile the qualified research billing claim.

II. SCOPE

- A. This policy applies to all UT Southwestern investigators conducting clinical trials/studies as defined by the Food and Drug Administration, International Committee of Medical Journal Editors, National Institutes of Health or submitting qualified research billing claims to the Centers for Medicare and Medicaid Services.

III. PROCEDURES

A. Researcher responsibilities

1. Identifying studies that require ClinicalTrials.gov registration

- a) Various entities, including the FDA, the International Committee of Medical Journal Editors (ICMJE), the National Institutes of Health (NIH), and the Centers for Medicare and Medicaid Services (CMS), have individually defined which studies must be registered on ClinicalTrials.gov.
 - i. NIH - Clinical Trials funded either in whole, or in part by National Institutes of Health (NIH). Applicable to all NIH-funded studies independent of whether the study meets the definition of an applicable clinical trial.
 - ii. ICMJE - Trials that meet the clinical trial definition of The International Committee of Medical Journal Editors (ICMJE) that the investigator may wish to publish.
 - a. ICMJE journals will consider [for publication] trials beginning on or after July 1, 2005 only if registration occurred before the first patient was enrolled ("prospective registration")
 - iii. CMS - Qualifying clinical trials which will render claims for items and services to the Center for Medicare and Medicaid Services (CMS)
 - a. The National Clinical Trial (NCT) number must be included on claims for items and services provided in clinical trials that are qualified for coverage as specified in the "Medicare National Coverage Determination (NCD) Manual," Section 310.1
 - iv. FDA - "Applicable Clinical Trials (ACT)" which include the following:
 - a. Trials of Drugs/Biologics: Controlled, clinical investigations of a product subject to FDA regulations. This includes preliminary studies or phase I trials to be published in an ICMJE journal.
 - b. Trials of Devices: Controlled trials with health outcomes, other than small feasibility studies, and pediatric post-market surveillance.
 - c. Applicable Clinical Trials generally include interventional studies (with one or more arms) of FDA-regulated drugs, biological products, or devices that meet one of the following conditions.
 - The trial has one or more sites in the U.S.
 - The trial is conducted under an FDA Investigational New Drug Application (IND) or Investigational Device Exemption (IDE) application
 - The trial involves a drug, biologic, or device that is manufactured in the U.S. or its territories and is exported for research
 - d. The following trials are generally excluded (unless funded either in whole, or in part by NIH):

- (Non-serious/life-threatening) Phase 1 drug trials, including studies in which drugs are used as research tools to explore biological phenomena or disease processes
 - Small clinical trials to determine the feasibility of a device or a clinical trial to test prototype devices where the primary outcome measure relates to feasibility and not to health outcomes
 - Trials that do not include drugs, biologics, or devices (e.g., behavioral interventions)
 - Non-interventional (observational) clinical research, such as cohort or case control studies
 - Trials that were ongoing as of September 27, 2007, and reached the Completion Date before December 26, 2007. An “ongoing” trial has enrolled one or more subjects and the final subject has not been examined or received an intervention for the purpose of collecting data on the primary outcome
- b) When studies are created in eIRB with a review level of Expedited or Full Board, the ClinicalTrials.gov questions must be completed. The questions ask the researcher to identify all applicable requirements for registration.
- c) The National Clinical Trial (NCT) Number is required for completed registrations.
2. ClinicalTrials.gov account set-up and modification
- a) ClinicalTrials.gov records are created and edited within ClinicalTrials.gov's Protocol Registration and Results System (PRS). To access the PRS, researchers/users must have a PRS user account. HRPPO staff assist researchers in obtaining a new account or modifying an existing account. To request a new user account, an email should be sent to ctgov@utsouthwestern.edu and include the following information: account holder name, user name; email address; phone number; account holder official title.
- b) If a current account is no longer accessible or requires modifications, HRPPO staff may assist. Users should send an email to ctgov@utsouthwestern.edu and include the following: account holder name and a description of the modification/issue.
- c) The person who creates the study record in ClinicalTrials.gov becomes the record owner. The record owner may maintain the record or may grant additional users access to make record changes. All email communications from PRS will be sent to the record owner.
- d) A record owner on an existing ClinicalTrials.gov record may need to be modified due to personnel or responsibility changes. To request modifications to an existing record owner, users should send an email to ctgov@utsouthwestern.edu and include the following information: National Clinical Trial Number; Institutional Review Board (IRB) protocol number; full name of new record owner; and account information if the user is new. The current record owner, the new record owner, and the principal investigator/responsible party should be copied on this request.

- B. Clinical Trials.gov registration, record maintenance, problem resolution
 - 1. Study registration
 - a) Specific data elements, such as study design, outcome measures, eligibility criteria, as well as information about the study's reviewing IRB and Data Monitoring Committee (if applicable), are required in the PRS system to register a study.
 - b) Resources, including instructions and reference materials related to the study registration process, are available on both the ClinicalTrials.gov website and the PRS website.
 - c) Once a study registration record has been completed by the user, it must be reviewed by both UTSW HRPP staff and by PRS staff before the study record will be published to the public ClinicalTrials.gov site
 - 2. Record maintenance
 - a) Ongoing maintenance and updates to the ClinicalTrials.gov record are required for Applicable Clinical Trials and National Institutes of Health clinical trials. Editing a ClinicalTrials.gov record is required when a reportable modification is made or an update to the verification date is completed.
 - b) The verification date in the ClinicalTrials.gov record needs to be modified at least **every 12 months**.
 - i. It is advised that this date be updated every time the ClinicalTrials.gov record is accessed.
 - ii. HRPP staff will confirm the verification date has been updated at each continuing review.
 - c) ClinicalTrials.gov records must be updated within **15 days** following a change to:
 - i. Device approval status, if the device under investigation was not approved or cleared by the Food and Drug Administration at the time of study registration, but undergoes a change in approval or clearance status
 - d) ClinicalTrials.gov records must be updated within **30 days** following a change to:
 - i. Study start date
 - ii. Intervention name
 - iii. Availability or type of expanded access
 - iv. Overall recruitment status
 - v. Individual site status
 - vi. Human subjects protection review board (IRB) status
 - vii. Primary completion date
 - viii. Study completion date

- ix. Responsible party and contact information
 - x. Protocol amendments
 - xi. Any content changes including modification needed to the posted protocol and/or statistical analysis plan
- e) Detailed instructions available on the PRS website.
3. Results reporting
- a) Results of research must be reported to the ClinicalTrials.gov record **12 months** after the Primary Completion Date for Applicable Clinical Trials (FDAAA) and National Institutes of Health clinical trials.
4. Problem resolution
- a) Problems may occur during the creation and modification of a record on ClinicalTrials.gov. Resolving problems can be accomplished through the main menu, in the record, and are received through notifications from ClinicalTrials.gov. Editing a ClinicalTrials.gov record is advised and often required when a problem is encountered. ClinicalTrials.gov identifies four types of problems:
 - i. **ERROR**—Problem is serious.
 - ii. **WARNING**—Problem is/may be required to be addressed by Food and Drug Administration Amendments Act of 2007 801.
 - iii. **ALERT**—Problem needs to be addressed.
 - iv. **NOTE**—Potential problem needs to be addressed.
 - b) An error can stop completion of ClinicalTrials.gov record status changes. Warnings, alerts, and notes may cause issues with meeting regulatory or system requirements.
 - c) Users are encouraged to review instructions on the PRS website to assist with problem resolution. HRPP staff are also available to assist.
- C. Regulatory noncompliance and principal investigator/responsible party change
- 1. External agency letter notification
 - a) Researchers receiving any correspondence from an external agency regarding Food and Drug Administration Amendments Act of 2007 801 requirements, National Institutes of Health policy requirements, a ClinicalTrials.gov record, registration requirements, maintenance requirements, or results reporting requirements, should notify the HRPP Office at ctgov@utsouthwestern.edu within **seven (7) days** of receipt.
 - 2. Principal investigator/responsible party change notification and modification
 - a) If the principal investigator acting as the responsible party on a ClinicalTrials.gov record leaves the institution, is no longer involved with the clinical trial, becomes incapacitated, or dies, the affected ClinicalTrials.gov record must be modified.

- b) Each of the following procedures must occur when there is a change to the principal investigator/responsible party. If the change is expected, the following tasks must be completed **30 days** prior to the expected change. If the change is unexpected, the following tasks must occur within **14 days** following the unexpected change:
- c) Notify the HRPPO Office at ctgov@utsouthwestern.edu.
 - i. If the trial is active, complete the modification to the principal investigator/responsible party, modify the record to reflect the current clinical trial information, and notify the newly assigned principal investigator/responsible party of responsibilities.
 - ii. If the clinical trial is a candidate for a record transfer, work with HRPPO to discuss a ClinicalTrials.gov record transfer and assist with the record transfer process.
 - iii. If the trial is not continuing, mark the record as completed/terminated/withdrawn and modify the record to reflect the current clinical trial information.
 - iv. In the event of a record that is given this status but requires results, a modification to the principal investigator/responsible party or record transfer is still required.

3. Record reassignment, transfer and status change

- a) Depending on the qualities of the clinical trial, the record may be reassigned to another principal investigator/responsible party, transferred to another institution, or its status may be changed.
- b) The qualities include whether the trial will remain open, if there is an IND or IDE associated with the record that will remain at UTSW, if there is external funding for the trial that will remain at UTSW, and if results reporting is required.
- c) If the clinical trial will not remain open and if results reporting for the trial is not required, then and only then may the record status be changed to Completed/Terminated/Withdrawn without a change to the responsible party.

D. Informed consent documentation

- 1. Applicable Clinical Trial informed consent statement. The following statement must be included in all applicable clinical trial consent documents:
 - a) *A description of this clinical trial will be available on [ClinicalTrials.gov](https://clinicaltrials.gov), as required by federal law. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.*
- 2. National Institutes of Health (NIH) Clinical Trial Informed consent statement. The following statement must be included in all NIH clinical trial consent documents:

- a) *A description of this clinical trial will be available on ClinicalTrials.gov. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.*

E. Ongoing monitoring for compliance

- 1. The HRPP Office will review for ClinicalTrials.gov compliance:
 - a) ClinicalTrials.gov website (at least monthly)
 - b) Individual studies during HRPP monitoring visits

IV. DEFINITIONS

[SEE GLOSSARY OF HUMAN RESEARCH TERMS](#)

V. REFERENCES

Resource
National Institutes of Health NIH Policy on the Dissemination of NIH-Funded Clinical Trial Information
International Committee for Medical Journal Editors – ICMJE Clinical Trials Registration
Center for Medicaid Services (CMS) – Section 310.1 of the “Medicare National Coverage Determination (NCD) Manual”
FDAAA – SEC. 801. EXPANDED CLINICAL TRIAL REGISTRY DATA BANK
FDA – Identifying an “Applicable Clinical Trial” under FDAAA
FDA – FDAAA 801 and the Final Rule (on clinicaltrials.gov website)
ClinicalTrials.gov

VI. REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	New policy Development for HRPP

VII. CONTACT INFORMATION

Human Research Protection Program Office
HRPP@UTSouthwestern.edu
 214-648-3060

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HUMAN RESEARCH PROTECTIONS PROGRAM AT UT SOUTHWESTERN

10.0 GLOSSARY OF HUMAN RESEARCH TERMS

RESPONSIBLE OFFICE: Human Research Protection Program Office (HRPPO)

EFFECTIVE DATE: NOVEMBER 18, 2019

[A](#) | [B](#) | [C](#) | [D](#) | [E](#) | [F](#) | [G](#) | [H](#) | [I](#) | [K](#) | [L](#) | [M](#) | [N](#) | [O](#) | [P](#) | [Q](#) | [R](#) | [S](#) | [T](#) | [U](#) | [V](#) | [W](#)

A

Accrual. The process of seeking eligible participants and obtaining their consent to participate in the research. Accrual generally starts with recruitment, leading to screening for eligibility, and consent to enroll in the study. *Also see [Enrollment](#).*

Acknowledged. UT Southwestern Institutional Review Board (IRB) uses the term "*Acknowledged*" when a document or memo is sent to the IRB that does not, according to applicable regulations or policy, require IRB approval. In this way the Investigator and sponsor are administratively notified that the document or memo was received by the IRB and reviewed by the IRB staff to ensure any regulatory issues are addressed and placed in the protocol record.

Administrative Change. A modification to an approved IRB application which does not require IRB approval. Administrative changes should be submitted to IRB for review and acceptance.

Examples include (but are not limited to):

- Correction of typos
- Translations of approved consent forms and recruitment material,
- Verification of media advertisements based on IRB approved scripts,
- Minor changes to contact information,
- Removal of a study sites,
- Changes requested by affiliated institutions,

Changes that correct administrative errors made during previous IRB review.

Adverse Drug Experience/Reaction (ADR). The United States Food and Drug Administration ([FDA](#)) defines an ADR as any adverse event associated with the use of a drug in humans, whether or not considered drug related, including the following: an adverse event occurring in the course of the use of a drug product in professional practice; an adverse event occurring from drug overdose whether accidental

or intentional; an adverse event occurring from drug abuse; an adverse event occurring from drug withdrawal; or any failure of expected pharmacological action.

Adverse Event (AE). In general AE is used very broadly and encompasses physical and psychological harms and includes:

Any experience or abnormal finding that has taken place during the course of a research project and was harmful to the subject participating in the research, or increased the risks of harm from the research, or had an unfavorable impact on the risk/benefit ratio. The FDA also includes in its definition abnormal preclinical or laboratory findings which may not yet have resulted in direct harm to subjects (e.g., a bacteria is identified in a culture from the same batch of cells used to produce a vaccine which has been administered, even if no cases of infection have been reported). The event may or may not be caused by an intervention (e.g., headache following spinal tap, death from the underlying disease, car collision). Adverse Events can include psychological, social, emotional, and financial harms. 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 it is considered related to the subject's participation in the research. See also, [Serious Adverse Event](#).

Advocate. An individual who has the background and experience to act in, and agrees to act in, the best interest of the child for the duration of the child's participation in the clinical investigation.

Affiliated Institution. Is any institution that relies on UT Southwestern's IRB.

A signed agreement between the relying institution and the IRB is required to establish the affiliation. There are three general categories of institutional agreements: 1) a **blanket agreement** indicates that any study from the relying institution can be reviewed by the IRB (e.g., Southwestern Health System) 2) a **limited agreement** applies to a defined category or group of studies (more than one study) and 3) a **single study** agreement applies to a single-study. Single-study agreements may be covered under an [Investigator Authorization Agreement \(IAA\)](#) without a Memorandum of Understanding or Agreement (MOU/MOA). However, blanket and limited agreements generally require both an IAA and an MOU/MOA.

Agent. Used to indicate when an individual is working on behalf of the institution (i.e., performing UT Southwestern designated activities or exercising UT Southwestern delegated authority or responsibility) in relation to research. An agent can be an employee of the institution (e.g., faculty or staff) or a non-employee who is authorized by the institution to act on behalf of the institution (e.g., student, affiliated faculty, emeritus professors).

An institution is considered [Engaged In Research Individuals](#) when an [Employee](#) or agent of the institution conducts human research activities.

It is possible for a UT Southwestern employee to conduct research and not be considered an agent of the university if the research is conducted during non-official duty time, is not in connection with her/his UT Southwestern responsibilities, is not being conducted at a UT Southwestern facility and the research is not supported by a direct UT Southwestern award to the UT Southwestern (review the Handbook of

Operating Procedures (HOP) on Conflict of Commitment). The institution however generally reserves the right to determine for themselves whether their employee (in whole or in part) is performing institutionally designated activities and acting on behalf of the institution or exercising institutional authority or responsibility in regard to that research and the IRB will generally consider this in determining whether the institution in question is engaged in research.

Allegation of noncompliance. An unconfirmed report of [noncompliance](#).

Alternate member. An individual appointed to the IRB to serve in the same capacity as the specific IRB member(s) for whom the alternate is named, who substitutes for the member at convened meetings when the member is not in attendance. *Note: IRB members and alternates have equal responsibilities in terms of required education, service, and participation.*

Amendment. Any changes to previously approved research. Investigators may not initiate any changes in research procedures or consent form(s) without prior IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject (Note: IRB approval of the actions taken in this circumstance must still be sought after the fact). See also [Major Change Or Modification](#)

Anonymous. Anonymous means entirely without name or identifier, so the individual cannot be discerned in any way by anyone. No one can link an individual person to the responses of that person, including the investigator. For this reason, face-to-face interviews are never anonymous. If phone numbers are not stored, then telephone interviews could be considered anonymous. Questionnaires that are returned via US Mail are considered anonymous only if no tracking codes are used.

Anonymous data. Information that was previously recorded or collected without any of the 18 identifiers as defined by HIPAA, and no code is assigned that would allow data to be traced to an individual.

Appropriate Institutional Officials. Officials determined by each organization to be points of contact for research. This may include an individual, an office or a committee. (This term should not be confused with another similar but distinctly different DHHS term [Authorized Institutional Official](#)).

Approval Date. The first date that research can be performed (following notification from the IRB), consistent with federal regulations, state and local laws, and university policy. The approval date is the date that the research is approved by convened or expedited review, or if modifications are required (to secure approval), the date that modifications/conditions are met by the investigator.

Approval Period. For initial review, the interval that begins on the day research is approved by convened or expedited review, or if modifications are required (to secure approval), the date that modifications/conditions are met by the investigator. For continuing review, the interval that begins on the day research is re-approved (by convened or expedited review) or modifications are required. *Note: An approval period for initial or continuing review may not be longer than one year.*

Approved. An IRB action taken when the required determinations are made that allow research involving human subjects to proceed consistent with federal regulations, state and local laws, and university policy.

Assent. Affirmative agreement by an individual not [Competence](#) to give legally valid informed consent (e.g., child or person with limited mental capacity) to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.

Association for the Accreditation of Human Research Protection Programs (AAHRPP). The AAHRPP promotes high quality research through an accreditation process that helps organizations worldwide strengthen their human research protection programs. An independent, non-profit accrediting body, AAHRPP uses a voluntary, peer-driven, educational model to ensure that HRPPs meet rigorous standards for quality and protection. To earn accreditation, organizations must provide tangible evidence, through policies, procedures, and practices, of their commitment to scientifically and ethically sound research and to continuous improvement.

Assurance Of Compliance. An assurance of compliance is a written document submitted by an institution (not an Institutional Review Board) that is [Engaged In Research with Individuals](#) in non-exempt human subjects research conducted or supported by a specific federal agency. Through the assurance, an institution commits to the governing agency that it will comply with the requirements set forth in the regulations for the protection of human subjects. For research supported or funded by DHHS, the Federalwide Assurance is the only type of assurance accepted and approved by UT Southwestern's Office of Human Protections Program (HRPP).

Assured Institution. An institution holding an approved assurance from the applicable federal agency.

Authorization. As outlined in 45 CFR 160 and 164 (HIPAA): An individual's written permission to allow a covered entity to use or disclose specified PHI for a particular purpose.

Authorized Institutional Official. Within the institution, there must be a point of responsibility for the oversight of research and IRB functions. This point should be an official of the institution who has the legal authority to act and speak for the institution, and should be someone who can ensure that the institution will effectively fulfill its research oversight function. The authority can be delegated.

Authorized Representatives. HIPAA 45 CFR - 164.502(g) defines authorized personal representatives as persons who have the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.

Persons who are authorized under Texas state law to make health care decisions on behalf of other individuals will also be personal representatives under HIPAA.

Audit. A systematic review, inspection, or verification, typically conducted by an independent individual or group.

Autonomy. Personal capacity to consider alternatives makes choices, and act without undue influence or interference of others.

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B

Bank (Tissue). Collection of data and/or specimens obtained and stored for future research uses and/or distribution, including a collection not originally or primarily obtained for research purposes.

Behavioral Research. The scope and diversity of research areas in the behavioral and social sciences is quite broad. Some research is readily applicable to human affairs; other studies may broaden understanding without any apparent or immediate application. Some research is designed to test hypotheses derived from theory; other research is primarily descriptive. Still other research may be directed at evaluating an intervention or social program. Behavioral research involving human subjects generates data by means of questionnaires, observation, studies of existing records, and experimental designs involving exposure to some type of stimulus or intervention.

Belmont Report. Ethical Principles and Guidelines for the protection of human subjects of research. On July 12, 1974, the National Research Act (Pub. L. 93-348) was signed into law, there-by creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. One of the charges to the Commission was to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines which should be followed to assure that such research is conducted in accordance with those principles. In carrying out the above, the Commission was directed to consider: (i) the boundaries between biomedical and behavioral research and the accepted and routine practice of medicine, (ii) the role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects, (iii) appropriate guidelines for the selection of human subjects for participation in such research, and (iv) the nature and definition of informed consent in various research settings.

Beneficence. Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. Two general rules have been formulated as expressions of beneficent actions ([Belmont Report](#), 1978):

1. Do no harm, and
2. Maximize possible benefits and minimize possible harms

Benefit. Something that promotes or protects well-being; an advantage. [Compensation](#) cannot be considered a benefit. Just as there are a range of harms: physical, social, economic, psychological, and legal, there can also be a range of benefits: physical benefit is clinically beneficial - as with standard-of-care procedures known to be helpful in guiding the subject's care when plans include using them as such (experimental procedures or procedures that must be verified by an approved device might not result in this benefit), notwithstanding that the subjects could have received the benefit without being in the study (this information comes to light in the alternatives description); psychological benefit of educational, informational, counseling or other resources provided in the study or empowerment. These can be directed at the individual (direct benefit, secondary benefit, monitoring benefit), the community or a general knowledge gained benefit (philanthropic on behalf of the individual). Only certain anticipated benefits may be considered appropriate for consideration to weigh against the probability of harm in certain populations and circumstances.

Bias. When a point of view prevents impartial judgment on issues relating to the subject of that point of view. In clinical studies, bias is controlled by blinding and randomization. See [Blind](#) and [Randomization](#)

Biography or Oral History. Interviews that collect, preserve and interpret the voices and memories of people, communities, and participants in past events as a method of historical documentation. The intent is to document a particular past or unique event in history.

Biological product. A biological product (biologic) is a medical product. Many biologics are made from a variety of natural sources, such as humans, animals or microorganisms. Like drugs, some biologics are intended to treat diseases and medical conditions. Other biologics are used to prevent or diagnose diseases. Examples of biological products include:

- Vaccines
- Blood and blood products for transfusion and or manufacturing into other products
- Allergenic extracts, which are used for both diagnosis and treatment, such as allergy shots
- Human cells and tissues used for transplantation, such as tendons, ligaments and bone
- Gene therapies
- Cellular therapies
- Tests to screen potential blood donors for infectious agents, such as HIV
- In general, the term "drugs" includes therapeutic biological products

Blind. A randomized study is "Blind" if the participant is not told which arm of the study he is on. A clinical project is "Blind" if participants are unaware on whether they are in the experimental or control arm of the study; also called masked.

Blinded Study Design. A study in which one party, either the investigator or participant, is unaware of what medication or study arm the participant is assigned to (Single-Blind study). A clinical study design in which neither the participating individuals nor the study staff knows which participants are receiving the experimental drug and which are receiving a placebo or another therapy (Double-Blind study). Double-blind studies are thought to produce more objective results, since the impact of expectations of the doctor and the participant about the experimental drug are minimized. Also referred to as a "masked" study.

Bonus Payment. Compensation tied to the rate or timing of recruitment or performance or other aspects of a clinical study. Examples of bonus payments include the following:

- the sponsor announces that the highest enrolling site in the nation will receive a \$10,000 bonus;
- the sponsor offers to pay an additional \$10,000 beyond the budgeted study costs to any site that enrolls five participants within a week;
- the sponsor offers to pay an additional \$10,000 beyond the budgeted study costs to any site that fulfills its recruitment target by the end of the month;
- the sponsor offers to pay an additional \$1,000 beyond the budgeted study costs for any subject who agrees to enroll within one day of initial contact.

This does not include compensation for services rendered which include screening and referral activity unrelated to whether the participant ultimately enrolls in or completes the research study.

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C

Capacity. The ability based on reasonable medical judgment to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decisions. Subjects who are incapacitated are not capable of giving informed consent for research but may be capable of providing assent. Also see [Incapacitated](#) and [Impaired Decision-Making Capacity](#).

Case Report Form (CRF). A paper or electronic questionnaire specifically used in clinical trial research. The CRF is the tool used by the sponsor of the clinical trial to collect data from each participating site. All data on each patient participating in a clinical trial are held and/or documented in the CRF, including adverse events. Information captured in a CRF must be supported by a [Source Document](#) (unless the CRF is the source document).

Example Source Documents

Original Study Documents – Completed Informed Consent Forms (ICF) and Case Report Forms (CRF)

Records from study execution or supporting documents on medical history including the following:

- Medical records
- Hospital, clinic, & office charts
- Progress notes, patient visit notes, physician’s notes/orders
- Records: laboratory, radiology, cardiology, medico-technical departments
- Pharmacy dispensing records
- X-Rays, Scans (bone, brain, MRI)
- Video (angiography, endoscopy)
- Instrumentation print-out: EKG, ECG, Spirometry, etc.
- Memos to record concerning the study
- Subjects’ diaries, evaluation checklists, or Quality of Life questionnaires
- Recorded data from automated instruments
- Certified transcription of recorded results including dictation (i.e., verified as accurate and complete)
- Photographs, negatives, microfilm or magnetic media

Cause. An assessment made by the investigator and/or sponsor regarding the proper attribution of an adverse event. Examples: Study intervention (e.g., drug, device, or therapy); Concurrent non-research therapy; Disease progression; Other or unknown source.

Certificate of Confidentiality. A Certificate of Confidentiality helps researchers protect the privacy of human research participants enrolled in biomedical, behavioral, clinical and other forms of sensitive research. Certificates protect against compulsory legal demands, such as court orders and subpoenas, for identifying information or identifying characteristics of a research participant. Researchers may apply for a Certificate through the NIH or Center funding the research, Contact information is available on the NIH website at: <http://grants2.nih.gov/grants/policy/coc/index.htm>

Certification. The official notification by the institution to the [DHHS](#) that a research project or activity involving human subjects has been reviewed and approved by the IRB in accordance with the approved assurance on file at DHHS. In order for a proposal involving human subjects to be eligible for federal funding, it must first be approved by the IRB and certified by the institutional representative.

Certified Translation. A certified translation is one that has been formally verified by a licensed translator or translation company for use in official purposes. Certified translators attest that the target-language text is an accurate and complete translation of the source-language text. Certified translation of consent documents ensures that the tone, meaning and content of the translated documents remain consistent with the IRB-approved English version.

Child/Children. Person(s) who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted. For purposes of HRPP policy, individuals under 18 years of age are considered children in Texas unless they meet the definition of emancipated minors. See [Minor](#).

Class Project. Academic projects or student assignments involving collection of data from human subjects, when the data is used solely for the purpose of teaching course content and not intended to be used to develop or contribute to generalizable knowledge.

Classified Research. In the interest of national security, federally funded research can be 'classified' in terms of limited access to data, information, and facilities (inputs) that may be required to carry out the research or in terms of the limited distribution of the results of the research (outputs).

Interested parties should contact the involved institution's Security Officer for further information regarding security clearances, classified document control, foreign visitor information, security inspections, and so forth.

Clinical Equipoise. A genuine uncertainty on the part of the expert medical community about the comparative therapeutic merits of each arm of a clinical trial. When the relative benefits and risks of the proposed intervention, as compared to standard therapy, are unknown, or thought to be equivalent or better, there is clinical equipoise between the historic intervention and the proposed test intervention.

Clinical Investigation. Involves the use of a [Test Article](#) (i.e., drug, device, food substance or biologic) and one or more human subjects. This applies to test articles that require prior submission to the FDA and those that do not if the results of the investigation are intended to be part of an application to the FDA for a research or marketing permit. It does not include the use of FDA approved devices or drugs in routine medical practice. (21 CFR 50.3(c), 21 CFR 56.102(c)) *Note: Non-clinical laboratory studies are not considered to be clinical investigations. See the [DHHS definition of research](#) for DHHS-regulated research.*

Clinical Trial. *Pre-2018 Common Rule Definition:* Any investigation in human subjects intended to: discover or verify clinical, pharmacological, and/or other pharmacodynamic effects of an investigational product; identify any adverse reactions to an investigational product; and/or study absorption, distribution, metabolism, and excretion of an investigational product to determine its safety and/or efficacy. *Note: Studies involving only behavioral interventions are not covered by this policy.*

2018 Common Rule Definition: A research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

Clintrials.gov. A [registry and results database of publicly and privately supported clinical studies of human participants](#) conducted around the world.

Co-Principal Investigator. The Local PI may designate a Co-Principal Investigator (Co-PI) to assist with local PI responsibilities (e.g., report unanticipated problems, authorize modifications or progress reports). The primary authority and accountability for the conduct of the research may not be assigned or delegated to the Co-PI although they are considered to share equal responsibility for all aspects of the study and are both allowed to submit any IRB required reports/requests.

Code of Federal Regulations (CFR). The CFR is a codification of the general and permanent rules published in the [Federal Register](#) by the executive departments and agencies of the Federal Government. The CFR is divided into 50 titles representing broad areas subject to Federal Regulation. Each Title is divided into chapters that are assigned to agencies issuing regulations pertaining to that broad subject area. Each chapter is divided into parts and each part is then divided into sections -- the basic unit of the CFR. The purpose of the CFR is to present the official and complete text of agency regulations in one organized publication and to provide a comprehensive and convenient reference for all those who may need to know the text of general and permanent Federal regulations.

45 CFR 46: The Federal Policy for the Protection of Human Subjects published in 1991. It includes 4 subparts:

- Subpart A- also known as the “Common Rule,” the basic Health & Human Services policy for protection of Human Research Subjects.
- Subpart B - additional protections for pregnant women, human fetuses, and neonates involved in research.
- Subpart C - additional protections involving prisoners as subjects.
- Subpart D - additional protections for children involved as subjects in research.

21 CFR: Title 21 of the Code of Federal Regulations (CFR) pertains to the rules of the Food and Drug Administration (FDA). Each title (or volume) of the CFR is revised once each calendar year. It includes multiple parts; the most commonly referenced in clinical research being:

- 21 CFR 11- (also known as part 11) sets forth the criteria under which the agency (FDA) considers electronic records, electronic signatures, and handwritten signatures to be trustworthy, reliable, and generally equivalent to paper records and handwritten signatures executed on paper.

- 21 CFR 50- applies to all clinical investigations regulated by the FDA under sections 505(i) and 520(g) of the act, as well as clinical investigations that support applications for research and marketing permits for products regulated by the FDA including foods, dietary supplements that bear a nutrient content claim or a health claim, infant formulas, food and color additives, drugs for human use, medical devices for human use, and electronic products. Note: This section also includes a subpart D with similar protections for children.
- 21 CFR 56- outlines the general standards for the composition, operation, and responsibility of an Institutional Review Board (IRB) that reviews clinical investigations regulated by the FDA under sections 505(i) and 520(g) of the act, as well as clinical investigations that support applications for research and marketing permits for products regulated by the FDA including foods, dietary supplements that bear a nutrient content claim or a health claim, infant formulas, food and color additives, drugs for human use, medical devices for human use, and electronic products.
- 21 CFR 312- contains procedures and requirements governing the use of investigational new drugs, including procedures and requirements for the submission to, and review by, the Food and Drug Administration of investigational new drug applications (IND's).
- 21 CFR 314- sets forth procedures and requirements for the submission to, and the review by, the Food and Drug Administration of applications and abbreviated applications to market a new drug under section 505 of the Federal Food, Drug, and Cosmetic Act, as well as amendments, supplements, and post-marketing reports to them.
- 21 CFR 812- provides procedures for the conduct of clinical investigations of devices. An approved investigational device exemption (IDE) permits a device that would otherwise be required to comply with a performance standard or to have premarket approval to be shipped lawfully for the purpose of conducting investigations of that device.
- 21 CFR 814- implements sections 515 and 515A of the act [Federal Food, Drug, and Cosmetic Act] by providing procedures for the premarket approval of medical devices intended for human use.

Coded information and data. (1) Identifying information (such as name or social security number) that would enable the investigator to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, or combination thereof (i.e., the code); and (2) a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens.

Coded pre-existing or coded prospective data or specimens. if 1) the private information/specimens were not/will not be collected specifically for the currently proposed research through an interaction or intervention with living individuals, or 2) the investigator(s) never obtains identifiable data/specimens because: a) the holder of the key to decipher the code, destroys the key before the data is provided to the investigator, or b) the investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, or until the individuals are deceased; or c) there are laws or IRB-approved written policies for a repository/data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased.

Coercion. This occurs when an overt threat of harm is intentionally presented by one person in order to obtain compliance ([Belmont Report](#)). To be coercive, a subject who refuses must be made worse off than

if he or she would have been, if never asked even if the harm is only perceived. Coercion occurs, for example, in cases where retribution is conceivable or perceived by the subject. Examples of coercion include situations where it is implied that continued services are dependent upon participation in the research; or where refusal may affect some future care or outcome. [Inducements](#) (including payment) are not considered coercion for the purposes of UT Southwestern HRPP applications of policy. See [Undue Influence concerning when judgment may be compromised by financial incentives especially when the subject is not the recipient of the financial incentive](#)).

The HRPP must eliminate all sources of coercion.

Cognitively Impaired. While having either a psychiatric disorder (e.g., psychosis, neurosis, personality, or behavior disorder), a developmental disorder (e.g., mental retardation), or a neurological disorder that affects cognitive or emotional functions to the extent that capacity for judgment is significantly diminished may be considered to have a [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#), cognitively impaired should not be automatically considered to be unable to provide valid consent or assent. Additionally, other individuals may also be considered by the PI or the IRB to be cognitively-impaired or have a [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#) or have limited decision-making ability because they are under the influence of drugs or alcohol, suffering from degenerative diseases affecting the brain, are terminally ill, or have disabling physical handicaps, depending on the circumstances. (Also see [Mentally Disabled, Diminished Autonomous Decision-Making Capacity \(DADMC\), Handicapped](#))

Cohort. A group of subjects initially identified as having one or more characteristics in common who are followed over time. In social science research, this term may refer to any group of persons who are born at about the same time and share common historical or cultural experiences.

Cohort Study. A form of [longitudinal study](#) used in medicine and social science.

Collaborating Individual Investigator. This term is limited to collaborative research between an institution with a Federalwide Assurance and an outside researcher. The local implementation of these type agreements is as follows. The research covered by this agreement must be conducted under the direction and supervision of a UT Southwestern Principal Investigator or a PI from an UT Southwestern Affiliated institution. The collaborating individual investigator may not be an employee or agent of a UT Southwestern [Affiliated Institution](#) and must be conducting the collaborative research activities outside the facilities of the affiliated institution(s). There are two types of collaborating individual investigators:

1. A collaborating **independent** investigator is not acting as an employee of **any** institution with respect to his or her involvement in the research being conducted by the assured institution(s).
2. A collaborating **institutional** investigator is acting as an employee or agent of a non-assured institution with respect to his or her involvement in the research being conducted by the assured institution and the non-assured institution that does not routinely conduct human subjects research.

Collector Of Data/Specimens. Anyone who obtains data/specimens from the source and provides it to the Management Center/Repository, see [Repository](#), for storage. A collector (sometimes referred to as collector-investigator) can be from an organization covered by the UT Southwestern IRB or from an

organization not covered by the UT Southwestern IRB. The source is where the data/specimens originated (e.g., hospital pathology department, electronic record system, or a research study).

Community-Based Participatory Research. A collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change ([Agency for Healthcare Research and Quality- AHRQ](#))

Common Rule. The '[Common Rule](#)' is the Federal Policy for the Protection of Human Subjects, as set forth in 45 CFR 46 subpart A, and parallel regulations promulgated by agencies such as the FDA.

Compassionate Use (Expanded Access). While the phrase "compassionate use" is commonly used to describe some of the ways of making unapproved products available to patients, the technical term for this is Expanded Access (to investigational drugs or devices for treatment). The use of an investigational drug or device when the primary purpose is to diagnose, monitor, or treat a patient's disease or condition. The distinction between expanded access and the use of an investigational drug (or device) in the usual studies covered under an IND (IDE) is that expanded access uses are not primarily intended to obtain information about the safety or effectiveness of a test article. Although not considered research, the FDA requires IRB approval prior to non-emergency use. (IRB approval required).

Compensation. Compensation is payment for participation in research and should be the same for each subject as opposed to [Reimbursement](#) which may be different for each subject if for example reimbursement is based on verification of travel expenses, etc. *Note: Compensation could also be considered payment or medical care for study-related injury in certain circumstances.*

Compensation For Services Rendered. Compensation for recruitment and screening related activities that are unrelated to whether the participant ultimately enrolls in or completes the research study (such as advertising, administrative and personnel costs) or compensation for the costs of services provided to those individuals who do ultimately enroll. Investigators should be sure to determine a reasonable budget amount that is directly related to the value of the services provided to the study, and to document how that amount was determined.

Examples include the following:

- the budget might include a portion of the salary of individuals that is related to the time spent recruiting and screening potential research participants (regardless of whether they are successful in recruiting those participants),
- time spent for subsequent study visits,
- survey administration, and so forth.

Staff may not be paid a fee for every successful recruitment (e.g., \$10 for every participant who signs the consent document to participate in the study). Further, any payments to University for personnel must be reflected in the study budget and in the written agreement that is reviewed by Sponsored Programs Administration (SPA).

Competence. Technically a legal term, used to denote [Capacity](#) to act in one's own behalf; the ability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a choice.

(Also see [Mentally Disabled](#), [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#), [Handicapped](#), [Incompetent](#), [Capacity](#))

Competitive Enrollment. Indicates that the local site may enroll more subjects than originally planned by the study sponsor. In this situation, the total number of subjects enrolled study-wide does not change.

Compliance. In relation to research: Adherence to all relevant trial-related requirements, good clinical practice (GCP) requirements, and the applicable institutional, state and federal regulatory requirements.

Concurrent Control. A concurrent or prospective control is a subject who is not given the treatment or intervention under the study and who is compared with subjects given the treatment under the study. There are **three types** of concurrent controls: a concurrent control may be given a placebo (concurrent placebo control) or no treatment (a non-treatment concurrent control), or an active drug (a concurrent active control).

Confidential Disclosure Agreement (CDA). Sometimes called a 'Confidentiality Agreement' or 'Non-Disclosure Agreement', is a legal document which ensures the confidentiality or 'secrecy' of information that one party discloses to another party.

Confidentiality. In the context of human subjects research, the condition that results when data are maintained in a way that prevents inadvertent or inappropriate disclosure of participants' identifiable information.

Conflict of Interest. Any interest that could reasonably be expected to affect the objectivity of an IRB member or consultant in relation to an application or other matter under IRB review. An IRB member or consultant has a conflict of interest if the individual:

- Is or will be an investigator or member of the research team (that is, listed on the IRB application)
- Has an immediate family member (that is, spouse, dependent children) or personal relationship with an individual who is one of the investigators
- Has a financial or managerial interest in a sponsoring entity or product being evaluated or provided by a commercial entity in the research, as defined by UT Southwestern Conflict of Interest Policy
- Has received or will receive compensation with value (as defined by UT Southwestern Conflict of Interest Policy) that may be affected by the outcome of the research project

- Has a proprietary interest in the research, such as a nonprovisional patent application, patent, trademark, copyright or licensing agreement as defined by UT Southwestern Conflict of Interest Policy
- Has a nonfinancial interest (personal circumstance, ethical belief, or other factor) that may be conflicting, for example, the IRB member has an interest that he or she believes conflicts with his or her ability to review a project objectively

Consent. Consent is a person's voluntary agreement to participate in research or to undergo a diagnostic therapeutic or preventive procedure in contrast to the term [Informed Consent](#) which is making this decision with a knowledge and understanding of the relevant information and [Legally Effective Informed Consent](#) of the subject or the subject's legally authorized representative as outlined in 45 CFR 46 (Common Rule). *Also see [Mentally Disabled](#), [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#), and [Handicapped](#). Also [Informed Consent](#) or [Legally Effective Informed Consent](#).*

Consent document. A structured, written description in understandable terms of relevant research project information. The consent document is not consent itself; it is the record of what has been communicated to a potential participant. It is the document that ensures all regulatory elements are present and communicated to a potential participant. When signed by the potential participant, the consent document is a record of the receipt of research-related information by the participant. It also serves as reference material for the participant as the research project progresses. It is not a contract and is not legally binding, and the participant may choose to withdraw consent at any time.

Consortium Agreement. Group of collaborative investigators/institutions; an arrangement that can be formalized with specified terms and conditions.

Consultant. A scientist or nonscientist from within or external to UT Southwestern who has special expertise to act — at the request of the IRB — as an ad hoc reviewer of a research project application. These individuals have access to all documents relevant to the specific project under review, may participate in the deliberations and make recommendations on the project, but may not vote and are not counted toward quorum.

Continuing noncompliance. A pattern of repeated noncompliance (in one or more protocols simultaneously or over a period of time) which continues **after** initial discovery, including inadequate efforts to take or implement corrective or preventive actions within a reasonable timeframe, which may or may not also constitute [Serious Noncompliance](#).

Continuing Review of Research. Designates the review of requests to re-approve a study for continuation at any time after initial approval is granted. Periodic review of research activities at intervals appropriate to the degree of risk, but not less than once per year. The criteria for approval are defined by federal regulations.

Contract Research Organization (CRO): An independent contractor with the sponsor who assumes one or more of the obligations of the sponsor.

Controlled Study. Before a new drug or biologic can be marketed, its sponsor must show, through adequate and well-controlled clinical studies, that it is effective. A well-controlled study permits a comparison of subjects treated with the new agent with a suitable control population, so that the effect of the new agent can be determined and distinguished from other influences, such as spontaneous change, "placebo" effects, concomitant therapy, or observer expectations. FDA regulation 21 CFR 314.126 cites five different kinds of controls that can be useful in particular circumstances:

1. placebo concurrent control
2. dose-comparison concurrent control
3. [No-Treatment Control](#), also No-Treatment Concurrent Control.
4. active-treatment concurrent control, and
5. historical control

No general preference is expressed by the FDA for any one type, but the study design chosen must be adequate to the task.

Convended IRB Review: Review of proposed human subjects research by an Institutional Review Board that meets the membership requirements specified in federal regulations regarding the number, qualifications, diversity, and affiliation of its members, at which a majority of the members are present including at least one member whose primary concerns are in nonscientific areas.

Cooperative Agreement. An award similar to a grant, but in which the sponsor's staff may be actively involved in proposal preparation, and anticipates having substantial involvement in research activities once the award has been made.

Cooperative Research. In cooperative research, UT Southwestern investigators (employees/agents) are engaged in research or UT Southwestern will receive a direct federal (DHHS) award to conduct human subjects research, even where all activities involving human subjects are carried out by a non-UTSW entity (e.g., subcontractor or collaborator).

The UT Southwestern PI may be: 1) the Lead PI for the entire collaborative study (e.g., coordinates or directs the research at all study locations), 2) a collaborating investigator under the direction of a Lead PI from another institution, or 3) a collaborating investigator equally sharing the Lead PI responsibility with a local PI.

The [Off-Site Research](#) study site may be either: 1) an institution that regularly relies on the IRB for review and continuing oversight of research [Affiliated Institution](#), or 2) an institution that is not normally affiliated with the IRB. The employees of an off-site location that is part of the cooperative research may or may not be [Engaged In Research Individuals](#). An off-site institution or facility may be domestic or international and may or may not have its own IRB. *Also see [Off-Site Research](#).*

Covered Entity. Federal: Health plans, health care clearinghouses and health care providers who transmit any health information in electronic form in connection with a transaction that is subject to federal HIPAA requirements, as those terms are defined and used in the HIPAA regulations 45 CFR Parts 160 and 164. **Texas State:** Texas Health and Safety Code, Chapter 181, Medical Records Privacy: (2) "Covered entity" means any person who: (A) for commercial, financial, or professional gain, monetary

fees, or dues, or on a cooperative, nonprofit, or pro bono basis, engages, in whole or in part, and with real or constructive knowledge, in the practice of assembling, collecting, analyzing, using, evaluating, storing, or transmitting protected health information. The term includes a business associate, health care payer, governmental unit, information or computer management entity, school, health researcher, health care facility, clinic, health care provider, or person who maintains an Internet site; (B) comes into possession of [PHI: Protected Health Information](#); (C) obtains or stores protected health information under this chapter; or (D) is an [Employee, Agent](#), or contractor of a person described by Paragraph (A), (B), or (C) insofar as the employee, agent, or contractor creates, receives, obtains, maintains, uses, or transmits [PHI: Protected Health Information](#).

Therefore, in Texas, all healthcare providers must comply with the provisions relating to notice of privacy practices and access, amendment and uses and disclosures of protected health information, even if they do not engage in electronic transactions

Custom Device. A custom device means a device that:

- (1) Necessarily deviates from devices generally available or from an applicable performance standard or pre-market approval requirement in order to comply with the order of an individual physician or dentist;
- (2) Is not generally available to, or generally used by, other physicians or dentists;
- (3) Is not generally available in finished form for purchase or for dispensing upon prescription;
- (4) Is not offered for commercial distribution through labeling or advertising; and
- (5) Is intended for use by an individual patient named in the order of a physician or dentist, and is to be made in a specific form for that patient, or is intended to meet the special needs of the physician or dentist in the course of professional practice.

A custom device may be exempt from the requirement for prior submission to the FDA for an IDE unless the device is being used to determine safety or effectiveness for commercial distribution. Note in some cases where not exempt, a custom device may still qualify for abbreviated requirements, in which case prior submission to the FDA for an IDE may not be required prior to IRB approval.

Customer Satisfaction Survey. This refers to surveys of program users to obtain feedback for use by program managers. This is similar to program evaluation.

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D

Data. When data is anonymous, they are not linked to the identity of individual subjects in any way that would make it possible to connect the information to the individual from whom it came. Anonymous data does NOT have direct identifiers like names, addresses, clinic or hospital number, Social Security

Number, or insurance agency numbers. Data that is linked to subjects via a CODE are NOT anonymous. When data is confidential, there is a link between data and the individuals who provide it, but the link is obscured by coding or other procedures so that even someone who has access to the raw data cannot identify a subject without also having access to the link between the subject code and the subject's identity.

Data Management Centers. Facilities that collect, store, and distribute human data for research purposes. Data management activities involve three components: (1) the collectors of data; (2) the data storage and management center; and (3) the recipient investigators. Data management centers may be combined with human [Repository](#).

Data and Safety Monitor. An individual assigned to conduct interim monitoring of accumulating data from research activities to assure the continuing safety of research participants, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. The individual should have expertise in the relevant medical, ethical, safety and scientific issues.

Data and safety monitoring board (DSMB). A data safety monitoring board is an independent committee set up specifically to monitor data throughout the duration of a study to determine if continuation of the study is appropriate scientifically and ethically. Factors that suggest a DSMB is needed:

- A large study population and
- Multiple study sites. It is more difficult to recognize a pattern of increased or unusual problems or events when investigators treat small fractions of the population separately;
- Highly toxic therapies or dangerous procedures;
- High expected rates of morbidity or mortality in the study population;
- High chance of early termination of the study. DSMB membership is usually comprised of experts in the fields of medicine and science that are applicable to the study — statistical experts, lay representatives and others who can offer an unbiased assessment of the study progress.

Data and safety monitoring plan (DSMP). A data and safety monitoring plan (DSMP) is meant to ensure that each clinical investigation has a system for appropriate oversight and monitoring of the conduct of the clinical investigation. The purpose of a DSMP is to ensure the safety of the participants, the validity of the data and the integrity of the study, and the appropriate termination of studies for which significant benefits or risk has been uncovered or when it appears that the investigation cannot be concluded successfully. A DSMP is commensurate with the risks involved with the research study. The DSMP may include a data and safety monitoring board (DSMB).

Data use agreement. An agreement into which UT Southwestern and the investigator enter with the intended recipient of a limited data set that establishes the ways in which the information in the limited data set may be used and how it will be protected.

Debriefing. Giving subjects previously undisclosed information about the research project following completion of their participation in the [Research](#).

Deception. The intentional misleading of subjects or the withholding of full information about the nature of the experiment. Misleading or omitted information might include the purpose of the research, the role of the researcher, or what procedures in the study are actually experimental. Deception increases ethical concerns, because it interferes with the ability of the subject to give informed consent. However, deception is arguably necessary for certain types of behavioral research. Because humans act differently depending on circumstances, full knowledge by the subject might bias the results.

Some research can only be conducted without the full knowledge of the research subjects. Yet the use of deception in research raises special problems that the IRB will review closely. One consideration is whether the deception is necessary. Present federal rules prohibit the use of deceptive techniques which place subjects at more than minimal risk.

Debriefing - IRBs expect investigators to debrief subjects who have been deceived during participation in research activities. The debriefing should include a detailed description of the ways in which deception was used. The investigator is responsible for ensuring that the subject leaves the research setting with an accurate understanding of the deception. The debriefing process, including any written materials, should be explained to the IRB as a part of submitted protocols.

Declaration of Helsinki. An international ethical code first issued in 1964 by the 18th [World Medical Assembly](#) in Helsinki, Finland. The Declaration contains 12 basic principles, which are similar to the [Nuremberg Code](#), but represent an expansion of what constitutes acceptable [Research](#) and the ethical responsibilities of investigators. Unlike the Nuremberg Code, the Declaration of Helsinki addresses the need for peer review (i.e., IRB review). It is interesting to note that the FDA will not accept foreign data unless the studies in which such data are generated are conducted in compliance with the Declaration of Helsinki (21 CFR 312.20, 46 Fed Reg 8953; Tuesday, January 17, 1981).

Belmont Report: A report consisting of ethical principles and guidelines for protection of human subjects in [Research](#). It was issued April 18, 1979, by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

Deferred. An IRB action taken when the IRB cannot fully evaluate the research under review and make the determinations required for approval without modifications to the protocol and/or informed consent document, or submission of clarifications or additional materials prior to reconsideration of the research. *Note: Convened IRB review of the investigator's response(s) is required.*

De-identified health information. All direct personal identifiers are *permanently* removed (e.g., from data or specimens), no code or key exists to link the information or materials to their original source(s), and the remaining information cannot reasonably be used by anyone to identify the source(s). *Note: For purposes of HRPP policy, health information is de-identified when it does not contain any of the 18 identifiers specified by the HIPAA Privacy Rule at 45 CFR Part 164 (or has been determined to be de-identified by a statistician in accordance with the standards established by the Privacy Rule).*

The 18 identifiers:

1. Names

2. All geographical subdivisions smaller than a state, including street address, city, county, precinct, ZIP code and their equivalent geocodes, except for the initial three digits of a ZIP code, if according to the current, publicly available data from the U.S. Census Bureau:
 1. The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people, and
 2. The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people are changed to 000;
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate and license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Uniform Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full-face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic or code (note this does not mean the unique code assigned by the investigator to code the data).

Department or Agency Head. If an institution engaged in research is subject to an assurance to said department or agency, federal reporting requirements include reports to said department or agency heads. Reports are made generally to OHRP when the department is [DHHS](#), but if not DHHS, then reports shall also be made to OHRP in addition to said department or agency head.

(See Department or Agency Heads, <http://www.usa.gov/directory/federal/index.shtml>)

Designated Reviewer. One or more experienced reviewers designated by the Chair from among the members of the IRB. Experience is determined by review of CV and interview with IRB Chair or HRPP Director and includes previous experience on IRBs (or other research review committees), or research regulatory/ethical education.

Deviation. See [Noncompliance](#)

Device. A device per the FDA is: "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: 1) recognized in the [United States Pharmacopeia–National Formulary](#) (USP–NF), or any supplement to them, 2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation,

treatment, or prevention of disease, in man or other animals, or 3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes."

See also [Medical Device](#)

DHHS. [The Department of Health and Human Services](#), under the Secretary of Health and Human Services, is responsible for "Improving the health and well-being of America". [The National Institutes of Health](#) (NIH), [Center for Disease Control](#) (CDC), [Health Resources and Services Administration](#) (HRSA) and [The Substance Abuse and Mental Health Services Administration](#) (SAMHSA) are examples of DHHS agencies.

Dietary Supplement. Congress defined the term "dietary supplement" in the Dietary Supplement Health and Education Act (DSHEA) of 1994. A dietary supplement is a product taken by mouth that contains a "dietary ingredient" intended to supplement the diet. The "dietary ingredients" in these products may include: vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissues, glandulars, and metabolites. Dietary supplements can also be extracts or concentrates, and may be found in many forms such as tablets, capsules, softgels, gelcaps, liquids, or powders. They can also be in other forms, such as a bar, but if they are, information on their label must not represent the product as a conventional food or a sole item of a meal or diet. Whatever their form may be, DSHEA places dietary supplements in a special category under the general umbrella of "foods," not drugs, and requires that every supplement be labeled a dietary supplement. If a research study is intended to show a certain health benefit, the supplement may be subject to regulation as a drug in that the study is considered to be designed to make a [Drug Claim](#).

Diminished Autonomous Decision-Making Capacity (DADMC). Refers to a person with limits in either mental capacity or voluntariness. Mental capacity is the ability to understand and process information. Voluntariness is the freedom from the control or undue influence of others. A person has full autonomy when he/she has the capacity to understand and process information, and the freedom to volunteer for research without coercion or undue influence from others.

Subjects with diminished autonomous decision-making capacity who have not been determined to have [Impaired Decision-Making Capacity](#), [Incapacitated](#) or [Incompetent](#), are capable of giving informed consent for research.

Directed (For-Cause) Audit/Review. An audit of research and/or investigators initiated at the request of the IRB or Institutional Official to obtain or verify information necessary to ensure compliance with regulations and institutional requirements and to inform decisions about the conduct of human subjects research and/or human subjects protection.

Disapproved. An IRB action taken when the determinations required for approval of research cannot be made, even with substantive clarifications or modifications to the protocol and/or informed consent process/document. *Note: Research cannot be disapproved by expedited review.*

Disclosure of PHI. The release, transfer, or provision of access to, or divulging in any manner of, information outside the covered entity.

Dissent. Behaviors that would indicate an individual does not want to participate (Where seeking assent, dissent behaviors may be interpreted in certain studies as simply moving away, certain facial expressions, head movements, etc.)

Documentation. The act or an instance of furnishing or authenticating with documents. Documentation of informed consent includes use of a written consent form, approved by the IRB and signed and dated by the subject or the subject's legally authorized representative.

Drug. A drug is defined as:

- A substance recognized by an official pharmacopoeia or formulary.
- A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.
- A substance (other than food) intended to affect the structure or any function of the body.
- A substance intended for use as a component of a medicine but not a [Device](#) or a component, part or accessory of a [Device](#).
- Biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process).

Drug Claim. Is that the product is useful in diagnosing, mitigating, treating or curing a specific disease or class of diseases. Nutrient content claims characterize the level of a nutrient in a food (e.g., "high in fiber"). Health claims describe the role of a food substance in reducing the risk of a disease (e.g., "Adequate folate in healthful diets may reduce a woman's risk of having a child with a brain or spinal cord birth defect. "). If a research study is intended to show a certain health benefit, care should be taken to consider whether the research is intended to claim that a [Dietary Supplement](#) is useful in diagnosing, mitigating, treating or curing a specific disease or class of diseases, as these are drug claims, not health claims. Dietary supplements that bear such disease claims are subject to regulation as [Drug](#).

The [Investigation / Investigational](#) use of approved, marketed [Drug](#) products to develop information about the product's safety or efficacy differs from the situation for food products or [Nutritional Supplement](#) used in scientific studies to develop information to support a "health claim". "Investigational use" of an approved drug product suggests the use in the context of a clinical study protocol, see 21 CFR 312.3(b). When the principal intent of the investigational use of a drug or device test article is to develop information about the product's safety or efficacy, submission of an IND or IDE may be required unless certain criteria are met. Under the Dietary Supplement Health and Education Act of 1994 (DSHEA), the dietary supplement manufacturer is responsible for ensuring that a dietary supplement is safe before it is marketed. FDA is responsible for taking action against any unsafe dietary supplement product after it reaches the market as well as reviewing safety information in 75-day premarket notifications for new dietary ingredients, to ensure that such products are reasonably expected to be safe (21 CFR 190.6). As of August 24, 2007, manufacturers of dietary supplements are required to follow current good manufacturing practices (cGMPs) for dietary supplements, known as the [Final Rule cGMPs For Dietary Supplements](#).

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Elements of Informed Consent. No investigator may involve a human being as a subject in research covered by UT Southwestern policy unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The information that is given to the subject or the representative shall be in language understandable to the subject or the representative. No informed consent, whether oral or written, may include any exculpatory language through which the subject or the representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution or its agents from liability for negligence.

(a) Basic required elements of informed consent. Except when waiver or alteration is sought and approved by the IRB, in seeking informed consent, the following information is required to be provided to each subject:

- (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 reasonably be 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; and
- (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.

(b) Additional elements of informed consent.

When appropriate (in part based on risk and complexity of the study), one or more of the following elements of information are required (NOTE: “required by the IRB when appropriate” means that after approval, they are considered part of the list of required elements that must be considered in the discussion of consent form changes that would not constitute a minor change) to be provided to each subject:

- (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 relate to the subject's willingness to continue participation will be provided to the subject; and
- (6) The approximate number of subjects involved in the study.

Eligibility Criteria. Summary criteria for participant selection. See [Inclusion/Exclusion Criteria](#)

Embryo. Early stages of a developing organism, broadly used to refer to stages immediately following fertilization of an egg through implantation and very early pregnancy (i.e., from conception to the eighth week of pregnancy).

Emergency research. Planned research involving human subjects who have a life-threatening medical condition that necessitates urgent intervention (for which available treatments are unproven or unsatisfactory), and who, because of their condition (such as traumatic brain injury) cannot provide informed consent.

Emergency treatment IDE. A mechanism through the FDA for providing eligible participants with investigational devices for the treatment of an immediate serious or life-threatening illness for which there are no satisfactory alternatives.

Emergency treatment IND. A mechanism through the FDA for providing eligible participants with investigational drugs, agents or biologics for the treatment of an immediate serious or life-threatening illness for which there are no satisfactory alternatives.

Emergency Use. Emergency Use of an unapproved drug (i.e., Emergency IND or Emergency Protocol) or device (Emergency Use)

When an unapproved drug or device was used to treat a patient emergency situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval. The FDA definition of an emergency is similar but slightly different for drugs and devices.

Drug – either [Life-threatening](#) or [Severely Debilitating](#)

- Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.
- Severely debilitating means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.
- For drugs, FDA authorization must be obtained (either telephone or written submission) **prior to use** of a drug.

Device – either life-threatening or serious disease or condition that needs immediate treatment

- For devices, the FDA must be notified within five days. The FDA recognizes that typically there will not be time to obtain prior IRB approval - must be reported within five (5) working days of initiation of treatment.

Emergency Deviation. Any changes to the approved investigational plan without prior IRB approval that is necessary to eliminate apparent immediate hazards or to protect the life or physical well-being of subjects or others.

- Examples include withholding study drug in response to a serious adverse event (actual harm) or to avoid a serious harm (risk of harm).

Emergency deviations may also be Unanticipated Problems Involving Risks to Subjects or Others ([UPIRSO](#)), which require prompt reporting to the reviewing IRB (and UTSW HRPP for reliance studies).

Employee. Used as a term within the definition of whether an institution is [Engaged In Research Individuals](#) (in combination “[Employee](#) or [Agent](#)”). An employee is a person who is hired for a wage, salary, fee or payment to perform work for an employer. Employees are individuals performing institutionally designated activities and acting on behalf of the institution or exercising institutional authority or responsibility.

Therefore, the critical issue in determining whether an institution is engaged in research is whether the facts indicate that someone is working on the institution’s behalf, on their own behalf, or someone else’s behalf, when they are performing the research activities in question. In certain cases, even though the individual may be employed in whole or in part by an institution, where the individual is performing research activities outside the institution, outside their affiliation with the institution in question, there exists the possibility that he/she may not be considered an employee or agent of the institution in question where the research activity is concerned since they are not “performing institutionally

designated activities and acting on behalf of the institution or exercising institutional authority or responsibility” in that regard. It is possible for a UT Southwestern employee to conduct research and not be considered an agent of the university if the research is conducted during non-official duty time, is not in connection with her/his UT Southwestern responsibilities, is not being conducted at a UT Southwestern facility and the research is not supported by a direct HHS award to UT Southwestern.

The institution however generally reserves the right to determine for themselves whether their employee (in whole or in part) is “performing institutionally designated activities and acting on behalf of the institution or exercising institutional authority or responsibility” in regard to that research and the IRB will generally consider this in determining whether the institution in question is engaged in research.

Employee of a Covered Entity. A covered entity is responsible for civil monetary penalties resulting from HIPAA violations committed by its agents, including employees, independent contractors, and other members of its workforce, therefore where the word employee is used in research policies where HIPAA may be applied, this definition will include such individuals. Note that although a covered entity will not be responsible for violations committed by its business associates, the covered entity must have complied with the HIPAA business associate contractual provisions and must not have known of the pattern of activity or practice of the business associate that resulted in the violation, or if aware of such pattern or practice, must have made a good faith effort to take appropriate corrective action.

Engaged In Research – Institutions. In general, an institution is considered engaged in a particular non-exempt human subjects research project when its employees or agents for the purposes of the research project obtain: (1) data about the subjects of the research through intervention or interaction with them; (2) identifiable private information about the subjects of the research; (3) the informed consent of human subjects for the research; 4) whenever the institution receives a direct HHS award to support such research, even if all of the human subjects activities will be performed by agents or employees of another institution 45 CFR 46.102(d),(f).

Institutions that are engaged in non-exempt human subjects research that is conducted or supported by any HHS agency must be covered by an Office for Human Research Protections-approved [Assurance Of Compliance](#). An institution holding an OHRP-approved Federal wide Assurance is referred to as an [Assured Institution](#).

Federally-supported is defined throughout the FWA and the Terms of Assurance as the U.S. Government providing any funding or other support.

An institution may extend its FWA to cover a collaborating individual investigator from a [Non-Assured Institutions](#) under certain conditions using the OHRP sample [Individual Investigator Agreement \(IIA\)](#) or a comparable agreement developed by the institution.

For detailed description of when an institution is engaged in research see the OHRP Website, <http://www.hhs.gov/ohrp/policy/index.html#engagement>.

Engaged In Research Individuals. HRPP has defined when an individual is engaged in research based on the OHRP policy guidance of when institutions are engaged.

In general, individuals are considered engaged in a non-exempt human research project (and therefore would need IRB approval) when their involvement in the human subjects research includes any of the following activities:

- The individual receives an award through a grant, contract, or cooperative agreement directly from HHS for the non-exempt human subjects research (i.e., awardee), even where all activities involving human subjects are carried out by individuals of another institution.
- The individual intervenes (see [Intervention](#)) for research purposes with any human subjects of the research by performing [Invasive](#) or Noninvasive procedures (e.g., drawing blood; collecting buccal mucosa cells using a cotton swab; administering individual or group psychotherapy; administering [Drug](#) or other treatments; surgically implanting medical [Device](#); utilizing physical sensors; and utilizing other measurement procedures).
- Individual intervenes for research purposes with any human subject of the research by manipulating the environment (e.g., controlling environmental light, sound, or temperature; presenting sensory stimuli; and/or orchestrating environmental events or social interactions).
- The individual interacts (see [Interaction](#)) for research purposes with any human subject of the research. (e.g., engaging in protocol-dictated communication or interpersonal contact; asking someone to provide a specimen by voiding or spitting into a specimen container; and conducting research interviews or administering questionnaires).
- The individual obtains the informed consent of human subjects for the research.
- Individual obtains for research purposes, [Identifiable](#) private information or identifiable biological specimens from any source for the research. Obtaining includes, but is not limited to: (a) observing and/or recording private behavior; (b) using, studying, or analyzing for research purposes, identifiable private information or identifiable specimens provided by another institution, and (3) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens already in the possession of the investigators. **Private information or specimens are considered to be individually identifiable when they can be linked to specific individuals by the investigator either directly or indirectly through coding systems.

Examples of when individuals are **NOT “Engaged”** in non-exempt human research:

- an appropriately qualified laboratory technician from Clements University Hospital performs routine serum chemistry analyses of blood samples for investigators as part of a commercial service.
- a radiology technician from the Dental School performs bite-wing x-rays and sends the results to investigators as a service.
- an individual whose only function is to: (a) inform prospective subjects about the availability of the research; (b) provide prospective subjects with information about the research (which may include a copy of the relevant informed consent document)

Enrolled Subject. See [Subject Status](#): Enrolled

Enrollment. The process of seeking eligible participants and obtaining their consent to participate in the research. Enrollment generally starts with recruitment, leading to screening for eligibility, and consent to enroll in the study. See [Accrual](#).

Equitable. Fair or just; used in the context of selection of subjects, to indicate that the benefits and burdens of research are fairly distributed.

Ethical Codes and Statements Of Ethical Principles. There are three major ethical codes that provide general ethical guidelines for the responsible conduct of [Research](#) in the United States and which provide the basis for the HHS/FDA regulations on the protection of human [Research](#) subjects. It should be noted that HHS/FDA regulations are not intended to serve as an ethical code. In fact, 45 CFR 46.103 requires each institution's Assurance of Compliance to include a statement of principles for ethical conduct of research which may be based upon "an appropriate existing code, declaration or statement of ethical principles."

Most institutions use the [Belmont Report](#), [Declaration of Helsinki](#) and the [Nuremberg Code](#).

Ex-Officio. Member by virtue of the office held.

Exception. A one-time, intentional action that departs from the IRB approved protocol for a single subject. An exception is identified before it occurs and is under the control of the investigator.

Single subject exceptions may not be initiated without prior IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.

Examples include (but are not limited to): enrollment of a single subject who does not meet all eligibility criteria for a study, but the investigator and sponsor have agreed this subject should be enrolled.

Exculpatory Language. As it applies to informed consent, any written or verbal communication through which a research participant (or his/her legally authorized representative) is asked to waive or appear to waive any of the participant's legal rights or to release (or appear to release) the investigator, sponsor, or institution or its agents from liability for negligence.

Exempt human subjects research. Research that involves human subjects that is not subject to regulations requiring IRB review and approval. Categories of research activities that may be determined to be exempt from review by the IRB are defined by federal regulations and UT Southwestern policy. *Note: Investigators performing exempt research must comply with the requirements of the HRPP even when the research is exempt.*

Exempt Review. What Exemption Means: "Exemption" as used in this document means exemption from the requirements set forth in Regulations for the Protection of Human Subjects (45 CFR 46), such as the requirement for a written informed consent document. What Exemption Does Not Mean: "Exemption" does not mean that the research activity is exempt from the law, and it does not mean that the research need not conform to the canons of sound research ethics. In order to qualify for exemption, a research study must fall entirely within one or more of the six categories for exemption and it cannot place subjects at greater than minimal risk. If the research involves prisoners, then it does not qualify for exemption from federal regulations and IRB review.

Existing Data/Specimen. Data/specimen in the records or on the shelf prior to IRB review and was created for a reason other than the proposed research. All data included in the request to analyze existing data must exist at the time the research is proposed.

Expanded Access: The use of an investigational medical product (i.e. one that has not received FDA approval), outside of a clinical trial, for the diagnosis, monitoring, or treatment of a serious disease or condition. It is also known as “compassionate use”.

Expedited Research. Non-exempt human research that is eligible for [Expedited Review Of Research](#).

Expedited Review of Research. Procedure used to review either or both of the following:

- Some or all of the research appearing on [HHS list of categories of research](#), as published in the Federal Register, and found by the reviewer to involve no more than minimal risk.
- Minor changes in previously approved research during the period (of 1 year or less) for which approval is authorized.

Experienced IRB Member: Member who has served for 1 year as an IRB member, or holds a CIP certification, or has 1 year of work experience within an IRB/HRPP office as a coordinator, analyst or a director. Experienced IRB members may be nominated by the HRPP Director and appointed by the IRB Chairs to serve as an expedited reviewer on behalf of each IRB.

Experimental. Term often used to denote a therapy ([Drug](#), [Device](#), procedure, etc.) that is unproven or scientifically yet to be validated with respect to safety and efficacy. Often used to denote [FDA](#) approval has not yet been obtained. A procedure may be considered “experimental” without necessarily being part of a formal study (research) to evaluate its usefulness.

Experimental subject: Involves any activity, for research purposes, where there is an intervention or interaction with a human subject for the primary purpose of obtaining the effect of the intervention of interaction (32 CFR 219.102(f)).

Expiration Date. The date that the IRB’s approval of research has lapsed and research can no longer be performed. *Note: An expiration date may not be longer than one year from the date the approval period begins.*

Expired study. When continuing review of the research does not occur prior to the end of the approval period specified by the IRB, IRB approval expires automatically. The study expires on the date specified on the approval letter and the consent document. No activities can occur after the expiration date.

Exploitation. When one has unfair advantage over another. Often raised as a concern when paying (offering [Inducements](#) to) vulnerable populations (e.g., economically disadvantaged or institutionalized individuals). Paying economically disadvantaged individuals the same amount as would be paid to others who are not disadvantaged may be seen as unduly influential. However, paying these individuals less to reduce [Undue Influence](#) may be seen as exploitative.

External. As it relates to adverse events and unanticipated problems, external refers to those events or problems experienced by subjects enrolled by investigator(s) approved by IRBs other than the UT Southwestern IRB, to perform research at their respective institutions. These reports might be received as part of a multicenter clinical trial, because a local site/institution has obtained UT Southwestern IRB approval, or even if not part of the same trial if the external event involves an FDA-regulated item under investigation at a local site/institution that has obtained UT Southwestern IRB approval.

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Family Member. For purposes of the waiver of informed consent for emergency research, any one of the following legally competent persons: spouse, parent, child (including an adopted child), brother, sister, spouse of a brother or sister, and any individual related by blood or affinity whose close association with the subject is the equivalent of a family relationship.

FDA. [US Food and Drug Administration](#), an agency of the Federal government, established by Congress in 1912 and presently part of the Department of Health and Human Services (HHS).

FDA Approved. Approved or cleared by the FDA is a general term in which FDA regulated articles which have been submitted to the FDA have been reviewed and resulted in any of the following:

Drugs, Biologics: FDA Approved or cleared refers to FDA having issued premarketing approval (PMA)

Devices: FDA Approved or cleared refers to FDA having issued a pre-market approval (PMA); cleared the device for marketing via a Premarket Notification 510(k); considered the device exempt under 510(k) (807.85).

FDA Regulatory Paths To Market Devices: Three regulatory paths to the market for devices are via Premarket Approval (PMA), Premarket Notification (510(k)), and HDE (see a brief description below).

A device with an approved PMA is approved for marketing based on valid scientific evidence and reasonable assurance that the device is safe and effective for its intended use. Once approved, it can be marketed and sold within its approved labeling. There are no restrictions on the price, and it can be used by anyone qualified to use the device.

A 510(k) device is cleared for marketing when the agency finds that it is at least as safe and effective, that is, substantially equivalent, to a legally marketed device that is not required to have a PMA. Using valid

scientific evidence, submitters compare their device to one or more similar legally marketed devices, comparing the indications for use and technological characteristics.

A device with an approved HDE is approved for marketing, but the approval is based on evidence of safety and probable benefit. The Act and implementing regulations exempt HUDs from the requirement to establish a reasonable assurance of effectiveness. The HUD is intended for use in the treatment or diagnosis of a disease or condition that affects or is manifested in fewer than 4,000 individuals in the US per year.

FDA-Regulated Human Research. Human research will be considered FDA-regulated and therefore may be subject to FDA regulations (including but not limited to those) specific to:

1. informed consent
2. IRB review and
3. drugs, biologics or devices as appropriate) when the human research activity is Human Research according to FDA Regulations.

Human research is considered FDA regulated when the activity involves an FDA-regulated test article and the activity involves human participants.

An activity involves an FDA regulated test article when one or more of the following is true:

- The activity involves the use of a [Drug](#), or other than the use of a marketed drug in the course of medical practice; **or**
- The activity involves the use of a [Device](#) to evaluate safety or effectiveness of that device; **or**
- Data from the activity will be submitted to, or held for inspection by, the FDA in support of a marketing or research application for an [FDA-Regulated Product](#).

An activity involves human participants when one or more of the following is true:

- The test article will be used on one or more humans; **or**
- Data obtained from controls will be submitted to, or held for inspection by, the FDA in support of a marketing or research application for an FDA regulated product; **or**
- Data obtained from use of a device on tissue specimens will be submitted to, or held for inspection by, the FDA in support of a marketing or research application for an FDA regulated product.

FDA-Regulated Product. Used in human research involves any product (e.g., food including dietary supplements that bear a nutrient content claim or a health claim, infant formulas, food and color additives, drugs for human use, biological products for human use, medical device for human use or electronic products,) used in or being developed for use in man. The FDA is responsible for determining whether sufficient evidence exists for such products to be claimed as safe and effective. For the purposes of human research, the term is often used to clarify when human research, in addition to being subject to other federal regulations, also falls under the FDA research regulations.

Feasibility Study. "Feasibility studies are pieces of research done before a main study to answer the question 'Can this study be done?' They are used to estimate important parameters that are needed to design the main study". Data collected would not be analyzed or included in publications. Feasibility studies typically do not meet the definition of research involving human subjects and therefore would not require IRB review.

Examples:

1. Going to a potential site to see if the research is possible
2. Checking to see what is the best approach to the research
3. Going through a consent process with friends to see if the information is comprehensible
4. Sending your survey instrument to a few experts in the field for their feedback as to whether or not the questions are appropriate for the topic and/or cohort of the research
5. Feedback from colleagues and peers about research design
6. Student researcher designs questionnaire for their study's target population and asks someone from a different population to test the questionnaire

Federalwide Assurance (FWA). The Federalwide Assurance (FWA) is the only type of new [Assurance Of Compliance](#) accepted and approved by [OHRP](#) for institutions engaged in non-exempt human subjects research conducted or supported by [HHS \(DHHS\)](#). Under an FWA, an institution commits to HHS that it will comply with the requirements set forth in 45 CFR part 46, as well as the Terms of Assurance.

Fetus. Unborn child; the product of conception from implantation until delivery.

Final report. A report the principal investigator may elect to submit to the IRB to serve as a final record of any pertinent activity since the last continuing review report and to record research project completion.

Final Rule CGMP For Dietary Supplements. The U.S. Food and Drug Administration issued the final rule establishing regulations to require current good manufacturing practices (CGMPs) for dietary supplements. The final CGMP is effective August 24, 2007. To limit any disruption for [Dietary Supplement](#) produced by small businesses, the rule has a three-year phase-in for small businesses. Companies with more than 500 employees have until June 2008 to comply, companies with less than 500 employees have until June 2009 to comply, and companies with fewer than 20 employees have until June 2010 to comply with the regulations. If a research study is intended to show a certain health benefit the a dietary supplement may be subject to regulation as a [Drug](#) in that the study is considered to be designed to make a [Drug Claim](#).

Financial Sponsor. The agency, organization, company, or person that pays for the trial.

Finder's Fee. Compensation of any type (e.g. cash, cash equivalents, office or medical supplies, educational stipends, gift certificates, travel cost in excess of normal reimbursement costs, or anything else of value) to an individual made in exchange for referral or recruitment of a participant to a research study. Such payments, generally, are made to study team members who are in a position to identify

potential participants who might qualify for enrollment into a study. The finder's fee is paid to the study team member for each participant they recruit who actually enrolls in the study. It is not permissible to pay or accept "finder's fees" at UT Southwestern. Additionally, it is not permissible for UT Southwestern employees or students to accept personal payments from sponsors or others in exchange for accelerated recruitment or referrals of patients. This does not include compensation for services rendered which include screening and referral activity unrelated to whether the participant ultimately enrolls in or completes the research study.

Finding of noncompliance. An occurrence or determination of noncompliance that does not require further confirmation or investigation (e.g., failure to respond to the IRB within established deadlines, allegation of noncompliance determined by the IRB to be true).

Food and Drug Administration (FDA). The regulatory authority in the United States that oversees the pharmaceutical and medical device industries. The FDA is responsible for ensuring that the drugs and medical devices marketed in the U.S. are safe and have a greater benefit than risk when used according to manufacturer's directions.

For-Cause Audit/Review. An audit of research and/or investigators initiated at the request of the IRB or Institutional Official to obtain or verify information necessary to ensure compliance with regulations and institutional requirements and to inform decisions about the conduct of human subject research and/or human subject protection.

Full board review. Studies reviewed by the full, convened IRB committee with a recorded vote and corresponding minutes to document the discussion. Review of proposed research at a convened meeting at which a majority of the membership of the IRB is present, including at least one member whose primary concerns are in nonscientific areas. For the research to be approved, it must receive the approval of a majority of those members present at the meeting.

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Generalizable Knowledge. Knowledge that is universally or widely applicable.

Genetic Information Nondiscrimination Act (GINA). Created in 2008, this [act](#) prohibits discrimination in health insurance and employment through the use of genetic information.

Good Clinical Practice (GCP). A standard established by the [International Conference on Harmonisation](#) for the design, conduct, performance, monitoring, auditing, recording, analyses, and reporting of clinical trials that provides assurance that the data and reported results are credible and accurate, and that the rights, integrity, and confidentiality of trial subjects are protected. *Note: In the United States, FDA has adopted GCP as guidance.*

Guardian. An individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care when general medical care includes participation in research. [21 CFR §50.3(s)]

A guardian also means an individual who is authorized to consent on behalf of a child to participate in research. [21 CFR§50.3(s)]

Guardian means an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care. [45 CFR §46.402(e)]

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Halt. (to research) is a cessation of some or all research activities voluntarily initiated by the Principal Investigator or sponsor (for example temporarily stopping enrollment or other research procedures, placing the study “on hold”). This does not constitute IRB [Suspension Of Research or Termination](#).

Handicapped. Handicapped person means any person who has a **Physical Or Mental Impairment** that substantially limits one or more **major life activities**, has a record of such an impairment, or is regarded as having such an impairment by criteria (for evaluating the subject during the screening process or scheduled evaluations during a research study) established in the research protocol that represent a need for additional safeguards for vulnerable populations described by the PI in the research protocol or as determined by the IRB (possibly including [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#) if the physical or mental impairment leads to a decreased capacity to make their wishes known).

As used in this research definition of handicapped, the phrase:

1. **Physical or mental impairment** includes as described below impairment that represent a need for additional safeguards for vulnerable populations described by the PI in the research protocol or as determined by the IRB (possibly including Diminished Autonomous Decision-Making Capacity if the physical or mental impairment leads to a decreased capacity to make their wishes known)-
 - Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; that represent a need for additional safeguards for vulnerable populations
 - Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and drug addiction and alcoholism that represent a need

for additional safeguards for vulnerable

2. **Major Life Activities** includes functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Health Information. Any information, whether oral or recorded in any form or medium, that (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. This constitutes a larger set of information which may be broken down into that health information which is not identifiable and that which is Identifiable Health Information. See [Individually Identifiable Health Information](#).

Health Insurance Portability and Accountability Act of 1996 (HIPAA). [The HIPAA Privacy Rule](#) regulates the use and disclosure of Protected Health Information (PHI) held by "covered entities" (generally, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions). By regulation, the DHHS extended the HIPAA privacy rule to independent contractors of covered entities who fit within the definition of "business associates". PHI is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted rather broadly and includes any part of an individual's medical record or payment history. They also must disclose PHI when required to do so by law, such as reporting suspected child abuse to state child welfare agencies.

Health Surveillance. Is an ongoing part of the medical care and public health care functions closely integrated with timely dissemination of these data to those responsible for preventing and controlling disease or injury (may include emergent or urgently identified or suspected imminent health threats to the population to document the existence and magnitude). Generally, not considered a research activity.

HHS (DHHS). Health and Human Services (HHS) or [The Department of Health and Human Services](#), under the Secretary of Health and Human Services, is responsible for "Improving the health and well-being of America". [The National Institutes of Health \(NIH\)](#), [Center for Disease Control \(CDC\)](#), [Health Resources and Services Administration \(HRSA\)](#) and [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) are examples of DHHS agencies.

Health Insurance Portability and Accountability Act (HIPAA). Passed by congress in 1996, this establishes the United States' standards for the protection of health information and makes it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs.

HIPAA authorization. A customized document or form that gives permission to use specified protected health information (PHI) for a specific purpose, or to disclose PHI to a third party specified by the investigator other than for treatment, payment or health care operations.

HRPP Policies and Procedures. Policies and procedures of the Office of Human Research Protection Program and IRBs that apply to the conduct, review, and oversight of human subjects research and describe the roles and responsibilities of those involved in these activities.

HUD Clinical Investigation. Once a HDE is granted, and if a clinical investigator or the HDE holder wants to conduct a clinical investigation (i.e., research study) using the HUD.

An HDE holder may collect safety and effectiveness data for the HDE-approved indication(s) without an IDE. While this is a clinical investigation, FDA considers the study exempt from the requirement of 21 CFR Part 812 as long as the HUD is being studied in accordance with the approved indication(s) described in labeling, because the HUD as such is legally marketed and can be lawfully shipped without an IDE. See 21 CFR 812.1. IRB approval (21 CFR Part 56) and informed consent (21 CFR Part 50) are still required for these studies, however, because they are FDA-regulated clinical investigations

Human Subject. *Pre-2018 Common Rule Definition:* “An individual who is or becomes a participant in [Research](#), either as a recipient of the [Test Article](#) or as a control. A subject may be either a healthy individual or a patient.” (21 CFR 56.102(e)) For research involving a [Medical Device](#), a human subject means “A human who participates in an investigation, either as an individual on whom or on whose specimen an investigational device is used or as a control. A subject may be in normal health or may have a medical condition or disease.” (21 CFR 812.3(p))

2018 Common Rule Definition: A living individual about whom an investigator (whether professional or student) is conducting research:

- (i) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or
- (ii) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.

Human Subject Research. Research involving [Human Subject](#).

Humanitarian Use Device Exemption (HDE). Is an application to the [FDA](#) that is similar to a premarket approval (PMA) application, but is exempt from the effectiveness requirements of sections 514 and 515 of the Food, Drug, and Cosmetic Act (the Act). FDA approval of an HDE authorizes an applicant to market a Humanitarian Use Device [Humanitarian Use Device \(HUD\)](#), subject to certain profit and use restrictions set forth in section 520(m) of the Act (i.e., HUDs cannot be sold for profit except in narrow circumstances and they can only be used in a facility after an IRB has approved their use in that facility, except in certain emergencies). An HDE approval is based on safety and probable benefit. HDEs are exempt from the requirement to provide a reasonable assurance of effectiveness as required in [Investigational Device Exemption \(IDE\)](#) applications. The person who obtains the Humanitarian Device Exemption (HDE) from FDA is the HDE holder.

The FDA will consider an HDE application for any of the following:

- no comparable device is available to treat or diagnose the disease or condition; or

- a comparable device is available under another approved HDE application; or
- a comparable device is being studied under an approved Investigational Device Exemption (IDE) (21 CFR 814.104(b)(2)).

If a comparable device with the same indications for use is marketed through either the premarket approval (PMA) process or the premarket notification (510(k)) process, a new HDE for a HUD device cannot be granted by the FDA.

Humanitarian Use Device (HUD). A device that is intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect (or are manifested in) fewer than 4000 individuals in the US per year.

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Identifiable. Identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Not all identifiable information is necessarily Identifiable Health Information. [Individually Identifiable Health Information](#). This would only be the case if it was actually associated with [Health Information](#).

Identifiable Data/specimens are generally identifiable health information and are either:

Coded samples – sometimes termed “linked” or “identifiable”, are those from identified materials with a code rather than a name or any other personal identifier such as a patient number, where the source retains information linking the code to particular human materials or where the extent of the clinical or demographic information provided with the sample is sufficient that the investigator, the repository, or a third party could link the biological information derived from the [Research](#) with material from a particular person or a very small group of identifiable persons. If the key is destroyed or not accessible by the investigator or repository, then it is possible that these samples would then be considered de-identified coded samples but they would be identifiable health information until this occurred.

or

Identified samples - are those samples supplied from identified materials with a personal identifier sufficient to allow the biological information derived from the research to be linked directly, with the particular person from whom the material was obtained.

Identifiable Biospecimen. 2018 Common Rule Definition: A biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

Identifiable Private Information. 2018 Common Rule Definition: Private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

Identified Prospective Subject. See [Subject Status](#).

Immediately Life-Threatening Disease. Means a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

Impaired consent capacity. A person lacking the ability based on reasonable medical judgment to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decisions. Also see [Incapacitated](#). Subjects who have impaired decision-making capacity are not capable of giving informed consent for research but may be capable of providing assent.

Implant. A device that is placed into a surgically or naturally formed cavity of the human body if it is intended to remain there for a period of 30 days or more.

In Vitro. Literally, “in glass” or “test tube” – used to refer to processes that are carried out outside the living body, usually in the laboratory, as distinguished from *in vivo*.

In Vivo. In the living body; processes, such as the absorption of a drug by the human body, carried out in the living body rather than in a laboratory.

Incapacitated. A person lacking the ability based on reasonable medical judgment to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decisions. Also see [Impaired Decision-Making Capacity](#). Subjects who are incapacitated are not capable of giving informed consent for research but may be capable of providing assent.

Incidents, Experiences OR Outcomes. Are general sources of information that may indicate an **actual harm** has occurred or that there is an **increased risk of harm**.

Information of **actual harm** can be:

- an [Adverse Event](#) (encompassing both physical and psychological harms); or
- a problem or event not considered an adverse event** (encompassing social or economic harms)

Information indicating an **increased risk of harm** is:

- a problem or event not considered an adverse event** that place subjects or others at increased [Risk](#) of harm than was previously known or recognized, but no harm occurred.

[** referred to as “*non-AE incidents, experiences or outcomes*”]

Inclusion/Exclusion Criteria. The medical or other standards determining whether a person may or may not be allowed to enter a research study. These criteria are based on such factors as age, gender, the type and stage of a disease, previous treatment history, and other medical conditions. It is important to

note that inclusion and exclusion criteria are not used to reject people personally, but rather to identify appropriate participants and keep them safe.

Incompetent. Referring to a person who is not able to manage his/her affairs due to mental deficiency (low IQ, deterioration, illness or psychosis) or sometimes physical disability and who has been appointed a guardian or conservator by a legal determination.

Persons determined to be legally incompetent are unable to provide [Informed Consent](#) or [Legally Effective Informed Consent](#). They may be able to provide assent.

[Incompetent is legal term removed from Texas Probate Code in 1993 but still used in various federal regulations (e.g., 38 CFR concerning guardian). Texas state law now uses the term "[Incapacitated](#)."]

Individual Investigator Agreement (IIA). An agreement between an [Assured Institution](#) and a [Collaborating Individual Investigator](#) or Collaborating Institutional Investigator that permits the assured institution to extend its Federalwide Assurance to cover the investigator.

Individually Identifiable Health Information. Information that is a subset of Health Information, see [Private Information](#) including demographic information collected from an individual, and (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (a) that identifies the individual; or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Individually Identifiable Private Information. [Private Information](#) or Specimens are individually identifiable when they can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

Private information or specimens are not individually identifiable when they cannot be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems. For example, if the following conditions are both met:

1. the private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals; and
2. the investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:
 - the key to decipher the code is destroyed before the research begins;
 - the investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the HHS regulations do not require the IRB to review and approve this agreement);
 - there are IRB-approved written policies and operating procedures for a repository or data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased; or

- there are other legal requirements prohibiting the release of the key to the investigators, until the individuals are deceased.

Inducements. Are offers that get people to do things they may not otherwise do. Inducements or incentives, rewards or payments may be acceptable depending on the population, level and type but they may also be considered [Undue Influence](#) if the reward/payment is so large as to persuade the person to take undue risks or volunteer against their better judgment. Another concern about undue influence (unacceptable inducements) is they can result in a subject lying or concealing information that may otherwise exclude them from the research. As a result, if the study involves no risk or minimal risk, the concern over undue influence is reduced. The IRB should consider ways to reduce the influence of payments or rewards that undermine a person's capacity to exercise free choice and could invalidate consent. The IRB should balance the need to reduce undue influence with the need to avoid [Exploitation](#) of populations.

Or, Potential For Undue Influence.

Informed Consent. A person's voluntary agreement, based upon adequate knowledge and understanding of relevant information, to participate in [Research](#) or to undergo a diagnostic therapeutic or preventive procedure. For the purposes of contrast, "[Consent](#)," is voluntary agreement without mention of whether full knowledge was imparted or understanding took place and "[Legally Effective Informed Consent](#)" is obtained when a subject or a subject's legally authorized representative as outlined in 45 CFR 46 (Common Rule) agrees to participate. Informed Consent (often used as a variation of "consent" or "legally effective informed consent") is obtained only after the prospective subject is provided sufficient opportunity to consider whether or not to participate. Neither, informed consent nor legally effective informed consent can be obtained from a subject with [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#) for research purposes ([Surrogate Consent](#) or [Legally Authorized Representative \(LAR\)](#) is obtained in such a case).

Initial Review Of Research. The review of new, not previously approved research including new studies tabled/deferred at previous meetings.

Innovative Therapy. Innovative therapy represents a deviation from standard medical practice. Physicians are free to innovate if the innovative procedure is applied solely to enhance the well-being of their patient. However, when innovative therapy differs significantly from routine practice it should be viewed and treated as experimental, with appropriate safeguards in place to protect the rights and welfare of the patients (subjects) (e.g., RSRB review, informed consent, etc.). In order to validate innovative therapy, the innovative procedure should be subjected early on to an evaluation via a formal [Research](#) protocol.

Institution. Any public or private entity or agency (including federal, state or other agencies).

Institutional official. The institutional official (IO) who is the signatory on the federalwide assurance (FWA) filed with OHRP to ensure compliance with regulations governing protection of human subjects. OHRP requires the institutional official to be a high-level official who has the authority to represent the institution named in the FWA.

Institutional Review Board (IRB). The institutional review board is a federally mandated, institution-designated regulatory body empowered to oversee [Human Subject Research](#).

- Internal IRB – for UT Southwestern, the UT Southwestern IRB’s
- External IRB – for UT Southwestern, any IRB managed by another organization

Institutionalized. Confined, either voluntarily or involuntarily, in a facility for the care of the mentally or otherwise disabled (e.g., a psychiatric hospital, home or school for the retarded).

Also see, [Mentally Disabled](#).

Interaction. Communication or interpersonal contact between an investigator and participant.

Internal Event. As it relates to adverse events and unanticipated problems internal refers to those events or problems experienced by subjects enrolled by the investigator(s) approved by the UT Southwestern IRB to perform research at their respective institutions.

Also, [Adverse Event](#) or [UPIRSOs](#).

Intervention. *Pre-2018 Common Rule Definition:* Includes both physical procedures by which data are gathered (for example, venipuncture) and manipulation of the subject or the subject’s environment that are performed for research purposes.

2018 Common Rule Definition: Both physical procedures by which information or biospecimens are gathered (e.g., venipuncture) and manipulations of the subject or the subject’s environment that are performed for research purposes.

Interventional Study. A clinical study in which participants **are assigned to receive** one or more interventions (or no intervention) so that researchers can evaluate the effects of the interventions on biomedical or health-related outcomes. The assignments are determined by the study protocol. Participants may receive diagnostic, therapeutic, or other types of interventions.

Also see, [Clinical Trial](#).

Interventional Study Phase (s). The phase of investigation including:

Phase 0: exploratory trials, involving very limited human exposure, with no therapeutic or diagnostic intent (e.g., screening studies, microdose studies). See FDA guidance on exploratory IND studies for more information.

Phase 1: includes initial studies to determine the metabolism and pharmacologic actions of drugs in humans, the side effects associated with increasing doses, and to gain early evidence of effectiveness; may include healthy participants and/or patients

Phase 1/Phase 2: for trials that are a combination of phases 1 and 2

Phase 2: includes controlled clinical studies conducted to evaluate the effectiveness of the drug for a particular indication or indications in patients with the disease or condition under study and to determine the common short-term side effects and risks

Phase 2/Phase 3: for trials that are a combination of phases 2 and 3

Phase 3: includes expanded controlled and uncontrolled trials after preliminary evidence suggesting effectiveness of the drug has been obtained, and are intended to gather additional information to evaluate the overall benefit-risk relationship of the drug and provide an adequate basis for physician labeling

Phase 4: studies of FDA-approved drugs to delineate additional information including the drug's risks, benefits, and optimal use

Interventional Study Purpose. The reason for the protocol.

- **Treatment:** protocol designed to evaluate one or more interventions for treating a disease, syndrome or condition
- **Prevention:** protocol designed to assess one or more interventions aimed at preventing the development of a specific disease or health condition
- **Diagnostic:** protocol designed to evaluate one or more interventions aimed at identifying a disease or health condition
- **Supportive Care:** protocol designed to evaluate one or more interventions where the primary intent is to maximize comfort, minimize side effects or mitigate against a decline in the subject's health or function. In general, supportive care interventions are not intended to cure a disease.
- **Screening:** protocol designed to assess or examine methods of identifying a condition (or risk factors for a condition) in people who are not yet known to have the condition (or risk factor).
- **Health Services Research:** protocol designed to evaluate the delivery, processes, management, organization or financing of health care.
- **Basic Science:** protocol designed to examine the basic mechanism of action (e.g., physiology, biomechanics) of an intervention.

Invasive. Invasive is considered to be entering the body via puncture or incision or requiring numbing or sedative medication for insertion into the body.

Note: Noninvasive does not always constitute minimal risk.

Examples of invasive procedures are those that: 1) penetrate or pierce the skin (except for simple venipuncture) or mucous membranes of the body, the ocular cavity, or the urethra, or (2) enter the ear beyond the external auditory canal, the nose beyond the nares, the mouth beyond the pharynx, the anal canal beyond the rectum, or the vagina beyond the cervical os.

Clarification: For procedures already being performed for standard care purposes: It is possible to consider a procedure to be noninvasive if performed in addition to the usual activities performed

during a standard care invasive procedure so long as the additional activity does not require further puncture or incision or require additional numbing or sedative medication for further insertion into the body. This does not mean the procedure qualifies as minimal risk simply by meeting the definition of noninvasive as extending the standard care procedure time or investigational nature of a device used in that activity might add risk to the standard procedure. Risk determination is a separate criterion for the purposes of Expedited Review for example or for the purposes of determining whether a Diagnostic device is exempt from submission to the FDA for an IDE.

Investigation / Investigational. Investigation is a term used by the FDA concerning activities subject to FDA regulations and means a [Clinical Investigation](#) (any experiment that involves a [Test Article](#) and one or more human subjects and that either is subject to requirements for prior submission to the Food and Drug Administration under section 505(i) or 520(g) of the FFD&C Act, or is not subject to requirements for prior submission to the Food and Drug Administration under these sections of the act, but the results of which are intended to be submitted later to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit) or [Research](#) involving one or more subjects to determine the safety or effectiveness of a drug, biologic or device. The terms research, clinical research, clinical study, study, and [Clinical Investigation](#) are deemed to be synonymous for purposes of the FDA.

Investigational agent. A pharmaceutical form of an active ingredient or placebo being tested or used as a reference in a clinical trial. This includes products with a marketing authorization when used or assembled (formulated or packaged) in a way different from the approved form, products used for an unapproved indication or products used to gain further information about an approved use.

Investigational Device. Includes unapproved devices and some approved devices:

A [Device](#) not yet approved for marketing by the FDA when used in research, see [Clinical Investigation](#), involving one or more subjects to determine the safety or effectiveness of a device is an investigational device.

Also, any medical device, including **approved devices** or transitional devices (devices previously approved as a drug (before 1976)), **are [Investigation / Investigational](#) devices if they are the object of a [Clinical Investigation](#)** (abridged: research involving one or more subjects to determine the safety or effectiveness of a device). They may then be considered exempt from certain FDA regulations (e.g. 21 CFR 812) in certain circumstances but they remain investigational devices if they are the object of the study and the study in most cases remains subject to other FDA regulations (e.g., 21 CFR 50 and 56).

Investigational Device Exemption (IDE). An IDE is like an IND for a new drug. It allows an unapproved medical [Device](#) to be shipped for use for [Investigation / Investigational](#) purposes. It is also required when an FDA approved or FDA cleared device is used in a [Clinical Investigation](#) for the purposes of testing safety or effectiveness (unless exempt from prior submission for the IDE or where abbreviated requirements may be allowed) where the intent is for the data to be included in a submission to the FDA or may later be held for inspection by the FDA. FDA has 30 days to review the IDE request and notify the sponsor if approval is withheld. The requirements for an IDE are similar to an IND and are designed to ensure that the sponsor conducts adequate preclinical testing, selects appropriate subjects for clinical [Research](#), obtains IRB approval, obtains adequate informed consent, uses qualified investigators,

monitors the investigation, and collects data promptly. In deciding whether to approve an IDE, the FDA focuses on how the investigation will be conducted rather than on a precise risk-benefit analysis. The IDE regulation is 21 CFR 812 (45 Fed Reg 3751, January 19, 1980).

Under abbreviated requirements when medical [Device](#) are classified as non-significant risk (NSR) by the sponsor and the IRB agrees, the investigation may begin without prior submission of an IDE. Under the abbreviated IDE requirements, the device is considered to have an approved IDE issued by the IRB. If, however, the IRB determines the [Device](#) to be a significant risk (SR) device, an IDE must be submitted and approved before the study can be initiated. In this circumstance, it does not matter if the sponsor has classified the device as NSR.

Investigational Drug. Includes those substances in any of the clinical stages of evaluation which have not been released by the FDA for general use or cleared for sale in interstate commerce. An investigational drug may also be defined by one of the following:

1. A drug in any of the clinical stages of evaluation (Phase I, II, III) which has not been released by the FDA for general use or cleared for sale in interstate commerce.
2. Any commercially available drug proposed for a new use.
3. A new dosage form or method of administration.
4. A commercially available drug which contains a new component such as an excipient, coating or menstruum.
5. A new combination of two or more commercially available drugs.
6. A combination of commercially available drugs in new proportions.

Investigational New Drug - Exemption (IND). An IND (Form FDA 1571) is an application filed (usually by the sponsor) with the FDA that includes a detailed description of the planned investigation including Phase I, II and III studies. The application must also contain names and addresses of the investigators and identification of the IRB responsible for initial and continuing review and approval of the proposed study. The FDA has 30 days to review the IND and notify the sponsor if approval is withheld. The applicable FDA regulation for INDs is 21 CFR 312.1. Each investigator who will participate in the study must provide the sponsor with a completed Statement of Investigator (Form FDA 1572) as required by 21 CFR 312.53(c). This form addresses investigator training and experience as well as investigator commitments.

Investigational New Drug Application. Once the clinical evaluation of a drug is completed, an NDA must be submitted to FDA to obtain approval to market the drug. The NDA regulations are 21 CFR 314. In an NDA review there is a much closer scrutiny of the data by FDA to ensure safety and efficacy. In contrast, the IND review requires only enough evidence of effectiveness to justify a clinical trial.

Investigator. A person responsible for the conduct of the clinical trial at a trial site. If a trial is conducted by a team of individuals at a trial site, the investigator is the responsible leader of the team and may be called the principal investigator. (*Definition from: International Conference on Harmonization Good Clinical Practice*)

Investigator's Brochure (IB). A compilation of the clinical and nonclinical data on the investigational products that is relevant to the study of the investigational product or products in human subjects.

Investigator-Initiated INDs/IDE's. See [Sponsor-Investigator](#).

IRB Authorization Agreement (IAA). An agreement between two institutions where one institution agrees to rely on the IRB from the other institution for the review and continuing oversight of its human research. The agreement can cover all human research conducted by the institution, all human research conducted under the institution's Federalwide Assurance (FWA), a subset of research studies, or a single study. A copy of the IAA is filed with [Office of Human Research Protections \(OHRP\)](#) for [Assured Institution](#).

IRB of Record. Denotes the IRB responsible for approval of a specific research study at a given institution. An institution may rely on any number of IRBs within or outside the institution. If an institution relies on an external IRB, an IRB Authorization Agreement must be in effect.

IRB Project Type. Given the various regulatory responsibilities, there are different types of projects that require IRB approval (not just research) including:

Human Subjects Research – research involving living individuals whenever the investigator obtains private identifiable private information or interacts/intervenes for research purposes. (IRB approval required)

Human Subjects Data or Specimen **Repository** – a special category of human subjects research where data and/or specimens are stored in a bank or repository for use in future research studies. (IRB approval required)

Non-Regulated Research determination – activities that do not meet the regulatory definition of research and do not require IRB approval. Examples include quality improvement, health surveillance, and program evaluation. This application should be submitted if you would like an official determination letter from the IRB Office.

Research Not Involving Humans – research that does not involve “human subjects” as defined by the IRB regulations and does not require IRB approval. Examples include research using leftover, de-identified specimens, cell lines and de-identified materials from a repository. This application should be submitted if you would like an official determination letter from the IRB Office.

Exempt Determination – certain minimal risk human subject research is exempt from the IRB regulations. Examples include retrospective chart review if not recording identifying information, survey of adults, and research comparing educational methods. This application should be submitted if you would like an official determination from the IRB Office.

Treatment Use of a **Humanitarian Device** – humanitarian devices receive a specific FDA approval (HDE) for treating rare conditions. Although not considered research, the FDA requires IRB approval prior to non-emergency use. (IRB approval required)

Expanded Access to Investigational Drugs or Devices for Treatment – refers to use of an investigational drug or device when the primary purpose is to diagnose, monitor, or treat a patient's disease or condition. The distinction between expanded access and the use of an

investigational drug (or device) in the usual studies covered under an IND (IDE) is that expanded access uses are not primarily intended to obtain information about the safety or effectiveness of a test article. Although not considered research, the FDA requires IRB approval prior to non-emergency use. (IRB approval required).

Emergency Use of an unapproved drug (Emergency IND or Emergency Protocol) or device (Emergency Use)

- This application should be submitted to notify the IRB that an unapproved drug or device was used to treat a patient emergency situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval. The FDA definition of an emergency is similar but slightly different for drugs and devices.
- Drug – either life threatening or severely debilitating
 - Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.
 - Severely debilitating means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.
 - For drugs, FDA authorization must be obtained (either telephone or written submission) **prior to use** of a drug.
- Device – either life-threatening or serious disease or condition that needs immediate treatment
 - For devices, the FDA must be notified within five days. The FDA recognizes that typically there will not be time to obtain prior IRB approval - must be reported within five (5) working days of initiation of treatment.

J

K

Key Personnel. Term used in federal grant applications to indicate individuals subject to additional conflict of interest rules and reporting. In general, key personnel include any individual responsible for the design, conduct, and reporting of research for a given study. Key personnel may or may not include the following: study staff, investigators, individuals engaged in human research and individuals not engaged in human research.

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L

Legally Authorized Representative (LAR). A person authorized either by statute or by court appointment to make health care decisions on behalf of another person who is [Incapacitated](#), [Incompetent](#), or has [Impaired Decision-Making Capacity](#). It is not always required that [Informed Consent](#) to participate in research be given by the legally authorized representative if another form of [Surrogate Consent](#) is available such as family member consent depending on applicable state law and institutional policy. Consent by a legally authorized representative should involve all the same considerations that informed consent from a competent subject involves.

See [3.2 INFORMED CONSENT BY SURROGATE](#) for specific information on who may serve as a legally authorized representative or surrogate.

Legally Effective Informed Consent. Is consent of a subject, or if the subject is incapacitated, incompetent, or has impaired decision-making capacity, then the consent of the subject's [Legally Authorized Representative \(LAR\)](#) or surrogate as outlined in 45 CFR 46 (Common Rule). "[Consent](#)" is often used as a short version of "[Informed Consent](#)" or "[Legally Effective Informed Consent](#)". It is not always required that [Informed Consent](#) to participate in research be given by the legally authorized representative if another form of [Surrogate Consent](#) is available such as family member consent depending on applicable state law, institutional policy and the determination of the IRB. Someone who is Incapacitated, Incompetent, or has Impaired Decision-Making Capacity cannot give legally effective informed consent for research purposes (a [Surrogate Consent](#) or [Legally Authorized Representative \(LAR\)](#) is obtained in such a case).

Life-threatening. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather, the recipients must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

Limited Data Set. Health information that excludes certain direct identifiers, but may include city, state, and ZIP code; elements of date; and other numbers, characteristics, or codes that cannot be used to identify an individual or the individual's relatives, employers, or household members. *Note: Limited data sets may be used or disclosed for purposes of research with a data use agreement as described by the HIPAA Privacy Rule at 45 CFR Part 164.*

Longitudinal Study. A longitudinal study is an observational research method in which data is gathered for the same subjects repeatedly over a period of time. Longitudinal research projects can extend over years or even decades. In a longitudinal cohort study, the same individuals are observed over the study period

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M

Major Change Or Modification. (to previously approved research)

Any change that does not meet the definition of a minor change or modification to previously approved research, and/or

A modification which in the judgment of the reviewer fundamentally alters the judgments relied upon to make determinations on any of the criteria for IRB approval under 45CFR 46.111 and/or involves modifications which would not be eligible for expedited review (considering risk and expedited review categories 1-9)

Major, Non-Emergency Deviations. See [Noncompliance](#)

Material transfer agreement (MTA). A contract that governs the transfer of tangible research materials between two organizations when the recipient intends to use the materials for his or her own research purposes.

Mature Minor. Someone who has not reached adulthood (as defined by state law), but who may be treated as an adult for certain purposes (e.g., consenting to certain types of medical care).

Medical Definition of Quality Assurance. a program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met.

Medical Device. The Food and Drug Administration (FDA) defines a medical [Device](#) as:

An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is

- recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them
- intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals.
- intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

Before 1976, medical devices could be marketed without review by the FDA. However, in 1976 the medical device amendments of 1976 to the Federal Food, Drug and Cosmetic Act were passed in order to ensure that new devices were safe and effective before they were marketed. The FDA regulations which govern medical devices are 21 CFR 812, 814, 860, 861.

Mental Capacity. See [Capacity](#).

Mentally Disabled. Having either a psychiatric disorder (e.g., psychosis, neurosis, personality, or behavior disorder), a developmental disorder (e.g., mental retardation), or a neurological disorder that affects cognitive or emotional functions to the extent that it results in a [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#). Neither, informed consent nor legally effective informed consent can be obtained from a subject with [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#) for research purposes ([Surrogate Consent](#) or [Legally Authorized Representative \(LAR\)](#) is obtained in such a case).

See [Cognitively Impaired](#), [Diminished Autonomous Decision-Making Capacity \(DADMC\)](#), [Handicapped](#).

Minimal Risk. “The probability and magnitude of harm or discomfort anticipated in the [Research](#) are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.” For VA studies the determination includes tangible or intangible risk.

Examples of research activities that may well be determined by the Board to involve no more than minimal risk include collection of blood samples from healthy, non-pregnant adults by venipuncture in amounts not exceeding 450 ml in an eight-week period and no more often than two times per week; electrocardiography; electroencephalography; and moderate exercise by healthy subjects. (Examples are not automatically deemed to be of minimal risk simply because they are included on this list).

While the harms and discomforts ordinarily encountered differ widely among individuals and individual populations, an ethically meaningful notion of "harms and discomforts ordinarily encountered" should reflect "background risks" that are familiar and part of the routine experience of life for "the average person" in the "general population." It should not be based on those ordinarily encountered in the daily lives of the proposed subjects of the research or any specific population.

Minimizing Risk. Federal regulations describe minimizing risks to subjects (i) By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes. Therefore, using the least number of procedures possible to answer the research question is a method of minimizing risk when additional procedures are required. Addressing whether you have minimized risk requires addressing all three aspects of this definition.

Minor. A person who has not attained the legal age of majority under the applicable law of the jurisdiction in which the [Research](#) will be conducted (18 years in the state of Texas), and therefore as a general rule cannot consent to treatment or procedures involved in research. For the purposes of research performed under DHHS regulations [Viable Neonates](#) are considered children, whereas neonates of uncertain viability and [Nonviable Neonates](#) require additional protections under section B of 45 CFR 46. See [3.2 INFORMED CONSENT BY SURROGATE](#) for specific information on minors and if/when they can give consent to participate in research.

Minor Change or Modification. (to previously approved research)

A modification which in the judgment of the reviewer does not fundamentally alter the judgments relied upon to make determinations on any of the criteria for IRB approval under 45CFR 46.111 does

not adversely impact the overall risk-benefit relationship for the subjects of the research (based on new or modified risk information).

For studies originally approved by expedited review, a minor change is a modification that does not change the study's eligibility for expedited review (considering risk and expedited review categories 1-9).

Minor or Administrative Deviations. See [Noncompliance](#)

Modifications (Changes) Required. An IRB action that specifies conditions under which research can be approved, pending the following: confirmation of specific understandings by the IRB about how the research will be conducted, submission of additional documentation, precise language changes to the protocol and/or informed consent document(s), and/or substantive changes to documents with specific parameters the changes must satisfy. *Note: Verification that the investigator's response(s) satisfies the conditions for approval set by the IRB may be performed by the IRB Chair and/or other designated individual(s). Also: contingent approval, approval with conditions.*

Modification of Research. See [Modifications](#)

Multi-Site Research. Research conducted at more than one location and under the jurisdiction of only one IRB.

Multicenter Research. Research conducted at more than one location and under the jurisdiction of more than one IRB.

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N

National Commission. In July 1974, in response to widespread publicity concerning unethical human experimentation in the U.S. (e.g., Tuskegee Syphilis Study, Jewish Chronic Diseases Hospital Study, Willowbrook Study, San Antonio Contraceptive Study), Congress passed the National **Research Act** (Public Law 93-348), which established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral **Research**. The charge of the Commission was to conduct a comprehensive investigation and study to identify the basic ethical principles which should underlie the conduct of biomedical and behavioral [Research](#) involving human subjects. Although both **FDA** and HHS had regulations for the protection of human subjects, they were obviously inadequate in light of the many human subject abuses that occurred in medical and behavioral research conducted in the U.S.

From 1975 through 1978 the Commission published eight reports on various aspects of research involving human beings. These reports formed the basis for the development of the 1981 [DHHS](#) and **FDA** regulations. Undoubtedly, the most ethically fundamental report produced by the Commission was the [Belmont Report](#). The other reports produced by the National Commission are: **Research** on the Fetus (1975), **Research** Involving Prisoners (1976), **Research** Involving Children (1977), **Research** Involving Those Institutionalized as Mentally Infirm (1978), Institutional Review Boards (1978), Ethical Guidelines for the Delivery of Health Services by DHEW (1978). The National Commission disbanded in 1978.

National Institute of Health (NIH): A part of the United States Department of Health and Human Services, the [NIH](#) is the largest biomedical research agency in the world, comprised of 21 Institutes established between 1937 and 2000.

Neonates. Neonates are newborns who are 28 days old or younger. For the purposes of DHHS regulations viable neonates are considered children and only require the protections under sections A and D of 45 CFR 46 whereas neonates of uncertain viability and nonviable neonates require additional protections under section B of 45 CFR 46.

No-Treatment Control. Placebo Control, No-Treatment Control (suitable where objective measurements are felt to make blinding unnecessary), and dose-comparison control studies are all study designs in which a difference is intended to be shown between the test article and some control. The alternative study design generally proposed to these kinds of studies is an active-treatment concurrent control in which a finding of no difference between the test article and the recognized effective agent (active-control) would be considered evidence of effectiveness of the new agent. There are circumstances in which this is a fully valid design.

Non-Assured Institutions. An institution that does not hold an OHRP-approved Federalwide Assurance is referred to as a non-assured institution. UTSW researchers who conducted [Cooperative Research](#) with investigators from non-assured institutions provide additional information to define the responsibilities of each institution. In some cases, an investigator from a non-assured institution may request the UTSW extend its FWA to cover his/her research activities by signing an [Individual Investigator Agreement \(IIA\)](#).

Noncompliance. Any failure to follow:

- Applicable federal regulations, state and local laws, or institutional policies governing human subjects protections, or
- The requirements or determinations of the IRB, including the requirements of the approved investigational plan (e.g., protocol, Smartform, ICD).

Noncompliance can result from performing an act that violates these requirements or failing to act when required.

Non-Scientist. An individual appointed to the IRB who (due to training, background, and/or occupation) is inclined to view research activities from the standpoint of someone outside the scientific or scholarly discipline of the IRB on which he/she serves.

Non-Significant Risk (NSR) Device. Used to define the risk classification of specific devices that do not present a potential for serious risk to the health, safety, or welfare of a subject. Non-Significant risk devices do not include implants, devices that support or sustain human life, or devices that are substantially important in diagnosing, curing, mitigating, or treating disease, or in preventing impairment to human health.

Non-Therapeutic Research. [Research](#) that has no likelihood of intent of producing a diagnostic, preventive, or therapeutic benefit to the current subjects, although it may benefit subjects with a similar condition in the future.

Nonviable Neonate. The inability of a baby, in the first 28 days of live birth, to survive outside the womb. In research federal regulations require, after delivery, there must be a determination as to whether the neonate is viable (viable means being able to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration. Additionally, there are limitations on determining viability of neonates - individuals engaged in the research may not have any part in determining the viability of a neonate being considered for inclusion in a study. In addition, after delivery, nonviable neonate may not be involved in research unless there is scientific justification for their inclusion, legally effective informed consent of both parents, (exceptions apply, see Research Involving Pregnant Women, Human Fetuses And/or Neonates) and all of the following additional conditions are met:

- (1) Vital functions of the neonate will not be artificially maintained;
- (2) The research will not terminate the heartbeat or respiration of the neonate;
- (3) There will be no added risk to the neonate resulting from the research;
- (4) The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- (5) The legally effective informed consent of both parents of the neonate is obtained (waiver or alteration of consent is not allowed). However, there are some exceptions.

Notification. Process of notifying research subjects of changes in the research by letter or phone.

Nuclear Regulatory Commission. The independent government agency established by the Energy Reorganization Act of 1974 to regulate civilian use of nuclear materials.

Nuremberg Code. An international ethical code published in 1947 which established standards for the conduct of [Research](#) involving human beings. It arose out of the Nuremberg War Crimes Trial, where 23 Nazis were charged with crimes against humanity that involved murderous pseudomedical experimentation. Twenty of the individuals charged were physicians.

Nutritional Supplement. See [Dietary Supplement](#).

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O

Observational Study. Studies in human beings in which biomedical and/or health outcomes are assessed in pre-defined groups of individuals. Subjects in the study may receive diagnostic, therapeutic, or other interventions, but the investigator does not assign specific interventions to the subjects of the study.

Observational Study Model. Primary strategy for subject identification and follow-up.

- **Cohort:** group of individuals, initially defined and composed, with common characteristics (e.g., condition, birth year), who are examined or traced over a given time period
- **Case-control:** group of individuals with specific characteristics (e.g., conditions or exposures) compared to group(s) with different characteristics, but otherwise similar
- **Case-only:** single group of individuals with specific characteristics
- **Case-crossover:** characteristics of case immediately prior to disease onset (sometimes called the hazard period) compared to characteristics of same case at a prior time (i.e., control period)
- **Ecologic or community studies:** geographically defined populations, such as countries or regions within a country, compared on a variety of environmental (e.g., air pollution intensity, hours of sunlight) and/or global measures not reducible to individual level characteristics (e.g., health care system, laws or policies median income, average fat intake, disease rate)
- **Family-based:** studies conducted among family members, such as genetic studies within families or twin studies and studies of family environment

Observational Study Time Perspective. Temporal relationship of observation period to time of subject enrollment.

- **Prospective:** look forward using periodic observations collected predominantly following subject enrollment
- **Retrospective:** look back using observations collected predominantly prior to subject selection and enrollment
- **Cross-sectional:** observations or measurements made at a single point in time, usually at subject enrollment

Obtaining Identifiable Private Information Or Specimens. Means receiving or accessing identifiable private information or identifiable specimens for research purposes. Obtaining includes an investigator's use, study, or analysis for research purposes of identifiable private information or identifiable specimens already in the possession of the investigator.

Off-Site Research. Designates research conducted at study sites that are not part of UT Southwestern Medical Center. Off-site locations may make arrangements to allow the UT Southwestern IRB to act as the reviewing IRB for research conducted at that location or the research may be reviewed by another IRB. Some institutions rely on UT Southwestern IRB to review all research covered by the institution's Federalwide Assurance. These [Affiliated Institution](#) are covered by an [IRB Authorization Agreement \(IAA\)](#) and a Memorandum of Understanding or Agreement (MOU/MOA) with UT Southwestern Medical Center.

Other off-site research may involve researchers from other (non-affiliated) institutions that may or may not already have an FWA/IRB or may involve individual investigators who either are not employed by an institution ([Collaborating Individual Investigator](#)) or is employed by an institution that does not routinely conduct research and does not have an FWA/IRB (Collaborating Institutional Investigator).

Office of Human Research Protections (OHRP). Is responsible for implementing HHS regulations governing [Research](#) with human subjects. [DHHS](#) elevated the Office for Protection from Research Risks (OPRR) to become the Office of Human Research Protections (OHRP) within OPHS, [DHHS](#).

Open-Label Study. In an open label study subjects are assigned to one treatment only. In an open label study two doses of a drug are often compared.

Operator Of Data Center/Repository. Individuals responsible for the operation of the repository and /or data management center. Generally, one individual has overall authority and responsibility for the repository (Principal Investigator). Depending on the structure and use of the repository, a data manager or specimen repository manager is appointed to oversee the operations of the repository. The manager is often the only member of the repository team who has access to the identifying information linked to the data/specimens (all other team members have access only to coded data/specimens).

Oral (verbal) consent. A spoken presentation of the elements of informed consent to the prospective subject or their legally authorized representative. The presentation may be based on information contained within an oral consent script or the written consent document. Oral consent is often associated with waiving the documentation of consent. Oral consent is usually recorded in the research project files.

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P

Parent. A child's biological or adoptive mother or biological or adoptive father.

Participation Complete. See [Subject Status](#).

Pediatric Research Equity Act (PREA). [PREA](#) is designed to address the lack of pediatric use information in drug product labeling.

Permission. Is defined as the agreement of parent(s) or guardian to the participation of their child or ward in research or clinical investigation and includes the elements of consent set forth in federal regulations and outlined in the informed consent template included in the IRB expedited and full review applications.

Pilot testing. "A small scale-study conducted prior to conducting an actual experiment; designed to test and refine procedures." The federal regulations indicate that pilot testing meets the definition of research involving human subjects and requires IRB review.

Examples:

1. Checking to see if the designed tool works
2. Asking people to complete a survey to find out whether a question results in the requested information
3. Testing the intervention with four people before trying it with 60 people
4. Asking people to complete your survey and then revising the questions based on their responses
5. Revising the study after analyzing preliminary data and determining that the data do not address their research question
6. Student researcher designs questionnaire for their study's target population, asks the population to try out the questionnaire, and the questions are revised based on the responses

Planned Emergency Research. Research involving human subjects who are in need of emergency medical intervention (e.g., comparison of methods for providing cardiopulmonary resuscitation), but who cannot give informed consent because of their life-threatening medical conditions and who do not have an available legally authorized representative to provide consent.

Policy. Formal statement of principles on which action(s) for a specific issue are based.

Premarket Approval Application (PMA). The Food and Drug Administration (FDA) process of scientific and regulatory review to evaluation the safety and effectiveness of Class III medical devices (those that support or sustain human life, are of substantial importance in preventing impairment of human health, or which present a potential, unreasonable risk of illness or injury). PMA is the most stringent type of device marketing application required by the FDA, and the applicant must receive FDA approval of the PMA application prior to marketing the device.

Pre-review. The process performed by ORRP staff to determine that a submission for IRB review is complete, including the required materials, copies, and signatures, and that institutional requirements, such as completion of human subjects' protection education and conflict of interest disclosure, have been met.

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

Principal Investigator. The individual with primary responsibility for the design and conduct of a research project. In multi-center Research, the *Study PI* is the individual with primary responsibility for the entire project and the *Local PI* is the individual with primary responsibility for the research activities under the purview of the UT Southwestern IRB.

The Local PI may be a UT Southwestern employee, student, or agent (e.g., affiliated faculty) or the PI may be an employee or agent of any institution affiliated with the UT Southwestern IRB through a current IRB Authorization Agreement or Memorandum of Understanding/Agreement. The type of relationship an

individual has with UT Southwestern determines whether they may serve independently as a PI on their own protocol or if a Faculty Sponsor is required.

The Local PI may designate a Co-Investigator to assist with local PI responsibilities (e.g., report unanticipated problems, authorize modifications or progress reports). The primary responsibility for the conduct of the research may not be assigned to the Co-I.

For FDA regulated research filling a Form FDA 1572, Statement of Investigator, the local PI is the individual listed in Section 1 (investigator).

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

Prisoner of War: any person captured, detained, held or otherwise under the control of Department of Defense personnel (military or civilian, or contractor employee). Such persons include: Enemy prisoners, civilian internees, retained persons, and lawful and unlawful enemy combatants. Such persons do not include Department of Defense personnel being held for law enforcement purposes.

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

Privacy versus confidentiality. Privacy is about people and their choice to share personal information. It is a right in health care and research. Confidentiality is about data. It is the investigator's obligation to protect subjects' information.

Private Information. *Pre-2018 Common Rule Definition:* Includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be **individually identifiable** (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects (bolding added for emphasis).

2018 Common Rule Definition: Includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information that has been provided for specific purposes by an individual and that the individual can reasonably expect will not be made public (e.g., a medical record).

Procedure or Care. A procedure or activity performed solely for the study.

Program Evaluation. Refers to assessments of the success of established programs in achieving objectives when the assessments are for the use of program managers, for example, a survey to determine if program beneficiaries are aware of the availability of program services or benefits. Not

generally considered a research activity as long as the evaluation is designed to assess or improve the program or service rather than to generate knowledge about a disease or condition.

Prospective Studies. Studies designed to observe outcomes or events that occur subsequent to the identification of the group of subjects to be studied. These studies need not involve manipulation or intervention, but may be purely observational or involve only the collection of data.

Protected Health Information (PHI). is the term given to health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations and payment for healthcare services. **Federal Definition:** PHI is [Individually Identifiable Health Information](#) transmitted by electronic media, maintained in electronic media, or transmitted or ***maintained in any other form*** or medium. PHI excludes education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g, records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by a covered entity in its role as employer.

The HIPAA definition of Protected Health Information is not meant to include all identifiable information or necessarily to protect identifiers. There is often the misconception that identifiers are removed to protect them from release when in fact they are removed from the health information to protect the individual from anyone knowing the health information that is released is theirs. Many of the actual identifiers are often public domain. The most practical definition is, “any” identifiable information (including demographic information) collected from an individual, that is **created or received by** a health care provider, health plan, employer or health care clearing house, **and relates to (a) the past, present, or future physical or mental health or condition** of an individual; (b) **the provision of health care to the individual and identifies the individual** or **there is a reasonable basis to believe can be used to identify the individual.**”

Note that the identifiable information is further divided into the identifiable information created or received by a health care entity and that identifiable information that is not, plus the requirement that it relate to the health of the patient versus identifiable information that is in no way associated with their health information. Therefore, the collection of health information that is recorded in a manner such that even if someone had the identifiable information they could not tell whose belonged to whom then this may not be considered PHI. An example would be collecting the name and identification number of potential subjects so the research can go into other electronic or paper files and write down (in a physically separate document/media) the health information (without identifiers) but since they do not need to go back later and confirm or check the information there is no need to maintain a link to the identifiers. They are only using the identifiers initially but not recording them with health information.

Alternately it could include identifiable information is further limited to the identifiable information created or received by a health care entity plus the requirement that it relates to the information about who, where, how and when the patient was cared for in the institution which can actually be traced back to the individual.

The concept that this would not be PHI if there was not a reasonable basis for identification can be established if anyone knowledgeable in statistical procedures were to certify that in their opinion subjects could not be identified with the information collected.

Privacy Rule “Safe-Harbor” Identifiers:

The categories of information below are considered identifiers under the privacy rule. Health information accompanied by any of these identifiers is considered PHI and subject to the Privacy Rule.

Data that are stripped of these 18 identifiers (the “safe-harbor” method) are regarded as de-identified, is not PHI and not subject to the Privacy Rule, unless the covered entity has actual knowledge that it would be possible to use the remaining information alone or in combination with other information to identify the subject)

- *Names; Address; Dates except year; Ages over 89 (can be grouped as age 90 or older); Phone numbers; Fax numbers; E-mail addresses; Social security numbers; Medical record numbers; Account numbers; Certificate/license numbers; Health plan beneficiary numbers; Vehicle identifiers and serial numbers, or license plate numbers; Device identifiers and serial numbers; Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers; Biometric Identifiers, including finger and voice prints; Full face photographic images and any comparable images; Any other unique identifying number, characteristic, or code*

Protocol. The formal design or plan of an experiment or [Research](#) activity; specifically, the plan submitted to an IRB for review and to an agency for research support. In some institutions this takes the form of a special template created by the institution. In other institutions who may accept a sponsor’s protocol as partial completion of the requirements for a full protocol additional description of local parameters may be required in the form of addendums or additional forms/sub-forms. In all cases the protocol must contain not only information concerning the larger scale multicenter trial but also address the local context.

Protocol Directed. Includes all procedures, therapies, interventions or interactions that are required by the protocol. Even procedures that are considered to be standard practice are still protocol directed if the protocol requires it.

Protocol Violation. See [Noncompliance](#)

Public Service Announcement. A public service announcement is generally a non-profit organization or government broadcast on radio or television, ostensibly for the public good. Public service announcements are intended to modify public attitudes by raising awareness about specific issues. Although technically it would be difficult to convince a newspaper, radio or television station that information concerning a research study constitutes raising public awareness or was intended for the public good, recruitment advertising activities that must be reviewed by the IRB prior to use include posted notices, paid and unpaid newspaper solicitations or magazine advertisements (which may include public service announcements), websites, radio or television advertisements (which may include public service announcements).

Publicly Available Data. Public data is information that can be freely used, reused and redistributed by anyone with no existing local, national or international legal restrictions on access or usage. Use of publicly available data sets that do not include information that can be used to identify individuals.

"Publicly available" is defined as information shared without conditions on use. This may include data sets that require payment of a fee to gain access to the data.

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Q

Quality Assurance. Refers to activities particular to an institution's QA program, as part of its confidential medical quality-assurance program or other equivalent programs.

Quality Improvement (QI). A process initiated to develop/enhance a practice or procedure and to institutionalize the practice or procedure. A systematic, data-guided activities designed to bring about immediate, positive changes in the delivery of health care in particular settings. QI involves deliberate actions to improve care, guided by data reflecting the effects (e.g., types of practical problem solving; an evidence-based management style; the application of science of how to bring about system change; review of aggregate data at the patient/provider/unit/ organizational level to identify a clinical or management change that can be expected to improve care). QI is generally not considered research – however, QI activities can be research if they are also intended to contribute to generalizable knowledge.

Quorum. The minimal number of members of IRB who must be present at a convened meeting for valid transaction of business.

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R

Radiation Exposure. In health physics, the quantity used to indicate the amount of ionization in air produced by X-ray or gamma radiation while conducting radiologic procedures.

Radiologic (Radiological) Procedure. Any procedure involving radiation (e.g., X-ray) or a radioactive agent (e.g., radionuclide used in a nuclear medicine study).

Randomization. In [randomized controlled studies](#), the research participants are assigned by chance, rather than by choice, to either the experimental group or the control group. Randomization reduces bias as much as possible. Randomization is designed to "control" (reduce or eliminate if possible) bias by all means.

Randomized Control Study. A type of scientific [experiment](#) - a form of clinical research - most commonly used in testing the safety (or more specifically, information about [adverse drug reactions](#) and adverse effects of other treatments) and [efficacy](#) or [effectiveness](#) of [healthcare services](#) (such as [medicine](#) or [nursing](#)) or [health technologies](#) (such as [pharmaceuticals](#), [medical devices](#) or [surgery](#)). Study subjects, after assessment of eligibility and recruitment, but before the intervention to be studied begins, are randomly allocated to receive one or other of the alternative treatments under study.

Random allocation is complex, but conceptually, the process is like tossing a coin. After randomization, the two (or more) groups of subjects are followed up in exactly the same way, and the only differences between the care they receive, for example, in terms of procedures, tests, outpatient visits, follow-up calls, etc. should be those intrinsic to the treatments being compared. The most important advantage of proper randomization is that it minimizes allocation bias, balancing both known and unknown prognostic factors, in the assignment of treatments."

Recipient Of Data/Specimens. Anyone who receives the data/specimens from the data center/repository. Recipient (sometimes referred to as recipient-investigator) can be from an organization covered by the UT Southwestern IRB or can be from an organization not affiliated UT Southwestern IRB.

Re-consenting. Process of notifying research subjects of changes in the research, including documentation of the subject's continued informed consent through signature on a revised written consent form.

Recorded. Regarding exempt research, "recorded" refers to information (data) that is "collected" or "documented" during the process of a research investigation. The information may be written, typed, copied, audio or video recorded, etc.

Recruitment. A "pre-enrollment" activity used to find potential research participants. It includes identification of potential participants and contacting Individuals to inquire if they are interested in participating in an IRB approved research protocol.

Recruitment activities include:

- reviewing PHI in medical records of Individuals for the purpose of identifying potential candidates for participation in an IRB approved research protocol
- advertisements or solicitations that are intended to be seen or heard by prospective subjects to solicit their participation in a study;
- encounters to discuss the availability of studies and the possibility of entry into a study with a prospective subject;
- dear doctor letters, etc.
- obtaining the results of procedures performed as part of the practice of medicine for the purpose of determining study eligibility (if the IRB approves a waiver of consent and HIPAA waiver).

Once potential subjects are Identified, see [Subject Status-Identified/referred](#), an assessment of eligibility ([Screening](#)) follows.

Recruiting Methods. Materials, compensation, and other practices or procedures used to inform potential participants about research. *Note: Methods for recruiting research participants are generally distinguished from those of marketing, advertising, or public relations' efforts, which have promoting a product, service, or idea as goals.*

Recruitment Bonus. Payment, merchandise, or other gift or service offered by a sponsor as an incentive or reward to an organization, investigator, or key personnel conducting research designed to accelerate recruitment that is tied to enrollment rate, timing, or numbers.

Recruitment Materials. Announcements; advertisements; flyers; posters; scripts for telephone or other oral communication; letters or email messages; bulletin board tear-offs; Internet postings; newspaper, radio, television, or video broadcasts, or other media used to attract potential participants for research.

Regulatory Binder (Essential Documents). Essential documents are those which individually and collectively permit evaluation of the conduct of a research study and the quality of the data produced. These documents serve to demonstrate the compliance of the investigator, sponsor, and monitor with the regulatory requirements of various federal, state and local agencies.

Regulatory Specialist. Individual who serves as the subject matter expert on institutional policies and federal regulations regarding human subjects' protections.

Regulatory Sponsor. The agency, organization, company or person primarily responsible for *initiating* and *overseeing* the research and ensuring the study complies with federal regulations

- For clinical trials (studies involving drugs or biologics) this is typically the IND holder, for device studies, this is the IDE holder
- For industry-sponsored trials, typically the pharmaceutical/ device/biotechnology company is the regulatory sponsor
- For non-industry sponsored trials, the regulatory sponsor is typically the PI

Reimbursement. Reimbursement is for expenses and generally requires justification/verification of the expense and should be available to all but may be different for each subject in contrast to [Compensation](#) which is usually required to be the same for each subject as payment for participation in [Research](#).

Related Adverse Event Or Probably Related Adverse Event. Means that there is at least a reasonable possibility that the [Unexpected Adverse Event](#) may have been caused by the procedures involved in the research. Possibly related should be considered more likely than not, e.g., > 50% chance that it is at least partially related should be the threshold since the alternative would not be considered a reasonable possibility).

Reportable event. An eIRB process (with an associated form) used by an investigator to report emergency deviations, serious noncompliance, continuing noncompliance, UPIRSOs, and research-related complaints to the reviewing IRB and/or institutional HRPP.

Repository. Data management centers (data centers) and human specimen repositories (sometimes called registries, banks, or libraries) are used to store data and/or specimens for future use. When the use is for [Research](#) purposes, the data centers/repositories must be approved by the Institutional Review Board (IRB). Human Specimen Repositories collect, store, and distribute human tissue/specimen materials for research purposes. Repository activities involve three components: (i) the collectors of tissue samples; (ii) the repository storage and data management center; and (iii) the recipient investigators. Human repository repositories may be combined with data management centers.

Links to Additional Definitions Specific to Repositories:

[Affiliated Institution](#), [Data Management Centers](#), [Collector Of Data/Specimens](#), [Operator Of Data Center/Repository](#), [Recipient Of Data/Specimens](#), [Unidentifiable Data/Specimens](#), [Identifiable Data/Specimens](#).

Research. *Pre-2018 Common Rule Definition:* A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program considered as research for other purposes. For example, some demonstration and service programs may include research activities.

Under **HHS Regulations (46.102)** research is defined as a “systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.” The general rule is that if there is any element of research in an activity, that activity should undergo review for the protection of human subjects. For example, some “demonstration” and “service” programs may include research activities.

Under **FDA Regulations (21 CFR 56.102)** the term “clinical investigation” is synonymous with “research” and is defined as “any experiment that involves a test article and one or more human subjects, and that either must meet the requirements for prior submission to the FDA under section 505(i) or 520(g) of the Food, Drug and Cosmetic Act, or need not meet the requirements for prior submission to the FDA under these sections of the act, but the results of which are intended to be later submitted to, or held for inspection by, the FDA as part of an application for a research or marketing permit. Clinical investigations regulated by the FDA under Sections 505(i) and 520(g) of the Act, include investigations of food, dietary supplements that bear a nutrient content claim or a health claim, infant formulas, food and color additives, drugs for human use, medical devices for human use, biological products for human use, and electronic products. The term “clinical investigation” does not include experiments that must meet the provisions of part 58, regarding nonclinical laboratory studies. The terms research, clinical research, clinical study, study, and clinical investigation are deemed to be synonymous for purposes of this part. Research is subject to 21 CFR 50 and 56 when it involves the use of any drug other than the use of an approved drug in the course of medical practice. Research is subject to 21 CFR 50 and 56 when it involves the use of any medical device other than the use of an approved medical device in the course of medical practice.

The [Belmont Report](#) provides additional clarification:

“...the term 'research' designates an activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective.”

Also see [Clinical Investigation](#) for FDA’s definition of research.

2018 Common Rule Definition: A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this

definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this rule, the following activities are deemed not to be research:

(i) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.

(ii) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).

(iii) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.

(iv) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

Research Only. A procedure or activity performed solely for the study.

Research Performance Site. Location/site at which human subjects research may be performed because of an understanding of the local research context and appropriate oversight mechanisms that ensure protection of research participants. *Note: A list of approved UT Southwestern research performance sites is available at [Research Performance Sites](#).*

Retrospective Research. The research study involves data or specimens that already exist in their entirety at the time of IRB submission.

Retrospective Studies. Research conducted by reviewing records (i.e., birth and death certificates, medical records, school or employment records) or information about past events elicited through interviews with persons who have, and controls who do not have, a disease under investigation.

Risk. A potential harm. Generally in research, risks of research that a reasonable person, in what the investigator knows or should know to be the subject's position, would be likely to consider significant in deciding whether or not to participate in the [Research](#) should be disclosed to the potential subject.

Risks may be physical, social, legal, economic or psychological in nature, and may relate to employability or insurability. In addition, risks may apply to the individual subject or may apply to a broader segment of the society

Risk is usually discussed in terms of two factors probability (chance) and magnitude (severity). In order to minimize the risk, the researcher and the IRB need to assess the chances the risk will occur and how severe that risk can be, then look at the mechanism or methods built into the research for decreasing both the chance and severity.

For example, risk that a metal object may become a projectile during an MRI procedure. The severity could be high, but if precautions are taken the probability is low.

Additionally, in certain circumstances additional parameters of risk such as permanence and immediacy should be included in the description of risk in research. For example, it may improve a potential subjects understanding of the risk and assist them in deciding whether or not to participate, if for some risks they were told whether the effect might be permanent rather than self-limiting or at least treatable and for some risks the subject should be informed whether they should only expect this effect immediately or whether it might occur after the have left the care of the researcher in which case might they need emergency care.

Routine (Not-for-Cause) Review. An assessment or examination of something (e.g., a practice or procedure) with the possibility or intention of instituting change if necessary.

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S

Sample. Also: specimen. Human biological material, including solid material (e.g., tissue, organs) body fluid (e.g., blood, urine, saliva, semen, cerebrospinal fluid), and cells.

Screen Failure. Subjects who consented to participate in research but who were disqualified during screening procedures. See [Subject Status](#).

Screened Participant. Individuals who are screened to determine eligibility.

Screening. See [Subject Status](#)

Serious Adverse Drug Experience (SADE). Any adverse drug experience occurring at any dose that results in any of the following outcomes: death, a life-threatening adverse drug experience, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect. Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered a serious adverse drug experience when, based upon appropriate medical judgment, they may jeopardize the patient or subject and may require medical or surgical intervention to prevent one of the outcomes listed in this definition. Examples of such medical events include (but are not limited to) allergic bronchospasm requiring intensive treatment in an

emergency room or at home, blood dyscrasias, or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse.

Serious adverse event (SAE). Is any [Adverse Event](#) that:

1. results in death;
2. is life-threatening (places the subject at immediate risk of death from the event as it occurred);
3. results in inpatient hospitalization or prolongation of existing hospitalization;
4. results in a persistent or significant disability/incapacity;
5. results in a congenital anomaly/birth defect; or
6. 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 (examples of such events include allergic bronchospasm requiring intensive treatment in the emergency room or at home, blood dyscrasias or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse).

(based on OHRP definition)

Serious Disease or Condition. Means a disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.

Serious noncompliance. Any noncompliance that:

- increases risk of harm to subjects; and/or
- adversely affects the rights, safety, or welfare of subjects (any of which may also be an unanticipated problem); and/or
- adversely affects the integrity of the data and research (i.e., substantially compromises the integrity, reliability, or validity of the research)

Severely Debilitating. Diseases or conditions causing major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

Short Form consent document. A written document stating that the elements of informed consent required by regulation have been presented orally to the subject or the subject's legally authorized representative. The short form consent document must be written in a language understandable to the subject or the subject's legally authorized representative.

Significant Risk (SR) Device. A Significant Risk device is defined [21 CFR 812.3(m)] as a device that presents a potential for serious risk to the health, safety, or welfare of a subject and (1) is intended as an implant; or (2) is used in supporting or sustaining human life; or (3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or (4) otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

Note: *A significant risk device requires submission to the FDA for an Investigational Device Exemption (IDE) in contrast to a nonsignificant risk device which may be approved by the IRB under FDA Abbreviated Requirements.*

The IRB does not make a SR/NSR device determination when considering requests to approve the use of a Humanitarian Use Device [Humanitarian Use Device \(HUD\)](#) under an FDA approved [Humanitarian Device Exemption \(HDE\)](#).

Single Masked Design. In a single masked design, the subject does not know the treatment assignment but the investigator does.

Source Document. Sometimes referred to as source data, all information in original records of clinical findings, observations, or other activities in a study necessary for the reconstruction and support of the progress and adjudication of outcomes described in the research design. Source data are the first recording of subject-related information. In a drug study, for example, an investigator is required to prepare and maintain adequate and accurate case histories that record all observations and other data pertinent to the investigation on each individual. Source documents must be complete, accurate, and valid.

Sponsor. Sponsors are the agencies, institutions, companies, organizations, foundations, or individual grantors responsible for the initiation, management, or financing of a research study. The term sponsor is understood to include any intermediaries, such as contract research organizations or coordinating centers, acting as agents of the sponsor in carrying out the responsibilities above. All research falling under these types of agreements is considered sponsored research.

In FDA regulated research, the Sponsor is the entity who takes responsibility for and initiates a clinical investigation. The sponsor can be any legal entity, including a company, an academic organization, or an individual. The intent of the sponsor's IND/IDE is to allow testing for marketing approval of the drug or device. These are generally considered commercial or corporate IND/IDEs.

Note: the sponsor is often but not always the entity that funds the clinical research – i.e., [Financial Sponsor](#)

Sponsor-Investigator. A sponsor-investigator is an individual who both initiates and conducts a clinical investigation and under whose immediate direction the investigational drug/device is being administered, used or dispensed. For administrative reasons, only one individual should be designated as the sponsor.

Usually, the intent of the sponsor-investigator IND/IDE is to gain scientific knowledge without seeking market approval for the drug or device. These are considered 'Investigator-Initiated' or sponsor-investigator IND/IDEs.

Sponsor-Investigator INDs/IDE's. There are three general categories of sponsor-investigator INDs/IDEs:

- 1) new drug/device developed by the investigator,
- 2) new uses, new routes of administration, new dosages, or new patient populations for currently approved drugs, or
- 3) new use of a significant risk device that has either been cleared under 510 (k) or approved under a Premarket Approval (PMA).

Also known as [Investigator Initiated](#).

Standard Care or Practice. Care or procedures that are routinely or typically provided absent a research study (or generally accepted practice, routine or conventional care). Is a medical or psychological treatment guideline, and can be general or specific. It specifies appropriate treatment based on scientific evidence and collaboration between medical and/or psychological professionals involved in the treatment of a given condition. Some common examples include: treatment standards applied within public hospitals to ensure that all patients receive appropriate care regardless of financial means; or treatment standards for gender identity disorders.

Stipulations (s). Express IRB provisions that must be satisfactorily addressed *before* a human subject research project can be approved and any involvement of human subjects in the research may begin. Under no circumstances do stipulations constitute contingent approval of the research project—approval is neither given nor implied until the PI has received written notice of IRB approval.

Study expiration. If IRB approval of a specific study expires before continuing review and approval occur, investigators must stop all research activities involving human subjects related to that study except where they judge that it is in the best interests of already enrolled subjects to continue to participate. When investigators make this judgment, they must promptly notify the IRB. When the IRB reviews the investigator's decision, it may decide whether it is in the best interests of already-enrolled subjects to continue to participate in the research by considering the best interests of subjects either one at a time or as a group. If an IRB determines that it is not in the best interests of already-enrolled subjects to continue to participate, investigators must stop all human subjects research activities, including intervening or interacting with subjects, or obtaining or analyzing identifiable private information about human subjects. Investigators may resume the human subjects research activity once continuing review and approval by the IRB has occurred.

Study Operations Center. Most multi-center studies designate an operations center (generally the lead [Principal Investigator \(PI\)'s](#) location). Study operations centers are designed to assist the study PI in meeting the oversight responsibility of the entire project. Examples of operation center responsibilities include: collection of data and specimens from satellite sites, monitoring safety data, communicating study-wide amendments, regulatory oversight, etc.

In order to meet these responsibilities, most operations centers obtain private, identifiable information from the satellite sites. This action alone constitutes human research requiring IRB approval.

Sub-Investigator. Any investigator who is not the Principal Investigator.

Also, Sub-I.

Subject Status. Used to track the various states (milestones) in a subject's trajectory through a specific research study. UT Southwestern's Clinical Trial Management System (CTMS) developed the following statuses for use in all types of clinical research (not just clinical trials):

- **Identified/Referred** -during recruitment, and individual is identified as a prospective subject: 1) by obtaining the results of procedures performed as part of the practice of medicine (reviewing medical records with an IRB waiver), 2) by responding to recruitment activities, or referred by a provider
- **Did Not Consent**- an identified subject who initially declines participation in research
- **Consent Signed**- identified subjects who have been appropriately consented and are awaiting screening to begin
- **Pre-Screen** -a consented subject who undergoes minimal procedures or gives authorization to obtain additional health records prior to a complete screening activity. The information obtained in prescreening is used to determine if a subject meets the minimum requirements to proceed to be screened. Consented subjects that are pre-screened are either eligible or ineligible. Eligible participants that pre-screen continue on to screening. Ineligible participants are considered a pre-screen failure.
- **Pre-Screen Failure**-a pre-screened participant determined to be ineligible to proceed to screening as the subject does not meet the minimum eligibility requirements for the study.
- **Screening/Eligibility**-A 'pre-enrollment' activity used to determine eligibility. Screening procedures are necessary solely for the purpose of determining eligibility (including fasting, withdrawal of medication), as a result informed consent must be obtained in some form (i.e., verbal, abbreviated or full informed consent). Prospective subjects that are screened are considered [Screened Participant](#). Screened participants either: eligible or ineligible. Eligible subjects that consent to continue are considered enrolled. Ineligible subjects are considered [Screen Failure](#).
- **Screen Failure**- A screened participant determined to be ineligible for enrollment because they do not meet the eligibility criteria, or whatever other requirements must be met for research participation.
- **Re-screening**- A subject that has previously completed screening and either did not complete the screening process or was determined to be ineligible. If previously arranged (by sponsor or PI) and approved (by IRB), subject can be reentered into the screening process a second time. The Re-Screening status is appropriate if the sponsor (or PI) wants the re-screening recorded under the same subject ID. If a new subject ID is assigned, the original subject ID status is changed to **Screen Failure**. Re-Screened participants are either: eligible or ineligible. Eligible subjects that consent to continue are considered [Enrolled](#). Ineligible subjects are considered [Screen Failure](#).
- **Enrolled** - Screened participants are enrolled if eligibility is verified (meet all inclusion criteria and none of the exclusion) and they consent to continue in the study.

- **Active Observations** - Applicable to non-interventional studies (e.g., [Observational Study](#), indicates subject is actively involved with study [Intervention\(s\)](#) or [Interaction\(s\)](#)).
- **Run In/Wash Out** - Applicable to [Interventional Study](#), indicates a pre-intervention step commonly involving a run-in or wash out of study interventions.
- **Active Treatment (intervention)** - Applicable to [Interventional Study](#), indicates subject is actively involved with study [Intervention\(s\)](#) (Including the intervention of being tested or evaluated) and other study intervention.
- **Follow-Up As Planned** - Applicable to [Interventional Study](#), indicates the subject has completed the intervention being tested or evaluated as planned and is continuing with non-interventional procedures or other study [Interaction\(s\)](#).
- **Intervention Stopped Early - following** -applicable to [Interventional Study](#) indicates the intervention being tested or evaluated was stopped pre-maturely and the subject is continuing with non-interventional procedures or other study [Interaction](#).
- **Intervention Stopped Early - following-up complete**- applicable to [Interventional Study](#) indicates intervention being tested or evaluated was stopped prematurely, the follow-up procedures have been completed.
- **Withdrawn** - (prior to active, during active, during follow-up) - an early end to all participation for an enrolled subject (even if the subject did not start the treatment).
- **Completed** - indicates that all study procedures (including [Intervention](#)), research related [Interaction](#) with the subject, and acquiring the subject's Private [Identifiable](#) Information were completed as planned. The subject is no longer participating in the research.

Substantive Changes Or Clarifications. Any change or request for additional information required by the IRB to an application (initial, progress report or amendment) that are directly relevant to the determinations required by the IRB under HHS regulations at 45 CFR 46.111.

Summary Document. A written version of the full information presented to a subject or the subject's legally authorized representative during the informed consent process, used in conjunction with a short form consent document. For non-English speaking individuals, the IRB-approved English language consent form may serve as the summary when an appropriately translated document is not available.

Supplement. See [Dietary Supplement](#).

Surrogate Consent. When [Informed Consent](#) is obtained from someone other than the participant such as with family member consent (parental consent for a minor, immediate family consent during an emergency, etc.) or [Legally Authorized Representative \(LAR\)](#) consent. It is not always required that [Informed Consent](#) to participate in research be given by the [Legally Authorized Representative \(LAR\)](#) if another form of surrogate consent is available depending on applicable state law, institutional policy and the determination of the IRB.

See [3.2 INFORMED CONSENT BY SURROGATE](#) for specific information on who may serve as a legally authorized representative or surrogate.

Survey Studies. Whenever you gather information from your constituents or the general public, you need to give some thought to why you are collecting the information and how you plan to use it. Studies

designed to obtain information from a large number of respondents through written questionnaires, telephone interviews, door-to-door canvassing, or similar procedures.

Suspension of Research. A suspension of IRB approved research that is required by the IRB, HRPP Director, IRB Chair or designee, or Institutional Official results in a temporary cessation of some or all of the research activities. Research may be suspended: 1) if it is not being conducted in accordance with the IRB approval; 2) when the continuation of the research may adversely affect the rights and welfare of research subjects; or 3) when continuation may represent an immediate threat of harm to the subjects.

Note: a Cessation of some or all research activities [Halt](#) voluntarily initiated by the Principal Investigator or sponsor is not considered suspension of research.

Systematic Investigation. Use of a clear plan, system or method to conduct a detailed examination or inquiry for facts.

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T

Tabled. An IRB “action” that indicates that review was not initiated or was not completed, resulting in postponement of IRB review, usually due to loss of quorum or other administrative issue. Research tabled at a convened meeting will be reviewed at a future convened meeting.

Termination of Research. A termination of IRB approval required by the IRB that results in a permanent cessation of all research activity. Research may be terminated: 1) if it is not being conducted in accordance with the IRB approval; 2) when the continuation of the research may adversely affect the rights and welfare of research subjects; or 3) when continuation may represent an immediate threat of harm to the subjects.

Note: Cessation of all research activities resulting from the PI’s decision to inactivate the study is not considered termination of research. Withdrawal of institutional support for research that results in cessation of all research activities is not considered termination of research.

Test Article. A general term that encompasses [Drug](#), [Device](#), food additives, etc. that are **regulated** by the **FDA**. A test article is any drug (including a biological product for human use), medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the Public Health Service Act sections 351 and 354-360 F or the Federal Food, Drug, and Cosmetic Act.

Therapeutic Research. Refers to interventions that are designed to determine the efficacy and safety of a therapeutic or diagnostic method. The interventions are not applied solely to enhance the well-being of the individual subject who is sick (note use of the term “subject” as opposed to “patient”). Achievement of maximum possible therapeutic benefit cannot, therefore, be presumed, since the intervention is still being evaluated. The objective of therapeutic [Research](#) is to increase generalized knowledge (i.e., test a hypothesis and draw conclusion), and at the same time provide the subject with a

needed health benefit. Accordingly, the responsibilities of a physician who is also an investigator must take into consideration the fact that the patient is also a research subject.

Therapeutic Intent. The research physician's intent to provide some benefit to improving a subject's condition (e.g., prolongation of life, shrinking of tumor, or improved quality of life, even though cure or dramatic improvement cannot necessarily be effected). This term is sometimes associated with Phase I drug studies in which potentially toxic drugs are given to an individual with the hope of inducing some improvement in the patient's condition, as well as assessing the safety and pharmacology of a drug.

Therapy. Refers to interventions that are applied solely to enhance the well-being of an individual patient who is sick. The interventions are procedures commonly accepted by the medical community and represent standard care.

Transitional Device. A device subject to section 520(l) of the Food, Drug, and Cosmetic Act; a device that FDA considered to be a new drug or an antibiotic drug before May 28, 1976.

Treatment. Interventions designed solely to enhance the well-being of a particular individual.

Treatment investigational device exemption (IDE). A mechanism through the FDA for providing eligible participants with investigational devices for the treatment of a serious or life-threatening illness for which there are no satisfactory alternatives.

Treatment investigational new drug (IND). A mechanism through the FDA for providing eligible participants with investigational drugs for the treatment of a serious or life-threatening illness for which there are no satisfactory alternatives.

Treatment Team. Refers to healthcare providers (e.g., physicians, nurses, aides, technicians, and administrative assistants that are normally involved with the delivery of routine medical care.

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U

Unanticipated adverse device effect (UADE). Is defined by the FDA (21 CFR 812.3(s)). Any serious adverse **effect** on health or safety, **or** any life-threatening **problem or death** caused by (or associated with) a device, **if that effect, problem, or death** was not previously identified in nature, severity, **or** degree of incidence in the investigational plan **or** application; any other unanticipated, serious problem associated with a device that relates to the **rights, safety, or welfare** of subjects.

Unanticipated problems involving risks to subjects or others (UPIRSO). Any events, incidents, experiences, or outcomes that meet **ALL three (3)** of the following criteria:

1. 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 protocol, investigator's

- brochure, and informed consent document; and (b) the characteristics of the subject population being studied;
2. probably or definitely related to participation in the research; and
 3. suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic/financial, legal, or social harm) than was previously known or recognized.

UPIRSOs require changes to the research documents or investigational plan (e.g., protocol, IB, and/or informed consent document/process) or corrective actions to protect the rights, safety, or welfare of subjects or others (e.g., notifying subjects of a breach). Therefore, if no changes to the research or corrective actions are made as a result of the event, it is probably **NOT** a UPIRSO.

Unapproved Medical Device. An unapproved medical device is defined as a device that is used for a purpose or condition for which the device requires, but does not have, an approved application for premarket approval under section 515 of the Federal Food, Drug, and Cosmetic Act {21 U.S.C. 360(e)}. An unapproved device may be used in human subjects only if it is approved for clinical testing under an approved application for an Investigational Device Exemption (IDE) under section 520(g) of the Act {21 U.S.C. 360(j)(g)} and 21 CFR part 812. Medical devices that have not received marketing clearance under section 510(k) of the FD&C Act are also considered unapproved devices which require an IDE. <http://www.fda.gov/oc/ohrt/IRBS/devices.html>

Undue Influence. [Belmont Report](#) states that undue influence occurs “through the offer of [Inducements](#) excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance” (National Commission, 1978, p.8). It also argues that “unjustifiable pressures” occur when “persons in positions of authority ... urge a course of action for a subject.” This includes manipulating a prospective subject’s choice by utilizing the “influence of a close relative.” Lastly issues may be raised as potential undue influence when judgment may be compromised by financial incentives especially when the subject is not the recipient of the financial incentive. Undue influence needs to be distinguished from coercion for the purposes of UT Southwestern IRB applications of policy. [Coercion](#) is considered the use of a threat of harm or punishment to influence behavior; e.g., in general, payments do not constitute coercion per se. There are also less apparent examples of vulnerability to undue influence such as **Institutional vulnerability** and **Deferential vulnerability** to undue influence. **Institutional** is when an individual is subject to the formal authority of others which could influence the subject’s participation. Examples- prisoners, military personnel, students, employees. **Deferential** is similar to institutional but arises from informal relationships characterized by inequities in social status (gender, race, class) power or knowledge (doctor-patient relationship), or cognitive ability (elderly person defer to adult kids). Heightened concern that subject’s decision re: participation not truly voluntary. Deferential vulnerability can be very subtle- investigators must be especially sensitive to potential for subjects to believe refusing to participate will negative impact their future treatment. Investigators need to be sensitive to such deference and assess whether subject is truly exercising his/her autonomy and adjust the informed consent accordingly (a suggested addition to the usual consent process might include discussing participation in absence of the individual to whom the potential subject ordinarily defers- additional because the PI or investigator with the relationship may be the best person to discuss the study and answer questions and it would not be appropriate to bypass them all together). Deferential may be misconstrued to include therapeutic misconception but it is generally a separate concept though still requiring consideration in the consent process. Where potential subjects may be drawn to research

because of lack of effective standard treatments and desire to find treatment they may be prone to misunderstand the risks and potential benefits and have unreasonable expectations about potential benefits. Pay special attention to ensuring potential benefits of participation are properly characterized. Where investigator is also treating physician, in addition to the issue of deference, there exists a higher risk of therapeutic misconception. Again you may want to consider having impartial third party obtain consent or finalize the consent process in the absence of the individual to whom the potential subject ordinarily defers.

Unexpected Adverse Drug Experience/Reaction (UADR). Any adverse drug experience that is not listed in the current labeling for the drug product. This includes events that may be symptomatically and pathophysiologically related to an event listed in the labeling, but differ from the event because of greater severity or specificity. For example, under this definition, hepatic necrosis would be unexpected (by virtue of greater severity) if the labeling only referred to elevated hepatic enzymes or hepatitis. Similarly, cerebral thromboembolism and cerebral vasculitis would be unexpected (by virtue of greater specificity) if the labeling only listed cerebral vascular accidents. “Unexpected,” as used in this definition, refers to an adverse drug experience that has not been previously observed (i.e. included in the labeling) rather than from the perspective of such experience not being anticipated from the pharmacological properties of the pharmaceutical product.

Unexpected adverse event. Any adverse event in which the nature, severity, or frequency is not consistent with either:

(1) the known or foreseeable risks of adverse events associated with the procedures involved in the research that are described in (a) the research-related documents, such as the IRB-approved protocol, any applicable investigator’s brochure, or the current IRB-approved informed consent document, and (b) other relevant sources of information, such as product labeling and package inserts;

or

(2) the expected natural progression of any underlying disease, disorder, or condition of the subject(s) experiencing the adverse event and the subject’s predisposing risk factor profile for the adverse event

Unidentifiable. sometimes referred to as “anonymous”, are an unidentified collection of human biological materials or data.

or

Unlinked – sometimes referred to as “anonymized”, originate from identified human biological materials or data but have been stripped by the source (not the researcher) of all identifiers (including the [18 HIPAA identifiers](#)) or codes such that the ability to identify particular individuals via clinical or demographic information supplied with the sample, or information derived from the [Research](#) would be impossible for the investigator, the repository, or a third party.

Unrelated. Unassociated or without a timely relationship; evidence exists that an outcome is definitely related to a cause other than the event in question.

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V

Viable. As it pertains to the fetus, means being able, after either spontaneous or induced delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heart beat and respiration. Once a fetus is viable it is a premature infant.

Violation. See [Noncompliance](#)

Voluntariness. is a legal and philosophical concept referring to a choice being made of a person's free will, as opposed to being made as the result of coercion or duress. i.e The participation in the clinical study rests on the concept of the voluntary consent of the individual.

Voluntary. Free of coercion, duress or undue inducement; used in [Research](#) context to refer to a subject's decision to participate (or to continue to participate) in a [Research](#) activity\

Vulnerable populations in research. Vulnerable populations may include (but are not limited to): individuals who are pregnant; prisoners; individuals who have been involuntarily committed to a medical facility; children; subordinates such as students, trainees and employees; individuals who are economically or educationally disadvantaged; individuals who have a language barrier; individuals with a cognitive disability; and individuals with an illness for which all standard treatment options have been exhausted. Federal regulations state that "when some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects." 45 CFR 46.111(b) FDA regulations expressly identify "mentally disabled persons" as a vulnerable category of subjects in clinical investigations for which IRBs may need to assume increased responsibilities. 21 CFR 56.107(a) and 56.111(b).

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Ward. A child who is placed in the legal custody of the state or other agency, institution or entity, consistent with applicable federal, state or local law.

Withdrawn. Subjects who signed the consent form, but later withdrew from the study, either before or after receiving a study drug, device or intervention. This does not include screen failures. See [Subject Status: withdrawn](#)

Written. 2018 Common Rule Definition: Or in writing, refers to writing on a tangible medium (e.g., paper) or in an electronic format.

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REVISION AND REVIEW HISTORY

Revision Date	Author	Description
November 2019	HRPP	Updated the following definitions (<i>major changes marked with a *</i>) <ul style="list-style-type: none"> • Continuing noncompliance* • Deviation (directs to Noncompliance) • Emergency Deviation • Experienced IRB Member (NEW) • Investigator (NEW) • Major, Non-Emergency Deviations (directs to Noncompliance) • Minor or Administrative Deviations (directs to Noncompliance) • Noncompliance • Protocol Violation (directs to Noncompliance) • Protected Health Information (PHI) • Recruitment • Related Adverse Event Or Probably Related Adverse Event • Reportable event • Serious noncompliance* • Unanticipated problems involving risks to subjects or others (UPIRSO) • Unexpected adverse event • Violation (directs to Noncompliance)
January 2019	HRPP	Revision to reference 2019 common rule
July 2018	HRPP	Updated “Expedited Review of Research Definition” to refer to Expedited Categories
August 2017	HRPP	New Policy Development