



TRINITY HEALTH OF NEW ENGLAND INSTITUTIONAL REVIEW BOARD POLICIES AND PROCEDURES

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SECTION I. GENERAL FUNCTIONS AND JURISDICTION OF THE IRB

The Institutional Review Board (IRB) at Trinity Health Of New England has been formally designated by the Institution to review and monitor research involving human subjects. All research projects involving human subjects, regardless of the source of funding, require review and approval by the IRB prior to their implementation.

Trinity Health Of New England is an integrated healthcare delivery system and includes Saint Francis Hospital and Medical Center (Trinity Health Of New England), Mount Sinai Rehabilitation Hospital (MSRH), Johnson Memorial Hospital (JMH), Mercy Medical Center (MMC), Saint Mary's Hospital (SMH) and all their components.

Trinity Health Of New England IRB holds a Cooperative Agreement with the University of Connecticut Health Center (UCHC) regarding reliance upon each other's IRB for review of human subject research projects. UCHC's IRB will be responsible for the review and approval of protocols where subject enrollment will be done exclusively at UCHC. This will include protocols where the investigators are employees of Saint Francis Hospital and Medical Center. Likewise, the Trinity Health Of New England's IRB will be responsible for the review and approval of protocols where subject enrollment will be done exclusively at Trinity Health Of New England. This will include projects where the investigators are UCHC employees collaborating with an investigator employed by Trinity Health Of New England. UCHC Medical Students, Residents, and Fellows cannot serve as the principal investigator. For IRB review of protocols that accrue subjects at both Trinity Health Of New England and UCHC, investigators may request that either UCHC or Trinity Health Of New England serve as the IRB of record. The request will be based on factors such as where the preponderance of subject enrollment is to occur, the institution employing the principal investigator, and the institution where the majority of clinical research interaction with subjects will occur. The IRB Chairs of each institution will decide which institution's IRB will act as the IRB of record. Each IRB will inform the investigator and the other IRB in writing of its role as either the IRB of record, or its delegation of that role to the other institution. The decision may be that such protocols must be reviewed by one or both IRBs. Both institutions may accept each other's application but reserve the right to require investigators to submit a complete local application packet(s).

The Cooperative Agreement between Trinity Health Of New England and UCHC includes the review of Connecticut Institute for Clinical and Translational Science (CICATS) protocols. The CICATS program is designed to encourage biomedical and health-related discoveries expedite the translation of those discoveries into products, treatments, and interventions to improve people's lives; and disseminate these discoveries into the community of physicians and healthcare providers throughout Connecticut and beyond. The agreement designates the UCHC CICATS IRB responsible for the review and approval of studies done as part of CICATS regardless of where subject enrollment or study procedures are done. Trinity Health Of New England may elect to have at least one employee serve on the CICATS IRB. Investigators from Trinity Health Of New England will be required to submit the UCHC application for all applicable CICATS protocols.

Under this Cooperative Agreement, both institutions reserve the right to insist on their own IRB review of any protocol that involves their patients, facilities, or investigators (including students) for non-CICATS and CICATS protocols. If both institutions are providing IRB oversight for the study, investigators must abide by the policies of both institutions. The IRB of record will provide to the other IRB copies of all correspondence related to study activity, including initial and continuing approval letters, modifications to the study, reports of serious or continuing non-compliance, unanticipated problems, and suspensions or termination of approval. Neither institution shall have the right to overrule a decision made by the other institution to disapprove a study.

Each institution will notify the other of any change in their Federalwide Assurance. The Principal Investigator's home institution will be responsible for required reporting the federal agencies and institutional officials in compliance with the terms of the home institution's FWA.

Trinity Health Of New England IRB does not consider the decisions of other IRBs when reviewing protocols and does not have a reciprocal agreement with any other Institution's IRB, with the exception of UCHC mentioned above. When research is being conducted at multiple sites, the research must be reviewed by the Trinity Health Of New England IRB. When research reviewed by this IRB will be conducted in outside sites such as schools, churches, or community centers, this IRB will require proof of approval from the IRB at those sites. If an outside site does not have an IRB, this IRB will utilize the OHRP definitions of Engagement of Institutions in Research to determine whether the outside site must hold a Federal Wide Assurance (FWA) for the conduct of research to be permitted. The IRB is based at Trinity Health Of New England and all policies and procedures abide by Catholic Church directives. Investigators and this IRB are required to comply with these directives.

The IRB at Trinity Health Of New England is the Institutional Board responsible for the review of human research protocols from Trinity Health Of New England, MSRH, JMH, MMC, SMH and their components. Trinity Health Of New England has filed a Federalwide Assurances (FWA) of Protection of Human Subjects with the Department of Health and Human Services (DHHS), Office for Human Research Protections (OHRP). The Federalwide Assurance Number for Trinity Health Of New England is FWA00020300. Trinity Health Of New England IRB has been assigned a unique number by OHRP (IORG0000212) and is registered with Trinity Health Of New England FWA.

In accordance with federal regulations, the IRB has the authority to approve, require modifications in (to secure approval), disapprove, terminate, or suspend research at these sites. No Institutional official or other Institutional committee may override the decisions of the IRB to disapprove a study. However, the Institution may prevent the performance of a study by the IRB. No Institutional official or other Institutional committee may approve research that has not been approved by the IRB, including research that was disapproved. The purpose of the IRB is to assure, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in research. The Office of the IRB is located in the Department of Research Administration, 260 Ashley Street, 3rd Floor, Hartford, CT.

The IRB at Trinity Health Of New England reviews protocols from qualified Investigators who are employed by Trinity Health Of New England, MSRH, JMH, MMC, SMH and their components and carry out research endeavors at these Trinity Health Of New England sites. The IRB also accepts protocols from members of the Medical/Dental staff who carry out research at Trinity Health Of New England sites and have filed a Federal-wide Assurance or an Unaffiliated Investigator Agreement. The IRB does not review protocols from members of the Medical/Dental staff for research carried out in private offices, since these are outside the jurisdiction of Trinity Health Of New England. The IRB at Trinity Health Of New England does not review protocols from individuals who are not members of the Trinity Health Of New England staff or of the Medical/Dental Staff. In cases where students, or trainees, or Investigators from other institutions are applicants, a member of the Medical/Dental Staff shall be a collaborator and sign the application and will be fully responsible to assure compliance with all applicable regulations and guidelines.

The IRB does not permit research staff who are not members of Trinity Health Of New England staff or medical/dental staff to review and extract data from medical records without a signed Unaffiliated Investigator Agreement. In addition, they are required to complete required IRB training and must be added to the specific research study, provided the research staff works with a Trinity Health Of New England Principal Investigator. Examples include, but are not limited to, retrospective record reviews with a request of waiver of individual authorization (waiver of consent).

In order to take part in research activities, Research Assistants may be hired by Trinity Health Of New England as Consultants. The Human Resources Department will be responsible for completion of background checks and appropriate hospital orientation, including the Health Insurance Portability and Accountability Act (HIPAA) and Compliance Training (may be completed by in the Director of Volunteer Services). The IRB Program Coordinator must receive email confirmation of completion from the Human Resources Department prior to releasing approval. Research Assistants are to work under the direct supervision of the Principal Investigator of the Study.

Independent or Central IRBs are not used for studies conducted at Trinity Health Of New England, MSRH, JMH, MMC, SMH, or their components with the exception of (1) Prisoners (2) Institution participation in Cooperative Group Oncology studies and (3) Studies involving unapproved radioisotopes.

Trinity Health Of New England holds an IRB Authorization Agreement with Yale University IRB. The agreement is specific to all oncology research protocols for which Trinity Health Of New England physician, who is also a Yale researcher serves as the Principal Investigator and for which all research interventions involving human subjects and/or their identified data take place at Trinity Health Of New England. It also covers all oncology research protocols for which Trinity Health Of New England physician serves as the Principal Investigator that engage Yale staff as members of the research team (e.g., nurse) and for which all interventions involving human subjects and/or their identified data take place at Trinity Health Of New England.

The PI is responsible for submission of all personnel amendments involving addition of Trinity Health Of New England research staff to the Trinity Health Of New England IRB prior to submission to Yale IRB. The Trinity Health Of New England IRB will review personnel amendments to ensure institutional compliance with training and conflict of interest policies. In the event a conflict of interest exists, the Trinity Health Of New England IRB will notify Yale IRB of any required management plan.

A copy of the approved above-referenced protocols and all approval letters (initial and continuing review and modifications) will be provided to the Trinity Health Of New England IRB by the PI.

Trinity Health Of New England holds an IRB Authorization Agreement with Saint Joseph Mercy Health System IRB to serve as the Trinity Health IRB of record to all system level research that is lead or sponsored by system office colleagues or involves at least three ministries. The reviews performed by the designated IRB will meet the human subject protection requirements of Trinity Health Of New England IRB. The Saint Joseph Mercy Health System IRB will follow written procedures for reporting its finding and actions to reporting officials of Trinity Of New England IRB. Relevant minutes of IRB will be made available to the Trinity Health Of England IRB upon request.

International Research

The Trinity Health Of New England IRB does not sponsor or conduct review of international research.

Case Reports

Case Reports are to be reviewed by the IRB except when the case is being reported by the physician managing the patient. In this instance, the physician should consent the patient (obtain permission to report) but does not need to apply to the IRB.

IRB Chair, Institutional Official, IRB Members, and IRB Program Coordinator

The Chair of the IRB is appointed by the Chief Executive Officer of Trinity Health Of New England. There is no designated term of service. Selection criteria for the IRB Chair requires that he/she be a member of the staff of any one of the Trinity Health Of New England hospitals with the academic and professional stature necessary to encourage respect from the IRB, Administration, and the research community. The Vice Chair of the IRB is appointed by the Chair. The Vice-Chair will assume the role of Chair in the event of illness, absence, or inability of the Chair to perform this function. There is no designated term of service. The IRB Program Coordinator is selected by the Chair of the IRB. Additionally, the IRB Chair's performance, knowledge, and skills will be assessed by the IRB Members and will be provided with feedback once per year. The IRB Chair evaluates the IRB Program Coordinator.

The Institutional Official is appointed by the Chief Executive Officer of Trinity Health Of New England. There is no designated term of service. The responsibilities of the Institutional Official include overseeing the IRB Chair and evaluating them, ensuring compliance with Institutional and IRB policies, and ensuring the Institution does not interfere with the decisions of the IRB. When the IRB evaluates the need for resources, they speak directly to the Institutional

Official. The plan to evaluate what is needed for the IRB include, but are not limited to: space, personnel, IRB educational program, Legal Counsel, Conflict of Interest, Quality improvement plan, and Community Outreach. These resources are evaluated twice a year and are done by the IRB Program Coordinator and the IRB Chair. The IRB is evaluated to determine whether or not the workflow is going smoothly and if needed, the IRB changes their process to see how well a new process may work. The Institutional Official may not approve research that has been disapproved by the IRB. The Institutional Official is evaluated by the Chief Executive Officer of Trinity Health Of New England and provided with feedback yearly as a function of their employment at Trinity Health Of New England.

The IRB is composed of twelve to fourteen members and one alternate, as deemed necessary. The members of the IRB represent a wide range of disciplines and have medical, nursing and social knowledge. At least two members are not affiliated with Trinity Health Of New England and do not have scientific expertise. Members are selected by active members of the IRB. Members are chosen by their area of professional expertise, experience and/or affiliation, depending on the needs of the board. Members are formally appointed by the Chair of the IRB. It is essential for IRB members to attend the majority of meetings. IRB members are required to attend 7 of 12 meetings per year. If a member is unable to attend the majority of meetings, an alternate member with similar background may be appointed by the IRB Chair to serve as a replacement when necessary. If an alternate member is designated, the IRB Roster will be revised to identify the member for whom the alternate can substitute. There is no designated term of service, and members of the IRB are not compensated for their services. IRB member's performance, knowledge, and skills will be assessed by the Chair and the Program Coordinator, and IRB members will be provided with feedback once per year. Contribution to IRB meeting discussion, attendance, thoroughness of review, and volume of work reviewed will also be assessed, contributing to the overall evaluation of individual IRB members. If it is determined that an IRB member is unable to perform the function, they will be asked to resign. Newly appointed members are provided with IRB policies and meet with the Chair and Program Coordinator of the IRB to review IRB policies, their member duties, and review information from OHRP and the FDA.

Trinity Health Of New England is a non-profit, physician-hospital partnership and prohibits individuals who are responsible for business development from serving as a member on the IRB or any involvement in the day-to-day operations of the review process.

Applicable Regulations, Hospital Policies and Definitions

The IRB at Trinity Health Of New England abides by the principles of the Belmont Report and ensures that human subject's research taking place at this Institution is in compliance with all applicable Federal and State laws and Hospital Policies.

Federal Regulations:

- Title 45 CFR 46
- Title 21 CFR 50 and 56
- Health Insurance Portability and Accountability Act (HIPAA)

Connecticut General Statutes

Connecticut law does not specifically address issues pertaining to human subject research, with the exception the statutes set forth in Chapter 368X on AIDS Testing and Medical Information (please see Obtaining Consent for HIV Testing in Human Research Participants). However, it is the policy of the IRB that statutes applicable to clinical care (i.e., confidentiality of records, consent for care), also be applied in clinical research. The general statutes of the State of Connecticut can be found at <http://www.cga.ct.gov/current/pub/titles.htm>.

Hospital Policies

All Hospital Policies apply to Research conducted under the auspices of this Institution. The Hospital Policy Manual is available on each of the Trinity Health Of New England hospital intranet websites, under "Policies and Procedures". Research-specific Hospital Policies include Investigational Drugs, Consent for Human Research and Experimentation, Investigator Conflicts of Interest in Funded Research and Conflicts of Interest Policy for Trinity Health Of New England Personnel.

Definitions

The following definitions will be applied when Trinity Health Of New England IRB reviews research as it pertains to exempt determinations and evaluations regarding whether a proposed activity is human subjects research (or activity).

Clinical trial means 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.

Human subject means 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.

Intervention includes 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.

Interaction includes communication or interpersonal contact between investigator and subject.

Private information 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).

Identifiable private information is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

An identifiable biospecimen is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

Legally authorized representative means 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. If there is no applicable law addressing this issue, legally authorized representative means an individual recognized by institutional policy as acceptable for providing consent in the non-research context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research.

Minimal risk means that 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.

Research means 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 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.

The information in this resource is based upon information available at the time of publication: December 21, 2017

(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.

“Test article” means any drug for human use, biological product for human use, medical device for human use, human food additive, color additive, electronic product, or any other article subject to FDA regulation.

Determination of Human Subjects Research

Any activity with access/use of individually identifiable health information for any purpose other than to provide feedback for a practice/process/program within Trinity Health Of New England is considered research. Projects must be submitted to the Trinity Health Of New England IRB for further review.

Quality Assessment (QA) and Quality Improvement (QI) activities done with the purpose/intent of prospectively implementing a change in a practice/process/program, whose outcomes will be evaluated through research at a later time, will require Trinity Health Of New England IRB oversight.

Internal Trinity Health Of New England activities, which do not include individually identifiable health information, are not considered research when:

- The purpose of the activity is to assess/evaluate the success of an established internal process/procedure/program in meeting objectives and goals.
- The intended results are to improve the practice/process/program within Trinity Health Of New England.
- The evaluation is used as a management tool for monitoring and improving practice/process/program at Trinity Health Of New England.

Employees and agents of Trinity Health Of New England who wish to complete a determination of whether an activity is human subjects research should submit a request, via Trinity Health Of New England electronic IRB submission system, with a description of the activity and an attached protocol. The request should be submitted on the “Request for Determination of Human Subject Research” Form.

The IRB will consider an activity to be human subjects research when, according to the above definitions, the activity is either 1) “research” that involves “human subjects”, or 2) a “clinical investigation”. The IRB Chair or IRB Program Coordinator will review each request, make the determination of whether the described activity represents “human subject research,” and provide a written response to the Investigator. If the request meets the determination of human subject research, the individual must submit a formal application to the IRB.

SECTION II.

RELATIONSHIP OF THE IRB TO OTHER INSTITUTIONAL COMMITTEES

Research Committees

Scholarly or scientific reviews done here at Trinity Health Of New England of proposed research address the following issues: the research uses procedures consistent with sound research design and the research design is sound enough to yield the expected knowledge needed for review. Since the institution follows ICH-GCP (E6) with regards to the available nonclinical and clinical information on investigational products to support the proposed clinical trials done here at Trinity Health Of New England, the scientific reviewer assigned to these protocols takes this into account when reviewing a study. If concerns arise during the initial review of a protocol by the IRB Chair regarding the scientific design or validity of a protocol, the IRB Chair can request that the protocol be reviewed by an outside consultant. If services are used by an outside consultant, they either attend the convened meeting and share their review or communicate with the Program Coordinator and the IRB Chair via email. If concerns regarding the scientific design or validity of a protocol that has been approved by expedited review arise during a convened meeting of the IRB, IRB members can request that the protocol be reviewed by outside consultants. Outside consultants are used when the area of expertise required to review a protocol is not covered by current members of the IRB. This can be decided by the IRB Chair at the time of initial review or by the members of the IRB at a convened meeting. The choice of an outside consultant is decided by the IRB Chair, or as recommended by an IRB member; however, chosen consultants do not vote with IRB members.

When necessary, outside consultants offer advice on experimental design to the Investigators. Training sessions in experimental design are offered by the Department of Research Administration, and announcements are shared with potential Investigators at all sites.

Ethics/Compliance

When deemed necessary, the IRB may consult with Trinity Health Of New England's ethics/compliance and obtain an opinion on specific issues related to clinical studies.

SECTION III. TRAINING IN THE PROTECTION OF HUMAN SUBJECTS

Investigators, Study Coordinators, and Research Staff

All investigators, study coordinators, and research staff are required to complete training in the protection of human subjects prior to receiving IRB approval of a protocol. The purpose of this training is to ensure that investigators conducting research are qualified to conduct the study, to uphold Belmont Report principles, and to ensure compliance with the regulations and the requirements of the IRB in the approved protocol. Minimum standards for approved training programs require the inclusion of the principles of the Belmont Report. The IRB provides CITI training and accepts CITI training from other institutions if the required training is current. Personnel can complete training at www.citiprogram.org.

Off-site investigators collaborating with an investigator from an approved site must create or affiliate their CITI training account with Trinity Health Of New England and complete all courses that the Trinity Health Of New England IRB requires of their staff.

Training of medical students and house staff usually is required but assessed on a case-by-case basis, depending on the type of research being conducted, and on whether the mentors are involved in the training process. The minimum training requirement for conducting record review studies is the successful completion of the CITI online training modules.

Subsequent to the initial training, the IRB requires all investigators, study coordinators, and research staff participating in active research to complete CITI refresher courses via www.citiprogram.org.

Individuals who do not meet the training requirements of the IRB may not be involved in human research activities. The IRB will take appropriate action to withhold or reverse the approval of research when training requirements are not met. The IRB will not approve protocols until training requirements have been fulfilled. When an investigator, study coordinator, or research assistant is added to a protocol after the initial approval, training requirements must be met before the individual is involved in human research activities.

IRB Members

Following their appointment, IRB members are provided with training materials, IRB Policies and Procedures, and are instructed personally by the IRB Program Coordinator and Chair. IRB members receive ongoing training during scheduled meetings. Completion of training is documented as meeting attendance in the meeting minutes and maintained in the IRB files. All members must complete CITI training protection of human subjects and IRB members training. IRB members can complete training at www.citiprogram.org.

When the written Policies and Procedures of the IRB are revised, members are updated during scheduled meetings. The IRB Program Coordinator instructs IRB members of the revisions, which are then documented in the minutes of the meeting. The IRB Program Coordinator is available to meet with IRB members to answer questions or concerns at their request. When the revisions include procedural changes to the conduct of IRB review of protocols, changes are implemented and then reviewed by the full board within a 3-month period to assess their effectiveness and make revisions, as necessary.

Signatory Officials of the FWA

Institutional officials that act officially and in an authorized capacity on behalf of this institution as signatories of the Federalwide Assurance with the OHRP are provided with training materials, IRB Policies and Procedures, and are instructed personally by the IRB Program Coordinator and Chair. OHRP on-line assurance training is recommended but not mandatory. The IRB Office also recommends CITI training.

SECTION IV. SUBMISSION AND REVIEW OF APPLICATIONS

Initial Contact

Following initial contact with the IRB, investigators are provided with:

1. Application Form
2. Consent Form Templates
3. Waiver or Alteration of Individual Authorization for Disclosure of Protected Health Information (*This is part of the application form and must be completed for all studies when a waiver of consent is requested.*)
4. Unaffiliated Investigator Agreement (*Required from research staff who are not members of the Medical/Dental/Nursing staff and/or not employed by a Trinity Health Of New England site with a Federal Wide Assurance*)
5. Conflict of Interest Research Financial Disclosure Form
6. Training materials, if indicated

Submission of Application

Instructions for submission of applications are on the IRB website, found at <http://www.trinityhealthofne.org/irb>. Incomplete protocols may be returned to Investigators.

IRB Fees

The number and complexity of research studies at Trinity Health Of New England has increased substantially over the past few years. The fee schedule is as follows:

- Initial Review: \$2750
- Continuing Review: \$1250
- Full Board Amendments: \$600
- Expedited Amendments: \$300
- Study Closure: \$300

IRB fees apply to all research involving human subjects, fully or partially funded by an external source.

Research studies not subject to IRB review fees:

- Internal Institutional grants
- Only those non-profit foundations and similar organizations that prohibit IRB fees in their policies
- Non –funded Investigator initiated studies

IRB Fees Waiver Request

If a PI feels the IRB review fee imposes an undue hardship, he or she may submit a written request to waive the fee. A waiver will be considered when funding is limited and when the fee will impede the conduct of the clinical research study. The waiver request may be approved or disapproved by the IRB. The waiver request must contain the following information for consideration:

1. A summary of the study objectives and procedures
2. The final clinical study budget summary
3. Justification for the waiver of the fees for IRB review

(a) Initial Review and Submission Checklists

The Chair and the Program Coordinator review the application to determine whether or not it qualifies for Expedited Review in accordance with guidelines in Title 45 CFR 46.110 and Title 21 CFR 56.110, qualifies for Exemption in accordance with guidelines in 45 CFR 46.101(b) and 21 CFR 56, or requires full board review. The IRB Program Coordinator ensures the completion of the application by checking the following items:

IRB Checklist

1. CITI Training - All required courses must be current for all study personnel
2. Unaffiliated Investigator Agreement – to be completed by residents/students
3. Sponsored studies: Financial Disclosure Form - completed by all study personnel fully executed contract/agreement submitted to Research
4. Protocol - All data in the protocol must match information within the IRB Initial Application
5. Data collection sheet for retrospective/prospective reviews
6. Questionnaires, interviews, assessment materials, surveys, advertisements, flyers, etc.
7. Informed consent or Waiver or Alteration of Individual Authorization for Disclosure of Protected Health Information

Checklist for Advertisements

1. Name and address of investigator
2. State it is research
3. Purpose of Research
4. Summary of eligibility criteria
5. Benefits (e.g., payment, free treatment)
6. Location of research
7. Name/Phone of person to contact for more information

Checklist for Sponsor Agreements/Contracts

1. Sponsor payment, compensation, or reimbursement schedules for Investigators and/or the Institution.
2. Indication of who (e.g., the sponsor or Institution) will provide additional care for research-related injuries and who will be responsible for the payment of this additional care.
3. The sponsor's obligation to promptly report to the investigator and Institution any significant new adverse effects, risks, or other findings related to the research study that could possibly affect the safety of subjects, affect the willingness of subjects to continue with participation, influence the conduct of the study, and/or alter the IRB's approval to continue the study.
4. Indication of how interim or final study results will be communicated to the

subjects when the information could possibly affect their safety, medical care, and willingness to continue with participation. This includes results from other studies using the same intervention for a similar or other indication.

5. Contract provisions for medical care for research-related injuries are consistent with the consent document.

Consent Form Checklist

1. Wording understandable to the subject population
2. Does not contain coercive language
3. Statement that study involves research
4. Purpose of research
5. Approximate number of subjects involved in the study
6. Procedures to be followed
7. Procedures which are experimental
8. Expected duration of subject's participation
9. Description of risks, discomforts, and side effects
10. Safeguards to be used
11. Benefits to the subject or others which may be expected
12. Alternative treatments that might be advantageous
13. Statement describing the extent to which confidentiality of records identifying the subject will be maintained
14. A statement that the FDA or other regulatory agencies may inspect the subject's medical records
15. List other organizations that may inspect and/or copy records for quality
 - i. Assurance and data analysis (NCI, sponsor, IRB)
16. For research involving more than minimal risk:
 1. explanation as to whether compensation and medical treatments are
 2. available if injury occurs and what they consist of
 3. where further information may be obtained
 4. statement that participation is voluntary; refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled
17. *If applicable:* Any additional costs the subject will incur, what will be paid for as part of study and by whom
18. Compensation for participation, if any
19. Trinity Health Of New England disclaimer "If you sustain injuries from your participation in this research study, you may not be automatically compensated by Trinity Health Of New England "
20. Statement that subject may withdraw from study, or be withdrawn, at any time
 - i. without penalty, loss of benefits to which he/she is entitled, or jeopardizing
 - ii. present or future care
21. *If applicable:* Anticipated circumstances under which participation may be

- iii. terminated by investigator without regard to subject's consent
- 22. *If applicable:* Consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject
- 23. *If applicable:* Statement that significant new findings developed during course of research which may relate to subject's willingness to continue participation will be provided to subject
- 24. Name/phone number of Investigator, Co-Investigator, or Study Coordinator to contact with questions or concerns about the research or procedures
- 25. Name/phone number of Principal Investigator or person to contact if subject experiences problems, adverse events or research-related injury during study
- 26. For questions about rights as a research subject, address and phone number of IRB. Indication that research participants may also call this number in case they wish to talk to someone not on the research team. (Participants should also be notified of steps the IRB will take to discuss concerns regarding the research. This can be handled when the participant calls the IRB directly. If there is a problem with the research staff, a safety related concern, and anything else the participant wishes to discuss, the IRB can discuss this with the participant, in which an audit will be conducted, and the findings will be discussed with the Institutional Official and legal and risk management if necessary. This concern will remain confidential to protect the patient's privacy.)
- 27. Name/phone number that research participants may contact to discuss problems, concerns, questions, obtain information or offer input with an informed individual unaffiliated with the specific research protocol (may be the IRB)
- 28. *If applicable:* Statement that clinical trial information will be entered into a databank (www.ClinicalTrials.gov)
- 29. *If applicable:* Statement that treatment/procedure may involve unforeseeable risks to subject, or to embryo or fetus, if subject is or may become pregnant
- 30. *If applicable:* Avoidance of pregnancy language that is in accordance with Catholic Church directives
- 31. *If applicable,* disclosure of benefits to investigators involved in the study
- 32. *If applicable,* assent statement included

PHI Authorization Checklist

1. A specific and meaningful description of what protected health information will be used or disclosed.
2. Identification of who may use or disclose the protected health information of the subject, and to whom this information may be disclosed.
3. Purpose of the use or disclosure of protected health information (i.e., for research purposes);
4. A statement that there is no expiration date related of the use or disclosure of the protected health information for this research project or a statement that the use or disclosure of the protected health information will conclude at the end of the study;

5. A statement of the individual's right to revoke the authorization in writing and the exceptions to the right to revoke;
6. A statement that information used may be subject to re-disclosure by the recipient and no longer be protected by this rule

Recruitment of Research Subjects and Advertisements

The four types of recruitment that are permissible at Trinity Health Of New England are:

1. An Investigator's own patients. When a physician has treated or continues to treat a patient who is eligible as a subject in a clinical trial that the physician is conducting, the informed consent process must differentiate between the physician's roles as clinician and investigator. This is best achieved when someone other than the treating physician obtains the participant's informed consent to participate in the trial. This individual should be protected from the pressure of financial incentives. The purpose of this disclosure is to ensure that a potential subject is not coerced or pressured into participating, especially in cases where a study may involve subjects who are vulnerable to undue influence.
2. A physician referring patients to an Investigator following a discussion with the patient regarding the study and the patients' permission to be contacted by the investigator.
3. Advertising. The IRB reviews direct advertising for research subjects which is defined as advertising that is intended to be seen or heard by prospective participants to solicit their participation in a study. All advertising materials must be approved by the IRB prior to its use and distribution. Advertisements to recruit subjects may be approved by expedited review, and should be limited to:
 - a. The name and address of the clinical investigator
 - b. Statement that it is research
 - c. Purpose of the research
 - d. Summary of eligibility criteria
 - e. A straightforward and truthful description of the benefits to the subject for participating in the study (e.g., payments or free treatment) and the commitment involved
 - f. The location of the research
 - g. Name/phone number of person to contact for further information

These basic guidelines apply to all forms of advertisements, including those utilizing flyers, social and digital media including, but not limited to newspapers, radio, television, and web postings.

Advertisements cannot make claims, either explicitly or implicitly, that the test article is safe or effective, or known to be equivalent or superior to any other biologic or device. Advertisements cannot contain language that is exculpatory or promise "free medical treatment" when the intent is to only say subjects will not be charged for taking part in the investigation. If language is to contain terms such as "new treatment", "new medication", or "new drug", the advertisement must explain that the test article is investigational. Advertisements may state that subjects will be paid but should not emphasize the payment or amount to be paid, by such means as larger or bold type.

The IRB reviews the final copy of printed advertisements, whenever possible, to evaluate the relative size of the type and other visual effects. The IRB will review the information contained in the advertisement and the mode of its communication (e.g., radio broadcast, newspaper ad, poster) to determine that the procedure for recruiting is not coercive to subjects. When advertisements are taped broadcasts or videos, the IRB reviews the final audio and/or video tape and requests a copy of the final transcript. If the advertisement will include a live interview or question/answer session, the IRB requests an outline of topics to be discussed prior to the broadcast and a tape or transcript of the session following the broadcast.

4. Clinical trial websites. Although websites use a different medium than traditional print or broadcast advertisements the requirements are the same. When information posted on a clinical trial website goes beyond directory listings, with basic descriptive information, such information is considered part of the informed consent process, and therefore, requires IRB review and approval. Basic descriptive information includes:

- a. Study title
- b. Purpose of the study
- c. Protocol summary
- d. Basic eligibility criteria
- e. Study site location(s), and
- f. How to contact the study site for further information.

Clinical trial websites that provide *only* directory listings with basic descriptive information about clinical trials in general (as listed above) do not need to be reviewed by the IRB.

Information exceeding such basic listing information will require IRB review and approval. The IRB will ensure that information is presented in a balanced and fair manner, will assess the types of incentives offered to prospective subjects, and will ensure that participation is voluntary.

If the clinical trial website asks viewers to answer questions regarding eligibility for a specific clinical trial, and therefore, identifiable private information is collected, the IRB will review plans for protecting the confidentiality of that information and ensure that the website explains how identifiable private information might be used.

Informed consent will be required for the collection of any information about the respondent unless the IRB has determined that the informed consent requirement can be waived, or altered, in two sets of circumstances, as described in 45CFR46.116 c and d:

1. Research activities designed to study certain aspects of state or local public benefit or service programs;
2. If the IRB finds and documents that:
 - 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;
 - d. whenever appropriate, the subjects will be provided with additional pertinent information after participation.

(Note that research involving children as subjects requires parental permission and child assent unless waived (45CFR46.408).)

- e. the research is not subject to FDA regulation.

The IRB will evaluate the selection of subjects and influence of payment(s) to subjects. Participant payment arrangements may be used to recruit and keep participants enrolled in research studies. The arrangements for such payments must be stated in a straightforward and honest manner on the initial application, and in the informed consent form to ensure that the participants understand what they are entitled to. Proposed payments to research participants are reviewed on a case-by-case basis by the IRB as part of the initial submission process. The IRB will take into consideration the payment fee(s), payment schedule, proposed method of payment (e.g., gift card, cash), and distribution to assure that payment(s) are not coercive or present undue influence. Payments should be based on research participants' time and/or reimbursement for reasonable expenses incurred during their participation in a clinical trial, such as parking, travel, and lodging expenses. The nature and amount of compensation or any other benefit should be consistent with the principle of voluntary informed consent. Per FDA guidelines, payment of a small proportion as an incentive for completion of the study is acceptable, providing that such incentive is not coercive. The entire payment should not be contingent upon completion of the entire study. The IRB determines that the amount paid as a bonus for completion is reasonable and not so large as to unduly induce subjects to stay in the study when they would otherwise have withdrawn. Compensation for participation in a trial offered by a sponsor may not include a coupon good for a discount on the purchase price of the product once it has been approved for marketing.

Outreach programs directed at patients at Trinity Health Of New England and the community are conducted by the Institution as well as by individual departments in order to educate the public about participating in research studies. These activities may include distribution of informative pamphlets, lectures or informational talks, and other educational programs. The phone number of the IRB is provided on the IRB web site and should be provided on pamphlets and on other handouts, to establish a safe, confidential and reliable channel for current, prospective, or past research participants or their designated representatives that permits them to discuss problems, concerns, and questions; obtain information; or offer input with an informed individual who may be unaffiliated with a specific research protocol or department. To evaluate the effectiveness of outreach programs, the IRB Program Coordinator will discuss the various activities engaged in during the past year with Study Coordinators.

Data Safety and Monitoring for Interventional Protocols

All interventional protocols require safety monitoring to review accumulated outcome data, including Adverse Event reports to determine whether any of the treatment procedures practiced should be altered or stopped. When evaluating new protocols for data safety monitoring, the type of monitoring required depends upon the size of the study, the nature of the investigation, the complexity of the study design, and the level of risk to study participants. Large, multi-center studies are required to have independent Data and Safety Monitoring Boards to gather and assess study information from all the sites involved in the trial. Local, investigator-originated protocols generally do not need data safety monitoring or a Safety Officer when addressing lesser outcome protocols that involve minimal risk. The IRB reserves the right to designate an independent Safety Officer for investigator-originated protocols to ensure the safety of research participants and compliance with regulations. This IRB also requires all interventional protocols to have a Study Coordinator.

SECTION V. THE REVIEW PROCESS

For **Full Board Review**, applicants are required to submit:

1. Full Board IRB Application completed in Trinity Health Of New England IRB's Electronic Submission system
2. Consent form and Research Authorization for Use/Disclosure of Protected Health Information (if not included in consent form) or questionnaire requesting waiver of authorization
3. Sponsor sample consent form template, if applicable
4. Documentation indicating why the sponsor sample consent form template or protocol (or both) have been altered in the procedure and/or risks sections, if applicable
5. Questionnaires, interview protocols, assessment materials, experiment session outlines and descriptions of materials that subjects will encounter
6. Advertisements for subject recruitment, if applicable
7. Protocol, e.g., proposal or grant
8. Investigators' Brochure and any previous animal and human experiments associated with the investigational article supplied by the manufacturer
9. 1 copy of curriculum vitae for each investigator listed on the application
10. Documentation of training of off-site investigators
11. Application fee, if applicable
12. Research Financial Disclosure Form
13. DSMB or Safety Officer designated (for all interventional protocols)

Expedited Review, applicants are required to submit:

1. Expedited IRB application completed in IRB's electronic submission system
2. Consent form and Research Authorization for Use/Disclosure of Protected Health Information (if not included in consent form) or completed questionnaire requesting waiver of authorization
3. Sponsor sample consent form template, if applicable
4. Documentation indicating why the sponsor sample consent form template or protocol (or both) have been altered, in the procedure and/or risks sections if applicable
5. Questionnaire, interview protocol, assessment materials, experiment session outlines and descriptions of materials subjects will encounter
6. One copy of curriculum vitae for each investigator listed on the application
7. Documentation of training of off-site investigators
8. Application fee, if applicable
9. Research Financial Disclosure Form

Applications not meeting the requirements of expedited review are resubmitted following the requirements for full board review (see below, Criteria for reviewing and approving research by the expedited procedure).

The IRB uses the following **criteria for reviewing and approving research by the expedited procedure**:

Applicability

- (A) Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by [45 CFR 46.110](#) and 21 CFR 56.110. The activities listed should not be deemed to be of minimal risk simply because they are included on this list. Inclusion on this list merely means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimal risk to human subjects.
- (B) The categories in this list apply regardless of the age of subjects, except as noted.
- (C) The expedited review procedure may not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
- (D) The expedited review procedure may not be used for classified research involving human subjects.
- (E) IRBs are reminded that the standard requirements for informed consent (or its waiver or alteration, or exception) apply regardless of the type of review-expedited or convened-utilized by the IRB.
- (F) Categories one (1) through seven (7) pertain to both initial and continuing IRB review.

Expedited Research Categories

Category 1: Clinical studies of drugs and medical devices only when condition (a) or (b) is met.

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

Category 2: Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:

- (c) from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8- week period and collection may not occur more frequently than 2 times per week; or
- (d) from other adults and children*, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser

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

of 50 ml or 3 ml per kg in an 8- week period, and collection may not occur more frequently than 2 times per week.

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

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

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

Examples:

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

Category 5: Research involving materials (data, documents, records, or specimens) that have been collected or will be collected solely for non-research purposes (such as medical treatment or diagnosis). (NOTE: Some research in this category may be exempt from the DHHS regulations for the protection of human subjects [45 CFR 46.101(b)(4)]. This listing refers only to research that is not exempt.)

Category 6: Collection of data from voice, video, digital, or image recordings made for research purposes.

Category 7: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview,

oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the DHHS regulations for the protection of human subjects [45 CFR 46.101(b)(2) and (b)(3)]. This listing refers only to research that is not exempt.)

Category 8: Continuing review of research previously approved by the convened IRB as follows:

- (e) where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or
- (f) where no subjects have been enrolled and no additional risks have been identified; or
- (g) where the remaining research activities are limited to data analysis.

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

Minor changes in previously approved research

Other categories added to this list by DHHS and published in the *Federal Register*

For **Exempt Review**, applicants are required to submit: Exempt IRB application completed via IRB's electronic submission system

The IRB uses the following **criteria for reviewing and granting research the exempt category** (as stated in 45CFR46.101(b) and 21 CFR 56.104): the HHS regulations, 45 CFR part 46, include four subparts: subpart A, also known as the Federal Policy or the "Common Rule"; subpart B, additional protections for pregnant women, human fetuses, and neonates; subpart C, additional protections for prisoners; and subpart D, additional protections for children.

Such a determination may include:

- (A) The research holds out no more than minimal risk to subjects.
- (B) Selection of subjects is equitable.
- (C) If there is recording of identifiable information, there are adequate provisions to maintain the confidentiality of the data.
- (D) If there are interactions with subjects, there will be a consent process that will disclose such information as: the activity involves research, participation is voluntary, name and contact information for the Researcher, and there are adequate provisions to maintain the privacy interest of subjects.

Exempt Research Categories

Unless otherwise required by law or a federal agency or department, research activities in which the only involvement of human subjects will be in one or more of the following categories are considered exempt.

Note: Other than exempt 8, these categories do not apply to research that is also FDA-regulated.

1. **Category 1: 45CFR46.104(d)(1):** Research conducted in established or commonly accepted educational settings, involving normal educational practices. 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.

2. **Category 2: 45CFR46.104(d)(2):** Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior unless the information is obtained in an identifiable manner and any disclosure of the subjects responses outside of research could reasonably place the subject at risk. 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.
 - 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;
 - 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
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 45CFR46.111(a)(7): "When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data."
3. **Category 3: 45CFR46.104(d)(3):** Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior, if (i) the human subjects are elected or appointed public officials or candidates for public office or (ii) federal statute(s) require(s) that the confidentiality of the subjects identifiable information will be maintained throughout the research and thereafter. 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:
 - (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;
 - (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
 - (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 45CFR46.111(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. The information in this resource is based upon information available at the time of publication: January 2019

4. **Category 4: 45CFR46.104(d)(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 in a de-identified manner. 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:
 - I. The identifiable private information or identifiable biospecimens are publicly available;
 - 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;
 - 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).
 - 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

5. **Category 5: 45CFR46.104(d)(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 public benefit or service programs. 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.
6. **Category 6: 45CFR46.104(d)(6):** Taste and food quality evaluation and consumer acceptance studies if, (i) wholesome foods without additives are consumed or (ii) if plant or animal raised food products are consumed which are at or below the regulated level found to be safe. Taste and food quality evaluation and consumer acceptance studies:
 - I. If wholesome foods without additives are consumed, or
 - II. If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.
7. **Category 7: 45CFR46.104(d)(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 46.111(a)(8):
 - 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 45CFR46.116(a)(1) – (4), (a)(6), and (d) (See Sections 8.1 and 8.3);
 - II. Broad consent is appropriately documented or waiver of documentation is appropriate, in accordance with 45CFR46.117 (See Sections 8.6 and 8.7); and

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.

8. **Category 8: 45 CFR 46.104(d)(8):** Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use.

THOfNE IRB is implementing the following two (2) of these exempt limited review categories:

- **Category 2: 45 CFR 46.104(d)(2)**
- **Category 3: 45 CFR 46.104(d)(3)**

THOfNE IRB will not implement the following two (2) of these exempt limited review categories due to the Broad Consent Requirements:

- **Category 7: 45 CFR 46.104(d)(7)**
- **Category 8: 45 CFR 46.104(d)(8)**

None of the exempt categories may be applied to research that involves prisoners as participants.

Research that meets the criteria for exemption may be referred for further review or disqualified from exempt status if the IRB Chair determines at the time of initial review that the research does not uphold Trinity Health Of New England ethical standards and/or there are concerns or issues with the protocol not related to the regulatory requirements. Such protocols will be reviewed by expedited or full board review, as determined by the IRB Chair. If there is a question about the potential for harm of participants in research exempt from federal regulations, that research will not be granted exempt status, and will be reviewed, approved and monitored by the IRB in a manner appropriate to ensure the safety of the participants.

The IRB Program Coordinator, IRB Chair, or the convened IRB may make exemption determinations. Exemption determinations are not to be made by Researchers or others who might have a conflict of interest regarding the studies. If the IRB Program Coordinator or IRB Chair makes an exemption determination, the category or categories of research allowing the exemption will be recorded in the correspondence to the investigator, and in the minutes of the next fully convened IRB meeting. If the IRB makes the exemption determination, the category or categories of exemption will be recorded in the minutes.

Protocols granted exempt status are exempt from further IRB review. However, investigators should consult the IRB whenever questions arise about whether planned changes to an exempt study might make that study nonexempt human subject research. The IRB Chair or designated IRB member will evaluate the planned changes and determine if the study continues to meet the criteria for exemption. Examples of planned changes that may make the study nonexempt

human subjects research include but are not limited to: 1) more than minimal risk and 2) collection of identifying materials or data.

The Review

The Chair of the IRB reviews protocols qualifying for expedited and exempt approval. If the Chair is unavailable to review a protocol qualifying for expedited and exempt approval, a qualified member of the IRB with expertise in the area of the study will be designated by the Chair of the IRB as a primary reviewer. Studies involving vulnerable populations, such as children, that are eligible for expedited or exempt approval will be reviewed by the Chair of the IRB. If there is a question of whether one of these protocols poses a greater than minimal risk, the study will be reviewed by a consultant with expertise in that area. If there is a question about whether additional state or local laws are applicable to the protocol, the IRB Chair or qualified member of the IRB may ask Legal Services for assistance in interpreting and applying appropriate laws. Exempt protocols and protocols approved by expedited review are presented to the members of the IRB at the following convened meeting. The approval letter to the investigator and minutes of the meeting indicates the category of the regulation under which expedited or exempt approval was granted. The research evaluated by expedited review procedures may be disapproved only following review by the full committee at a convened meeting. Protocols granted exempt status are exempt from further IRB review.

Limited IRB Review Limited IRB review is a process that is required only for certain exemptions. In limited IRB review, the IRB must determine that certain conditions, primarily that adequate provisions are in place to protect the privacy of subjects and maintain the confidentiality of the data, are met.

Single IRB (sIRB) Most federally funded collaborative research projects based in the US will be required to use a sIRB.

Approval of a New Study

When the IRB reviews research that is not eligible for expedited or exempt approval and involves subjects likely to be vulnerable to coercion or undue influence, the IRB Chair evaluates each protocol and ensures that at least one IRB member knowledgeable about or experienced in working with subjects will be present at the meeting.

Approval of protocols are granted following exempt, expedited, or full board review and is communicated in writing to the investigator. The letter may include conditions of the approval and the responsibilities of the investigator.

When approval of a new protocol is granted by full board review pending specific revisions requiring simple concurrence by the investigator, a letter is sent to the investigator within five days of the IRB decision, listing the additional requirements needed for approval. A response from the investigator is required at least two weeks prior to a fully convened meeting.

In instances where the IRB determines that sufficient information has not been provided to adequately judge the safety of a study, the protocol is not approved. In instances where there is

not sufficient expertise among IRB members to make a determination of a protocol, an outside expert opinion may be requested. This can be decided by the IRB Chair at the time of initial review, or by the members of the IRB at a convened meeting. The choice of an outside consultant is decided by the IRB Chair, or as recommended by an IRB member. In such cases, voting will be deferred pending the consultant's review. The IRB can request further supporting documentation from the Investigator, and will review that material, along with the consultant's critique, at a subsequent convened meeting. Investigators are informed in writing of the decision. If the IRB votes for disapproval of a study, the investigator can appeal by responding in writing and presenting the reason for their appeal to the full board at a regularly convened meeting. Institutional officials cannot overturn this decision of the IRB.

Approval Term

Research protocols are most often approved for a period of one year. The expiration date is the last date that the protocol is approved. The calculation of the expiration date is one year minus a day from the date of the initial approval. The IRB may also approve a protocol for a period less than one year. For protocols requiring full board review, the duration of the approval period is determined by members of the IRB at a convened meeting. More frequent review may be required in cases considered to have increased risk to the research subjects. If a study is determined to be potentially risky to participants, it is audited at intervals determined by the members of the IRB as a contingency of the approval.

The criteria which the IRB uses to determine which projects require review more often than annually are:

1. randomly selected projects
2. complex projects involving unusual levels or types of risks to subjects
3. projects conducted by investigators who previously have failed to comply with the requirements of the OHRP regulations or the requirements or determinations of the IRB
4. projects where concern about possible material changes occurring without IRB approval have been raised based upon information provided in continuing review reports or from other sources.

SECTION VI. THE CONSENT PROCESS

Consent and Consent Forms

Informed consent is a process of information exchange that may include, in addition to reading and signing the informed consent documents, subject recruitment materials, verbal instructions, question/answer sessions, and measures of subject understanding. The IRB requests that the principal investigator provide on the initial application a complete list of individuals who will be authorized to obtain consent, assent, or authorization from subjects. Individuals must be listed as an investigator or study coordinator on the research application and must be knowledgeable of the research protocol and able to respond to questions from subjects. The IRB will consider on a case-by-case basis each individual and determine whether their level of training and experience are appropriate for conducting the consent process for the research study. In some cases, the IRB may require that the individual receive additional training in conducting the consent process. The principal investigator is ultimately responsible for ensuring that the informed consent process is conducted appropriately, and the consent is obtained from each research subject before that subject participates in the study. The individual conducting the consent process shall give the subject adequate opportunity to review the consent and ask any questions regarding the research procedures.

A written document which includes the elements of an informed consent must be provided to the IRB for review and approval. Recommended consent form templates are provided with the application form. Consent forms are reviewed and approved by members of the IRB to ensure compliance with 45 CFR 46.116 and 21 CFR 50.25. The IRB places an approval stamp with effective and expiration dates on each page of the original consent form document and stipulates that copies of the approved original document be used in obtaining consent. It is the policy of the IRB that potential subjects are contacted initially by a health care provider involved in their care to assess their willingness to participate in the study. Patients willing to participate are referred to the principal investigator or a study coordinator, and either one will explain the protocol in detail to the subject and obtain a signed consent form. Individuals without full knowledge of the protocol and not listed as participants in the application form cannot consent subjects entering the study. The principal investigator is ultimately responsible to ensure that the subject is fully cognizant of the risks and benefits of the study.

In some instances, the patient's primary care physician may also be the Principal Investigator or a co-investigator conducting the study. This must be verbally disclosed to the patient during the consent process and included in the consent form. The purpose of this disclosure is to ensure that a potential subject is not coerced or pressured into participating, especially in cases where a study may involve subjects who are vulnerable to undue influence. In addition, the investigators must disclose to the subject any benefits which may be realized for conducting and recruiting subjects into a study. Investigators and study coordinators are encouraged to document in the subject's record the procedure followed to obtain consent. A subject is considered enrolled in a research study once the subject has agreed to participate and signed the Informed Consent document, whether or not interventions have been initiated.

Unless waived by the IRB, informed consent shall be:

1. Documented by the use of a written consent form approved by the IRB.
2. Signed by the participant or the participant's legally authorized representative, when applicable (for the definition of a legally authorized representative,
3. Dated by the participant or the participant's legally authorized representative, when applicable
4. A copy given to the individual signing the form

The use of telephone consenting may be appropriate for studies that involve no more than minimal risk to subjects and do not employ the use of an interventional test article or device. Please refer to the section "Waiver of Documentation of Informed Consent" for more information regarding terms and use of telephone consenting procedures.

Written consent documents must be in language understandable to the subject. When the study subject population includes non-English speaking individuals, the consent interviews are to be conducted in the language understood by the subject, using a translator if necessary, and a translated consent form is prepared. When the study subject population includes illiterate persons who understand English, the form may be read to the subject or subject's legally authorized representative (when applicable) and the subject may "make their mark" on the consent. When this method is used, there shall be a witness to the oral presentation. A Short form may be used for blind or illiterate persons.

It is the policy of the IRB not to allow any form of interventional research in subjects unable to consent themselves unless it meets requirements stipulated under conditions of medical emergencies. Unconscious patients or those unable to consent due to the influence of drugs or intoxicants, mental illness, or other temporary impairment of reasoning capability, may be enrolled in research that is non-interventional and involves no more than minimal risk to the subjects. In such cases, the investigator may obtain permission to enroll the subject from a legally authorized representative. Subsequent to regaining their mental capabilities, enrolled subjects will be consented for the research to continue.

It is within the authority of the IRB to observe, or have a third party observe, the consent process for purposes of an audit, or when the IRB determines at the time of initial or continuing review that there is concern regarding the consent process of a protocol. The IRB may consider observing the consent process as a method to protect subjects when study inclusion criteria may hinder the capacity of an individual to provide informed consent, as it is a policy of the IRB not to allow any form of interventional research in subjects unable to consent themselves. The IRB may also consider observing the consent process to ensure protection of subjects as a result of a complaint from a previously enrolled subject. The IRB requires that all consent documents list the name(s) and phone numbers of the investigator(s), co-investigator(s), or study coordinator(s) to contact if the subject should experience problems, adverse or unanticipated events or research-related injuries, and to address any questions or concerns that study participants have. The address and phone number of the IRB is also included should subjects have questions or concerns regarding their rights as a research participant.

Instructions for the completion of an acceptable consent form are included in templates located in the IRB electronic submission system/IRB website.

Consent Form, Individual Authorization Form and Waivers

The Consent Form is the subject's consent to participate in research. The Health Insurance Portability and Accountability Act (HIPAA) is the subject's permission to use and disclose their Protected Health Information (PHI). The IRB may approve a consent procedure that does not include, or which alters, some or all of the elements of informed consent set forth in the "Consent and Consent Forms" section of these policies. Please refer to the section on Consent for criteria for approval of a waiver of consent.

It is required that a Research Authorization for Use/Disclosure of Protected Health Information be obtained from research subjects, unless a waiver of authorization is requested and granted. The Informed Consent template currently available on the IRB website has a Research Authorization for Use/Disclosure of Protected Health Information Authorization Form incorporated into the "Confidentiality" section.

Specific criteria must be met for approval of a research project which involves accessing or using an individual's PHI without the express authorization of the individual. Refer to the section entitled "HIPAA Compliance" for the criteria for approval of a Waiver of Individual Authorization.

Waiver or Alteration of the Consent Process:

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

- The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine:
 - Public benefit or service programs;
 - 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;
- The research could not practicably be carried out without the waiver or alteration.
- The research involves no more than minimal risk to the participants;
- The waiver or alteration will not adversely affect the rights and welfare of the participants;
- Whenever appropriate, the participants will be provided with additional pertinent information after participation.
- The research is not subject to FDA regulations.

Where DHHS guidance requires specific findings on the part of the IRB the IRB will document such findings in the minutes of the IRB meeting, including protocol-specific information justifying each IRB finding.

a). Waiver of Documentation of the Consent Process – Screening, Recruiting, and Determining Eligibility

- The researcher will obtain information through oral or written communication with the prospective participant or legally authorized representative, or
- The researcher will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.
- The research is not regulated by the US FDA.

b). Waiver of Documentation of Informed Consent - Confidentiality

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

That all of the following are true:

- The only record linking the participant and the research would be the consent document.
- The principal risk would be potential harm resulting from a breach of confidentiality.
- Each participant will be asked whether the participant wants documentation linking the participant with the research, and the participant's wishes will govern.
- The oral or written information provided to participants includes all required and appropriate additional elements of consent disclosure.
- The IRB has determined whether the participant should be provided written information.
- The research presents no more than minimal risk of harm to participants.
- The research involves no procedures for which written consent is normally required outside of the research context.
- The research is not regulated by the US FDA.

c). Waiver of Documentation of the Consent Process: Consent normally not required outside the research context.

- The research involves no procedures for which written documentation of the consent process is normally required outside of the research context.
- The oral or written information provided to participants includes all required and appropriate additional elements of consent disclosure.
- The IRB will determine whether the researcher should provide participants with a written statement regarding the research.
- The research is not regulated by the US FDA.

d). Waiver of Documentation of the Consent Process: Distinct Cultural Groups

- The research presents no more than minimal risk of harm to

participants.

- The participants or legally authorized representatives are members of a distinct cultural group or community in which signing consent documents is not the norm.
- There is an appropriate alternative mechanism for documenting that informed consent was obtained.
- The oral or written information provided to participants includes all required and appropriate additional elements of consent disclosure.
- The IRB will determine whether the researcher should provide participants with a written statement regarding the research.
- The research is not regulated by the US FDA.

When following FDA requirements:

- The IRB is allowed to waive or alter the consent process by determining that the regulatory criteria for waivers or alterations of the consent process are met.
- Written materials allow the IRB to waive the requirement to document the consent process by determining that the regulatory criteria for waivers are met.
 - When the IRB considers waiving the requirement to obtain written documentation of the consent process, policies and procedures have the IRB review a written description of the information that will be provided to participants.
 - When granting waivers of the requirement to obtain written documentation of the consent process, policies and procedures have the IRB consider requiring the researcher to provide participants with a written statement regarding the research.

In cases where the documentation requirement for informed consent is waived, the IRB may require the investigator to provide participants with a written statement regarding the research. The written statement must be submitted to the IRB for review and approval prior to its use in the research. The IRB will consider each case and determine whether to have the investigator provide the subject with the written statement. Where DHHS guidance requires specific findings on the part of the IRB, such as approving a procedure which waives the requirement for obtaining a signed consent form, the IRB will document such findings in the minutes of the IRB meeting, including protocol-specific information justifying each IRB finding.

In cases where the use of a telephone informed consent process will replace documentation of written informed consent, the investigator must submit to the IRB for review and approval a text script which will be read to each subject. The text script must include all the elements of consent and a copy must be provided to the subject following their verbal assent to participate in the study.

c) Exception from Informed Consent in Planned Emergency Research

Planned emergency research allows research on life-threatening conditions for which available treatments are unproven or unsatisfactory, and when it is not possible to obtain informed consent. Both the FDA and OHRP permit a waiver of the general requirements for informed consent for research involving greater than minimal risks to subjects when specific conditions are

met (21 CFR 50.24). Currently, this Institution does not participate in planned emergency research.

Obtaining Consent for HIV Testing in Human Research Participants

If research includes HIV testing, Chapter 368x of the Connecticut General Statutes requires adults and parents of children to provide written informed consent for HIV testing using the hospital HIV consent form. At the time of communicating test results to the patient, the attending physician should inform the patient of the possible need for counseling and medical care. Please refer to the hospital's "Consents Policy" available on the intranet.

Obtaining Permission of the Parent(s) / Assent of the Child

For research involving children as subjects, the IRB must determine that adequate provisions are made for soliciting the assent of the children, when the IRB determines the children are capable of providing assent. In determining whether children are capable of assenting, the IRB takes into account the ages, maturity, and psychological state of the children involved. This judgment may be made for all children to be involved in research under a particular protocol, or for each child, as the IRB deems appropriate. If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research. Even where the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances in which consent may be waived in accordance with the requirements for waiver of consent contained in 45 CFR 46.116 of Subpart A. The IRB will document assent determinations and requirements in the meeting minutes and study approval letter.

The IRB will also determine that adequate provisions are made for soliciting the permission of each child's parents or guardian. Where parental permission is to be obtained, the IRB will determine if: 1) the permissions of both parents are required unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent had legal responsibility for the care and custody of the child, or 2) the permission of one parent is sufficient even if the other parent is alive, known, competent, reasonably available, and shared legal responsibility for the care and custody of the child. The IRB may find that the permission of one parent is sufficient for research to be conducted under [§46.404](#) (research not involving greater than minimal risk) or [§46.405](#) (research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects). Where research is covered by [§46.406](#) (research involving greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition) or [§46.407](#) (research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children), and permission is to be obtained from parents, both parents must give their permission unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child.

If the IRB determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect

the subjects (for example, neglected or abused children), it may waive the consent requirements in accordance with the requirements for waiver of consent contained in 45 CFR 46.116 of Subpart A provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further that the waiver is not inconsistent with Federal, State, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.

When research studies involving children are reviewed and approved by the IRB, determinations as required by the regulations, or protocol-specific findings justifying the IRB's determinations, are documented by citation in the approval letter to the Investigator and in the minutes of the IRB.

Obtaining consent involving pregnant women or fetuses

The IRB determines whether the approval criteria for consent and permission are met when research involves pregnant women or fetuses. The IRB determines and documents that:

- The consent of the mother is obtained in accordance with the regulations.
- If the research holds out the prospect of direct benefit solely to the fetus, then the consent of the father is also obtained in accordance with the regulations, except that the father's consent does not need to be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
- Individuals providing consent are fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate.

The IRB determines whether the approval criteria for consent and permission are met when research involves neonates of uncertain viability. The IRB determines and documents that:

- Individuals providing consent are fully informed regarding the reasonably foreseeable impact of the research on the neonate.
- The legally effective consent of either parent of the neonate is obtained in accordance with the regulations.
- If neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective consent of either parent's legally authorized representative is obtained.
- The consent of the father or his legally authorized representative does not have to be obtained if the pregnancy resulted from rape or incest.

The IRB determines whether the approval criteria for consent and permission are met when research involves nonviable neonates. The IRB determines and documents that:

- Individuals providing consent are fully informed regarding the reasonably foreseeable impact of the research on the neonate.
- The legally effective consent of both parents of the neonate is obtained in accordance with the regulations.
- If either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the consent of one parent of a nonviable neonate is sufficient,

except that the consent of the father does not have to be obtained if the pregnancy resulted from rape or incest.

- The consent of a legally authorized representative of either or both of the parents of a nonviable neonate is not allowed.
- The waiver and alteration provisions are not applied.

SECTION VII. SHORT FORM WRITTEN CONSENT DOCUMENT

The use of the short form is allowed under certain circumstances.

Use of a Short Form Written Consent Document for English Speaking Subjects

The Institutional Review Board allows oral presentation of informed consent information in conjunction with a short form written consent documents (stating that the elements of informed consent required by Sec. 46.116 have been presented orally) and a written summary of what is presented orally to the subject. When this method is used, there shall be a witness to the oral presentation. Also, the IRB shall approve a written summary of what is to be said to the subject. Only the short form itself is to be signed/dated by the subject. However, the witness shall sign/date both the short form and a copy of the summary, and the person actually obtaining consent shall sign/date a copy of the summary. A copy of the summary shall be given to the subject, in addition to a copy of the short form.

Use of a Short Form Written Consent Document for Non-English Speaking Subjects

When this procedure is used with subjects who do not speak English, the oral presentation and the short form written documents should be in a language understandable to the subject. The IRB-approved English language informed consent document may serve as the summary. It is strongly recommended that the full English consent be translated into the participant's language. The translator/interpreter should be fluent in both English and the language of the subject. There must be a witness during the entire consenting procedures. Adequate time should be afforded to the subject, to make an informed decision regarding participation in the research.

At the time of consent, the short form document must be signed and dated by the subject and the witness. The summary must be signed/dated by the person obtaining consent (as authorized under protocol) and the witness. The translator/interpreter may serve as the witness. A copy of the summary shall be given to the subject, in addition to a copy of the short form.

If a member of the study staff speaks the subject's language, the staff member can act as the translator/interpreter and person obtaining consent but should not also act as a witness.

Expedited review of all foreign language versions are acceptable if the protocol, the full English language informed consent document, and the English version of the short form document have already been approved by the convened IRB.

It is the responsibility of the IRB to determine which of the procedures at 46.117(b) is appropriate for documenting informed consent in protocols that it reviews.

SECTION VIII. NON-ENGLISH SPEAKING/READING POPULATIONS

When some or all of the participants of a research protocol are likely to be non-English speaking/reading populations, the recruitment materials, consent documents, and other study documents (i.e. questionnaires) must be translated into the language understood by the targeted group (45CFR46.116-117 and 21CFR50.20).

When non-English speaking/reading individuals are to be consented, an interpreter must be present to facilitate oral communication in more than one language.

All documents translated from English to another language must receive IRB review and approval before use, to assure that the rights and welfare of research participants are adequately protected and the accuracy of the translation. The IRB does not provide translation or interpretation services. Investigators can contact Center for Health Equity for more information on translation and language services.

The IRB recommends that document be translated in one of two ways:

- (a) **Single Back Translation:** The translated document is translated back into English. The translator providing the back translation into English must be different from the person who provided the original translation. Each person providing translation service must complete and sign the Translation Certification Form
- (b) **Double Translation:** Two individuals independently translate the same document from English into another language. An arbitrator reviews both translated documents to determine any differences between the two translated documents. Changes to documents will be made, if applicable. Both Translators must complete and sign the Translation Certification Form (
- (c) The IRB encourages the use of a certified translator. Written documentation of qualification of each translator must be submitted if they are not certified. The IRB may invite a consultant to review the translated materials to determine cultural appropriateness.

SECTION IX. MEETINGS OF THE IRB

Meetings and Quorum

The IRB convenes monthly and Emergency meetings are convened when requested by a physician to treat urgent medical situations requiring the use of experimental drugs or devices. In this situation, the IRB meets within five working days of notification and, in most instances, within 24 to 48 hours. The IRB does not provide expedited review for emergency medical care or expanded access use. Scheduled and emergency meetings require the presence of a quorum (51% or greater of the membership), including one unaffiliated non-scientific member. The unaffiliated non-scientific member will represent the general perspective of participants. Quorum is established by the IRB Chair and is documented in the IRB minutes for each monthly meeting. If quorum is lost during a meeting, the IRB cannot take votes until the quorum is restored. If required, members (e.g., non-scientific) leave the room, and if a quorum is lost, votes cannot be taken until the quorum is restored, even if half of the members are still present. To the extent allowable by applicable laws and regulations, meetings will be considered closed. At the discretion of the Chair, outside observers or experts will be allowed to attend IRB meetings.

The IRB Chair runs the meetings and is responsible for calling a vote. The IRB Chair votes on every item that is presented at the meeting. However, in the case that the IRB Chair has a conflict with a protocol, they step out and the Vice-Chair will assume responsibility for the vote. This is then noted in the minutes. The Vice-Chair also covers for the Chair if the Chair cannot make a meeting. The IRB Chair arrives at the meeting prior to the members and is available for questions before, during and after the meeting. The Vice-Chair is readily available when their schedule permits. The Vice-Chair signs off on anything the Chair is involved on.

Review Process

At scheduled and emergency meetings, members of the IRB review all submitted materials. All new protocols are reviewed by the Chair of the IRB or a qualified member designated by the Chair of the IRB. Investigators are encouraged to be present and answer questions at the convened IRB meeting. Investigators are not present during protocol discussion and voting. Approval or disapproval requires majority vote. All submitted materials are available to all members of the IRB with the meeting agenda at least one week prior to a scheduled meeting. The Chair of the IRB reviews or assigns a primary reviewer to assess each protocol to ensure appropriate and complete review of submissions. A summary of findings is presented by the IRB Chair or primary reviewer to the full board at fully convened meetings.

For the review of new protocols, IRB members can access electronic copies of all submitted materials, which includes the protocol application, consent form, investigator's brochure, full protocol (proposal or grant) (if applicable), and questionnaires and advertisements (if applicable). Primary reviewers are assigned and required to complete a review criteria checklist which will be submitted to the IRB following the review and kept on file with the initial protocol application in IRB's electronic submission system. For protocols involving the participation of pregnant women, fetuses, neonates, children, or other vulnerable population, the primary reviewer must also complete a vulnerable population review criteria checklist. Members may also request a checklist

prior to a convened meeting to be used as a review reference or if they wish to complete a checklist for a particular research proposal or study under review.

For conducting continuing review, IRB members have access to all materials in IRB's electronic submission system which includes continuing review request forms, abstract/summary forms, and current consent forms (when applicable). Amendments made to the protocol that were approved by the IRB in the past year are summarized on the renewal form, and the full protocol is available to the IRB members at the time of the convened meeting. The IRB Chair conducts continuing review and receives all submitted materials, as stated above, including the review criteria checklist. For protocols involving the participation of pregnant women, fetuses, neonates, children, or other vulnerable population, the reviewer must also complete a vulnerable population review criteria checklist. Completed checklists will be kept on file with the application submitted for continuing review.

For protocol amendments, IRB members can access the amendment form and supporting documentation of the changes and consent forms (when applicable) via IRB's electronic submission system. The reviewer will receive modifications to previously approved research and all submitted materials, which includes the revised protocol and investigator's brochure, amendment form with supporting documentation of the changes, and consent form (when applicable).

Criteria used for the approval of research include:

1. Risks to subjects are minimized: (i) By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.
2. Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility. Informed consent will be sought from each prospective subject, unless a waiver is appropriate or the research falls under emergency research provisions or life threatening situations.
3. Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted and should be particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.
4. Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by [§46.116](#), unless a waiver is appropriate or the research falls under emergency research provisions or life threatening situations.

5. Informed consent will be appropriately documented in accordance with, and to the extent required by [§46.117](#).
6. Where appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects. Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
7. When some or all of the subjects, such as children, pregnant women, handicapped or mentally disabled persons, or economically or educationally disadvantaged persons, are likely to be vulnerable to coercion or undue influence, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

IRB Member Conflicts of Interest

The Conflict of Interest in Research Policy applies to IRB members, as well as any reviewer of a research protocol, and any outside consultants. It is contingent upon IRB members to disclose any conflict of interest, as defined in the Conflict of Interest in Research Policy. At the start of each convened meeting, the IRB Program Coordinator or IRB Chair will verbally ask members if the disclosure status has changed since the previous convened meeting. When an IRB member is an investigator on a research study being considered, that member may not participate in the initial or continuing reviews of any study, in review of unanticipated problems involving risks to participants or others, or in the review of non-compliance with regulations or laws of the requirements of the IRB (either in full board meetings or in the expedited review process) associated with a study, except to provide information requested by the IRB. All members will disclose conflicts of interest that are not apparent on a disclosure form. Members with a financial disclosure status change will fill out a new disclosure form noting disclosure changes. Members are not present during IRB deliberations, voting, and are not counted towards quorum on protocols in which they have a conflict of interest. Outside consultants will be notified in the written correspondence requesting their opinion that any potential conflict of interest as defined in the Conflict of Interest in Research Policy must be divulged prior to their acceptance of the invitation. A copy of the policy will be sent with the correspondence. If a significant conflict of interest is identified, an alternate consultant will be obtained.

If the Chair has a conflict of interest, the Vice Chair will assume the responsibilities of signing off on submissions. If both the Chair and the Vice Chair have a conflict of interest, the Program Coordinator will assign a primary reviewer to assume responsibilities of signing off on submissions.

Minutes of IRB Meetings

The minutes of the IRB meetings are recorded by the IRB Program Coordinator and are reviewed and signed by the Chair of the IRB. Minutes of the meetings are sent electronically in PDF format to all members of the IRB for review and voting at the following meeting. The minutes are filed in the office of the IRB, and will provide the following information:

1. Date and time the meeting was called to order
2. Members present and absent
3. Identification of members present via telephone, and a statement justifying the members' ability to vote (a statement such as the member has received and reviewed the agenda)
4. Identification of non-scientific members
5. When an alternate member replaces a primary member.
6. Guest Observers, if applicable
7. When members arrive after the meeting was called to order, or when members leave the meeting, prior to its completion, if applicable
8. Review of minutes of previous meeting
9. The training topic
10. Information regarding audits that were performed, if applicable
11. For non-compliance, a definitive statement describing the determination regarding whether reports were serious or continuing non-compliance
12. Listing of protocols and amendments approved by expedited review since the previous meeting, the minutes will provide the appropriate subparts of the Code of Federal Regulations under which the protocol was approved
13. Protocol-specific findings justifying determinations for:
 - a. waiver or alteration of the consent process
 - b. research involving participants with diminished capacity
14. Information regarding closures of protocols, if applicable
15. For termination of protocols by the IRB, the minutes will provide the details of the discussion, voting, and conflicts of interest.
16. New protocols, amendments and progress reports requiring full IRB review. In the review of research involving children, the additional protections of 45 CFR 46 Subpart D and 21 CFR 50 and 56 Subpart D will be followed. In the review of research involving pregnant women, human fetuses, and neonates, the additional protections of 45 CFR 46 Subpart B will be followed. The determinations of the IRB required by these regulations along with protocol specific information the IRB used to justify the determinations will be documented the minutes and the approval letter.
17. For protocols, renewals and amendments requiring full review, the minutes will provide
 - a) Summary of the discussions and controversial issues
 - b) Documentation of reasons for disapproval and tabling of protocols
 - c.) Documentation of consideration of appropriate subparts of the Code of Federal Regulations
 - d) Documentation of approval of protocols, consent forms, and advertising material
 - e) Documentation of required revisions
 - f) Voting, including number of votes in favor, against, and abstentions (including name(s) of abstaining members)g) Conflicts of interest, including the name(s) of

the member(s) – (Members with conflicts of interest do not count towards quorum and must excuse themselves during discussion and voting. The term “total” in the minutes reflects quorum, therefore the “total” does not include the recused vote. The “total” includes in favor, against, and abstained votes.)

- h) For initial and continuing review, the approval period.
- 18. Follow-up actions or votes on protocols that IRB members have expressed serious concerns.
- 19. Documentation of the basis for requiring changes to protocols.
- 20. For protocols involving the use of a test device or article, the minutes will provide the rationale for significant risk/non-significant risk device determinations.
- 21. For protocols submitted with a Department of Health and Human Services (HHS) approved sample consent document, the meeting minutes will provide the justification of any deletion or substantive modification of information concerning risks or alternative procedures contained in the document.

To the extent allowable by applicable laws and regulations, all IRB files and documentation will be considered privileged information, and every effort will be made to maintain confidentiality and non-disclosure of this information.

Documentation and Retention of IRB Records

All correspondence and documents received by the IRB office are date stamped upon receipt. All submission components, including, but not limited to protocols, data collection, surveys, questionnaires, consent forms, other forms requiring IRB approval, and letters with the approval signature of the IRB Chair are sent to the Investigator. IRB maintains records of all correspondence and forms sent to the Investigator. The effective date and the expiration date, if applicable, are clearly noted on all documents.

Prior to the implementation the electronic submission system, all IRB records are retained for at least 3 years after the completion of the research conducted at a Trinity Health Of New England site. IRB records for protocols that have been 1) withdrawn prior to the release of approved materials, or 2) cancelled without subject enrollment are retained for at least 3 years after withdrawal/cancellation. These records are maintained and stored locked file cabinets in the IRB office, currently in the Education and Research Building, 3rd floor, on the campus of Saint Francis Hospital and Medical Center (260 Ashley Street) following which they are stored at an offsite location. Following the implementation of the electronic IRB submission system, all submission components are kept indefinitely. Retention of records as per IRB policy, Section IX follows the retention policy of the Trinity Health Of New England.

Protocols that are approved through the expedited or full board review mechanism are assigned and given an IRB number. Each study contains information relating to:

1. Initial application and all associated documents and materials that may include the protocol, informed consent form, investigator brochure(s), questionnaires, advertisements, grant information, sponsor/investigator contracts/agreements, IND or IDE information, and pertinent correspondence. Copies of approval letters from the IRB and all collaborating IRBs are kept with the initial application.
2. Protocol and consent form revisions, amendments, continuing review and progress reports, and continuing investigator-sponsor-IRB correspondence, safety reports and adverse event reports will also be maintained.

IRB records for initial research by the expedited procedure include:

- The justification for using the expedited procedure.
- Actions taken by the reviewer.
- Any findings required by laws, regulations, codes, and guidance to be documented.

The IRB's electronic submission system maintains information in order of receipt by the IRB Office from newest to oldest to allow a reconstruction of a complete history of all IRB actions related to the review and approval of the protocol, the IRB maintains records of, but not limited to:

- Scientific evaluations, when provided by an entity other than the IRB.
- Unanticipated problems involving risks to participants or others.
- Documentation of non-compliance.
- Significant new findings.

Protocols meeting criteria for exempt review and approval are maintained by year in chronological order of approval. The following information is filed with each exempt protocol: initial application and supporting documentation, any investigator-IRB correspondence, and determination letter with review category.

All IRB records are accessible for inspection and copying by authorized representatives of federal agencies or departments at reasonable time and in a reasonable manner.

Retention of Investigator Records

The HHS regulations require institutions to retain records of IRB activities and certain other records frequently held by investigators for at least 3 years after completion of the research (45 CFR 46.115(b)). In addition, other regulations may apply and require retention of these records for a longer period of time. Documentation of the informed consent of the subjects must be retained for at least 3 years after completion of the research, unless the IRB waived the requirement for informed consent or the requirement for documentation of informed consent. Such records may be preserved in hardcopy, electronic or other medical form and must be accessible for inspection and copying by authorized representative of HHS at reasonable times and in a reasonable manner. If investigators who have been designated to retain records on behalf of the institution leave Trinity Health Of New England, the investigators and the IRB should identify the successor responsible for maintaining those institutional records, either at the original institution or wherever the records are relocated, for the period of time required under HHS regulation. Other regulations or policies may apply to the retention of records, including study data.

SECTION X. REVIEW OF RESEARCH INVOLVING VULNERABLE POPULATIONS

When some or all of the participants of a research protocol 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 must be included in the study to protect the rights and welfare of these participants. In the review of research involving children, the additional protections of 45 CFR 46 Subpart D and 21 CFR 50 and 56 Subpart D will be followed. In the review of research involving pregnant women, human fetuses, and neonates, the additional protections of 45 CFR 46 Subpart B will be followed. The determinations of the IRB required by these regulations along with protocol specific information the IRB used to justify the determinations will be documented in the minutes and the approval letter. When evaluating protocols to determine whether there is a need for additional protections for participants, some of the factors that the IRB considers include the equitable selection of subjects, the inclusion/exclusion criteria, and the fair distribution of risks and benefits.

Additional Protections for Research Involving Pregnant Women, Fetuses or Neonates

The IRB will abide by provisions stipulated under **45 CFR 46.201 to 46.207 (Subpart B)** and the guidelines and directives of the Catholic Church in research involving pregnant women, fetuses or neonates. For the purposes of this policy, the definition of pregnancy encompasses the period of time from the implantation until delivery. Research protocols involving pregnant women, fetuses or neonates as subjects will be reviewed by the IRB using the “IRB Member Review Checklist for Vulnerable Subjects”.

45CFR46.201 - To what do these regulations apply?

- (a) Except as provided in paragraph (b) of this section, this subpart applies to all research involving pregnant women, human fetuses, neonates of uncertain viability, or nonviable neonates conducted at Trinity Health Of New England whether or not it is supported by the HHS.
- (b) The exemptions at Sec. 46.101(b)(1) through (6) are applicable to this subpart.
- (c) The provisions of Sec. 46.101(c) through (i) are applicable to this subpart. Reference to State or local laws in this subpart and in Sec. 46.101(f) is intended to include the laws of federally recognized American Indian and Alaska Native Tribal Governments.
- (d) The requirements of this subpart are in addition to those imposed under the other subparts of this part.

45CFR46.202 - Definitions

The definitions in Sec. 46.102 shall be applicable to this subpart as well. In addition, as used in this subpart:

- (a) Dead fetus means a fetus that exhibits neither heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord.
- (b) Delivery means complete separation of the fetus from the woman by expulsion or extraction or any other means.
- (c) Fetus means the product of conception from implantation until delivery.
- (d) Neonate means a newborn.
- (e) Nonviable neonate means a neonate after delivery that, although living, is not viable.

(f) Pregnancy encompasses the period of time from conception until delivery. A woman shall be assumed to be pregnant if she exhibits any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.

(g) Secretary of HHS and any other officer or employee of the HHS Services to whom authority has been delegated.

(h) Viable, as it pertains to the neonate, means being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration. The Secretary may from time to time, taking into account medical advances, publish in the Federal Register guidelines to assist in determining whether a neonate is viable for purposes of this subpart. If a neonate is viable then it may be included in research only to the extent permitted and in accordance with the requirements of subparts A and D of this part.

45CFR46.203 - Duties of IRBs in connection with research involving pregnant women, fetuses, and neonates

In addition to other responsibilities assigned to IRBs under this part, each IRB shall review research covered by this subpart and approve only research which satisfies the conditions of all applicable sections of this subpart and the other subparts of this part.

45CFR46.204 - Research Involving Pregnant Women or Fetuses

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

(a) Where scientifically appropriate, preclinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;

(b) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;

(c) Any risk is the least possible for achieving the objectives of the research;

(d) If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, her consent is obtained in accord with the informed consent provisions of subpart A of this part;

(e) If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the informed consent provisions of subpart A of this part, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.

(f) Each individual providing consent under paragraph (d) or (e) of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;

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

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

(i) Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and

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

(k) All activities will be in accordance with Catholic Church directives.

45CFR46.205 - Research Involving Neonates

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

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

(b) Neonates of uncertain viability. Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research unless the following additional conditions have been met:

- (1) The IRB determines that:
 - (i) The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective, or
 - (ii) The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and
- (2) The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accord with subpart A (45CFR46.101 to 46.124) of this part, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

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

- (1) Vital functions of the neonate will not be artificially maintained;
- (2) The research will not terminate the heartbeat or respiration of the neonate;
- (3) There will be no added risk to the neonate resulting from the research;
- (4) The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- (5) The legally effective informed consent of both parents of the neonate is obtained in accord with subpart A of this part, except that the waiver and alteration provisions of Sec. 46.116(c) and (d) do not apply. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements of this paragraph, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice to meet the requirements of this paragraph.

(d) Viable neonates. A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of subparts A (45CFR46.101 to 46.124) and D (45CFR46.401 to 46.409) of this part.

45CFR46.206 - Research Involving, After Delivery, The Placenta, The Dead Fetus or Fetal Material

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

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

45CFR46.207 - Research Not Otherwise Approvable Which Presents An Opportunity To Understand, Prevent, or Alleviate a Serious Problem Affecting the Health or Welfare of Pregnant Women, Fetuses, or Neonates

Research that the IRB does not believe meets the requirements of Sec. 46.204 or Sec. 46.205 will be considered only if:

(a) The IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates; and

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

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

(2) The following:

(i) The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates;

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

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

(d) The research is in accordance with Catholic Church directives.

Additional Protections for Children Involved as Subjects in Research

The IRB will abide by provisions stipulated under **45CFR46.401 to 46.409 (Subpart D)** for clinical investigations involving children. Research protocols involving children as subjects will be reviewed by the IRB using the “IRB Member Review Checklist for Vulnerable Subjects”

45CFR46.401 - To what do these regulations apply?

(a) This subpart applies to all research involving children as subjects conducted at Saint Francis Hospital and Medical Center, whether or not it is supported by the Department of Health and Human Services.

(1) This includes research conducted by Department employees, except that each head of an Operating Division of the Department may adopt such non substantive, procedural modifications as may be appropriate from an administrative standpoint.

(2) It also includes research conducted or supported by the Department of Health and Human Services outside the United States, but in appropriate circumstances, the Secretary may, under paragraph (e) of [§46.101](#) of Subpart A, waive the applicability of some or all of the requirements of these regulations for research of this type.

(b) Exemptions at [§46.101\(b\)\(1\)](#) and (b)(3) through (b)(6) are applicable to this subpart. The exemption at [§46.101\(b\)\(2\)](#) regarding educational tests is also applicable to this subpart. However, the exemption at [§46.101\(b\)\(2\)](#) for research involving survey or interview procedures or observations of public behavior does not apply to research covered by this subpart, except for research involving observation of public behavior when the investigator(s) do not participate in the activities being observed.

(c) The exceptions, additions, and provisions for waiver as they appear in paragraphs (c) through (i) of [§46.101](#) of [Subpart A](#) are applicable to this subpart.

45CFR46.402 - Definitions

The definitions in [§46.102](#) of Subpart A shall be applicable to this subpart as well. In addition, as used in this subpart:

(a) "Children" are persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted. In the state of Connecticut, a child is a person under the age of 18. Under Connecticut law, any minor who has reached his or her sixteenth (16) birthday and is residing within the state may qualify, after a Probate Court petition, as a legally emancipated minor. The court order of emancipation gives the minor the legal status of an adult. A minor may also be considered emancipated under common law in the following circumstances:

1. The minor has been validly married at any time.
2. The minor is on active duty with the Armed Forces of the United States.
3. The minor lives willingly separate and apart from his or her parents or guardian.
4. The minor manages his or her own financial affairs, regardless of the source of any lawful income.

Please see attached Institutional "Consents Policy". Any minor who has given birth to a child may give consent for the child.

(b) "Assent" means a child's affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.

(c) "Permission" means the agreement of parent(s) or guardian to the participation of their child or ward in research.

(d) "Parent" means a child's biological or adoptive parent.

(e) "Guardian" means an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care. In the state of Connecticut, a court appointed guardian or court appointed conservator may act as a patient representative for a child.

45CFR46.403 - IRB duties

In addition to other responsibilities assigned to IRBs under this part, each IRB shall review research covered by this subpart and approve only research which satisfies the conditions of all applicable sections of this subpart.

45CFR46.404 - Research not involving greater than minimal risk

DHHS will conduct or fund research in which the IRB finds that no greater than minimal risk to children is presented, only if the IRB finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in [§46.408](#).

45CFR46.405 - Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects

DHHS will conduct or fund research in which the IRB finds that more than minimal risk to children is presented by an intervention or procedure that holds out the prospect of direct benefit for the individual subject, or by a monitoring procedure that is likely to contribute to the subject's well-being, only if the IRB finds that:

- (a) the risk is justified by the anticipated benefit to the subjects;
- (b) the relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and
- (c) adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in [§46.408](#).

45CFR46.406 - Research Involving Greater Than Minimal Risk and No Prospect of Direct Benefit to Individual Subjects, but Likely to Yield Generalizable Knowledge About the Subjects' Disorder or Condition

The IRB will find and document that:

- (a) The risk represents a minor increase over minimal risk;
- (b) The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social or educational situations;
- (c) The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition that is of vital importance for the understanding or amelioration of the subjects' disorder or condition; and
- (d) Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians.

45CFR46.407 - Research Not Otherwise Approvable Which Presents an Opportunity to Understand, Prevent or Alleviate a Serious Problem Affecting the Health or Welfare of Children

If the IRB does not believe a study meets the requirements of 46.404, 45.405, or 46.406, such studies will be considered only if:

- (a) the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children; and
- (b) the Secretary of DHHS or the Commissioner of Food and Drugs, after consultation with a panel of experts in pertinent disciplines (for example: science, medicine, education, ethics, law) and following opportunity for public review and comment, has determined either:

(1) that the research in fact satisfies the conditions of [§46.404](#), [§46.405](#), or [§46.406](#), as applicable, or (2) the following:

- (i) the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;
- (ii) the research will be conducted in accordance with sound ethical principles;
- (iii) adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians, as set forth in [§46.408](#).

45CFR46.408 - Requirements For Permission By Parents or Guardians and For Assent By Children

- (a) In addition to the determinations required under other applicable sections of this subpart, the IRB shall determine that adequate provisions are made for soliciting the assent of the children, when in the judgment of the IRB the children are capable of providing assent. In determining whether children are capable of assenting, the IRB shall take into account the ages, maturity, and psychological state of the children involved. This judgment may be made for all children to be involved in research under a particular protocol, or for each child, as the IRB deems appropriate. If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research. Even where the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances in which consent may be waived in accord with [§46.116](#) of [Subpart A](#).
- (b) In addition to the determinations required under other applicable sections of this subpart, the IRB shall determine, in accordance with and to the extent that consent is required by [§46.116](#) of [Subpart A](#), that adequate provisions are made for soliciting the permission of each child's parents or guardian. Where parental permission is to be obtained, the IRB may find that the permission of one parent is sufficient for research to be conducted under [§46.404](#) or [§46.405](#). Where research is covered by [§46.406](#) and [§46.407](#) and permission is to be obtained from parents, both parents must give their permission unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child.
- (c) In addition to the provisions for waiver contained in [§46.116](#) of [Subpart A](#), if the IRB determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children), it may waive the consent requirements in Subpart A of this part and paragraph (b) of this section, provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further that the waiver is not inconsistent with Federal, State, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.
- (d) Permission by parents or guardians shall be documented in accordance with and to the extent required by [§46.117](#) of [Subpart A](#).
- (e) When the IRB determines that assent is required, it shall also determine whether and how assent must be documented.

45CFR46.409 - Wards

- (a) Children who are wards of the State or any other agency, institution, or entity can be included in research approved under [§46.406](#) or [§46.407](#) only if such research is:
 - (1) related to their status as wards; or
 - (2) conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.
- (b) If the research is approved under paragraph (a) of this section, the IRB shall require appointment of an advocate for each child who is a ward, in addition to any other individual acting

on behalf of the child as guardian or in loco parentis. One individual may serve as advocate for more than one child. The advocate shall be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization.

Prisoners

The Trinity Health Of New England IRB does not review studies enrolling prisoners. Retrospective non-federally funded/supported studies aimed at involving a broader subject population that only incidentally includes prisoners may qualify for exemptions. However, if an enrolled subject may become a prisoner during the course of a study. In this circumstance, the investigator must notify the IRB immediately, and all research interactions and interventions with the now-incarcerated subject will cease, unless it is in the best interest of the subject to remain in the research study, as determined by the IRB Chairperson. Following this determination, the IRB will notify the OHRP and ensure compliance with all OHRP requirements as specified in 45 CFR 46, Subpart C. The continued participation, or withdrawal, of the incarcerated subject then will be reviewed by a central IRB, which includes a prisoner representative. Research that involves prisoners is not exempt from federal guidelines.

Cognitively Impaired Subjects in Research

It is the policy of the IRB not to allow any form of interventional research in subjects unable to consent themselves unless it meets requirements stipulated under conditions of medical emergencies. Patients whose decision-making capacity may be in question, and whose current and prospective ability to understand and consent to research is uncertain, may not be enrolled as research subjects in this Institution.

Unconscious patients or those unable to consent due to the influence of drugs or intoxicants, mental illness, or other temporary impairment of reasoning capability, may be enrolled in research that is non-interventional and involves no more than minimal risk to the subjects, as determined by the IRB Chair (for protocols eligible for expedited review) or by the full IRB (for protocols reviewed by the full board) at the time of initial review and approval of a protocol. Research protocols will be reviewed by the IRB using the IRB member review criteria and review of vulnerable subject checklists.

In such cases, the investigator may obtain permission to enroll the subject from a legally authorized representative. A legally authorized representative is an individual or other body authorized under applicable law who can consent on behalf of an individual and may be any of the following, in order of preference:

- a legal guardian or court appointed conservator of person; or if none,
- an individual in possession of a patient appointed health care power of attorney; or,
- the patient's next of kin.

Subsequent to regaining their mental capabilities, enrolled subjects will be consented for the research to continue.

The IRB must determine that adequate provisions are made for soliciting the assent of the cognitively impaired subject, when the IRB determines the subject is capable of providing assent. In determining whether the subject is capable of assenting, the IRB takes into account the

age, psychological, and physiological state of the individual involved. This judgment may be made for all subjects to be involved in research under a particular protocol, or for each subject, as the IRB deems appropriate. Even where the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances in which consent may be waived in accordance with the requirements for waiver of consent. The IRB will document assent determinations and requirements in the meeting minutes and study approval letter.

SECTION XI. PRIVACY AND CONFIDENTIALITY IN RESEARCH

HIPAA Compliance

Privacy is the right of persons not to share information about themselves. Confidentiality is the obligation to keep private information that has been collected from being shared with others. It is the obligation of this Institution and all Investigators, Study Coordinators and employees involved in medical research to respect the rights of human research subjects by protecting their privacy and confidentiality before, during and after their participation in research. Trinity Health Of New England conforms to the Health Insurance Portability and Accountability Act (HIPAA), and all federal, state and local laws regarding patient privacy and confidentiality.

The IRB serves as the Privacy Board and ensures compliance with HIPAA regulations as they apply to Research. Consequently, the IRB ensures the privacy of the Protected Health Information (PHI) that is created, accessed or shared in the course of Research activity. PHI is individually identifiable information transmitted or maintained in any form (electronic means, on paper, or through oral communication) that relates to the past, present, or future physical or mental health or conditions that can reasonably be used to identify an individual. The use and disclosure of PHI requires review and approval by the IRB (Privacy Board). "Use" of PHI is the sharing of PHI within the institution (i.e., from nurse to doctor). "Disclosure" of PHI is the sharing of PHI outside of the institution (i.e., from principal investigator to study sponsor).

The "Notice of Privacy Practices" is a written document, that is available to all patients and research subjects entering Trinity Health Of New England sites, describing the Institutional policy on how medical information is used and disclosed and how patients can access their records. Research subjects will provide "authorization" for the use and disclosure of PHI, unless the investigator requests a waiver of authorization to the IRB. In this form, the subjects will have information on how to access the notice before signing the authorization.

Categories of Health Information

The HIPAA regulations categorize information in the following way:

1. Identifiable information (PHI, to which HIPAA applies)
2. De-identified information (to which HIPAA does not apply)
3. Limited Data Set (a middle option, to which limited parts of HIPAA apply)

(1) Identifiable Information and HIPAA Authorization

Investigators will incorporate a HIPAA authorization into the Consent Form.

Waiver or Alteration of and Individual Authorization for Disclosure of Protected Health Information:

The THOfNE IRB may approve a consent procedure (**45CFR46.116**) which does not include, or which alters, some or all of the elements of informed consent or waive the requirements to obtain informed consent.

Waiver of consent is permitted provided that the research is no more than minimal risk and meets specific criteria. This is most frequently granted for retrospective research but is also possible for some types of prospective research.

Alteration of consent is appropriate if one or more of the required elements is not relevant to the research activity.

Investigators are required to meet specific requirements and to submit a Request for Waiver or Alteration of and Individual Authorization for Disclosure of Protected Health Information with the IRB application. This is reviewed and approved by the IRB Chair and or the Board members.

Criteria for approval of a Waiver or Alteration of and Individual Authorization for Disclosure of Protected Health Information are:

1. Disclosure involves no more than minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
 - a) an adequate plan to protect patient identifiers from improper use and disclosure
 - b) an adequate plan to destroy patient identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law
 - c) adequate written assurances that protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, and restricts most disclosures of information to the minimum intended purpose
2. Research could not be conducted without the waiver or alteration of consent
3. The waiver or alteration will not adversely affect the rights and welfare of the subjects; and
4. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.
5. 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;

(2) De-Identified Information

For record review studies, it may be required that the PHI being requested be de-identified prior to its release. The 18 criteria for de-identification of PHI are:

1. Names
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes (initial 3 digits of zip code may be retained)
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death
4. Telephone 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/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal 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
18. Any other unique identifying number, characteristic, or code

De-identified information is not considered PHI and is therefore exempt from HIPAA regulations.

De-identified and limited data set information are used primarily for research involving the review of records.

(3) Limited Data Sets

A limited data set allows for the retention of specific types of dates, geographic information, and other unique codes or characteristics that are not expressly excluded. The investigator must submit a "Data Use Agreement" to the IRB to be permitted access and use of this level of information. A limited data set is PHI that **excludes** the following 16 direct identifiers of the individual, or of relatives, employers, or household members of the individual:

1. Names
2. Postal address information, other than town or city, state, and zip code
3. Telephone numbers
4. Fax numbers
5. Electronic mail addresses
6. Social Security numbers
7. Medical record numbers
8. Health plan beneficiary numbers

9. Account numbers
10. Certificate/license numbers
11. Vehicle identifiers and serial numbers, including license plate numbers
12. Device identifiers and serial numbers
13. Web Universal Resource Locators (URLs)
14. Internet Protocol (IP) address numbers
15. Biometric identifiers, including finger and voice prints
16. Full face photographic images and any comparable images

A limited data set allows for the retention of:

- Dates (e.g., date of birth, admission and discharge dates)
- Some geographic information (city, state and zip code but not street address)
 - Other unique codes or characteristics that are not expressly excluded (see above)

Preparatory to Research

For activities involved in preparing for research, the IRB will obtain from the researcher a Data Collection for Reviews Preparatory to Research Agreement indicating that 1) the use or disclosure is sought solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research, 2) that no PHI will be removed from the Institution in the course of the review, and 3) that the PHI for which use or access is sought is necessary for the research purposes.

Decedent's Information

To obtain medical information from deceased patients, investigators are required to complete an IRB application within the IRB Electronic Submission System. This application should indicate that the use or disclosure sought is solely for research on the PHI of decedents; that at the request of the institution, documentation of the death of such individuals will be provided; and that the PHI for which use or disclosure is sought is necessary for research purposes.

Tissue Banking

When tissue samples from research subjects are provided to entities outside Trinity Health Of New England for future research, the IRB requires that:

1. A review at a convened meeting will be conducted prior to the release of tissue samples to other investigators for future research
2. The specific groups or agencies that may have access to the tissue samples for future research be disclosed
3. The participant specifically consents to the future use of tissue samples and is offered the opportunity to decline to this use. Whenever possible, the enrolled subject is offered a mechanism to withdraw consent for future use of the tissue sample.
4. Tissue banking is not conducted for financial gain or commercial purposes.

It is recommended, but not required, that studies with a tissue banking component where tissues are being released to entities outside of Trinity Health Of New England sites, that the agency or cooperative responsible for receiving and maintaining the tissue have a Certificate of Confidentiality. The purpose of this measure is to ensure the highest level of confidentiality in the handling of individually identifiable health information of research subjects at this institution.

The following are the requirements for obtaining a Certificate of Confidentiality:

- Written materials specify that research is automatically covered by a Certificate of Confidentiality whenever the study is funded in whole or in part by the NIH and involves identifiable, sensitive information.
- Written materials define “identifiable sensitive information.”
- Written materials include examples of research automatically covered by a certificate of confidentiality:
 - Biomedical, behavioral, clinical or other research, including exempt research, except where the information obtained is recorded in such a manner that human participants cannot be identified or the identity of the human participants cannot readily be ascertained, directly or through identifiers linked to the participants.
 - The collection or use of biospecimens that are identifiable to an individual or for which there is at least a very small risk that some combination of the biospecimen, a request for the biospecimen, and other available data sources could be used to deduce the identity of an individual.
 - The generation of individual level, human genomic data from biospecimens, or the use of such data, regardless of whether the data is recorded in such a manner that human participants can be identified, or the identity of the human participants can readily be ascertained.
 - Any other research that involves information about an individual for which there is at least a very small risk, as determined by current scientific practices or statistical methods, that some combination of the information, a request for the information, and other available data sources could be used to deduce the identity of an individual.
- Researchers may also apply for a Certificate of Confidentiality for non-federally funded research.
- Written materials specify that when research is covered by a certificate of confidentiality, researchers:
 - May not disclose or provide, in any federal, state, or local civil, criminal, administrative, legislative, or other proceeding, the name of such individual or any such information, document, or biospecimen that contains identifiable, sensitive information about the individual and that was created or compiled for purposes of the research, unless such disclosure or use is made with the consent of the individual to whom the information, document, or biospecimen pertains; or
 - May not disclose or provide to any other person not connected with the research the name of such an individual or any information, document, or biospecimen that contains identifiable, sensitive information about such an individual and that was created or compiled for purposes of the research.
 - May disclose information only when:

- Required by federal, state, or local laws (e.g., as required by the Federal Food, Drug, and Cosmetic Act, or state laws requiring the reporting of communicable diseases to state and local health departments), excluding instances of disclosure in any federal, state, or local civil, criminal, administrative, legislative, or other proceeding.
- Necessary for the medical treatment of the individual to whom the information, document, or biospecimen pertains and made with the consent of such individual.
- Made with the consent of the individual to whom the information, document, or biospecimen pertains; or
- Made for the purposes of other scientific research that is in compliance with applicable federal regulations governing the protection of human participants in research.
- Written materials require that when research is covered by a certificate of confidentiality, researchers must inform participants (for example, in the consent document) of the protections and limitations of certificates of confidentiality:
 - For studies that were previously issued a Certificate, and participants were notified of the protections provided by that Certificate, NIH does not expect participants to be notified that the protections afforded by the Certificate have changed, although IRBs may determine whether it is appropriate to inform participants.
 - If part of the study cohort was recruited prior to issuance of the Certificate, but are no longer actively participating in the study, NIH does not expect participants consented prior to the change in authority, or prior to the issuance of a Certificate, to be notified that the protections afforded by the Certificate have changed, or that participants who were previously consented to be re-contacted to be informed of the Certificate, although IRBs may determine whether it is appropriate to inform participants.
- Written materials require that researchers conducting NIH- supported research covered by a certificate of confidentiality must ensure that if identifiable, sensitive information is provided to other researchers or organizations, regardless of whether or not the research is federally funded, the other researcher or organization must comply with applicable requirements when research is covered by a certificate of confidentiality.
- Researchers conducting research covered by a certificate of confidentiality, even if the research is not federally funded, must ensure that if identifiable, sensitive information is provided to other researchers or organizations, the other researcher or organization must comply with applicable requirements when research is covered by a certificate of confidentiality.

Storage and Access of Research Data

All new protocols must have a plan for the secure storage of research data, including procedures to protect against or minimize potential risks and to assure privacy and confidentiality. Research data are the property of Trinity Health Of New England and may not be removed from hospital premises unless permission has specifically been granted by the Institution. If a study is sponsored by a pharmaceutical company or a cooperative research group, the investigator and this Institution have been contracted to provide research data to that entity. Therefore, the data is owned by the contracting company or agency, as stipulated in the research agreement.

The IRB reviews all new applications for proposed methods of recruitment, justification for the access, use and disclosure of PHI, potential risks to subjects, the plan to protect patient identifiers from improper use and disclosure, plan to destroy identifiers at the earliest opportunity, justification for retaining the identifiers, and the plan to protect or destroy audio or videotapes or research data at the conclusion of the research project.

Research Data Retention

The IRB follows the FDA's policy of data retention regarding the withdrawal of subjects from a clinical investigation, whether the subject elects to discontinue further interventions or the clinical investigator terminates the subject's participation in further interventions.

When a subject withdraws from a study, the data collected on the subject to the point of withdrawal remains part of the study database and may not be removed. The IRB does not allow consent documents to give the subject the option of having data removed.

An investigator may ask a subject who is withdrawing whether the subject wishes to provide continue follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the subject would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through noninvasive chart review and address the maintenance of privacy and confidentiality of the subject's information.

If a subject withdraws from the interventional portion of the study but agrees to continued follow-up of associated clinical outcome information as described above, the investigator must obtain the subject's consent for this limited participation in the study (assuming such a situation was not described in the original informed consent form). IRB approval of consent documents would be required (21 CFR 50.25, 56.109(b), 312.60, 312.66, 812.100).

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

SECTION XII. CONTINUING REVIEW and STUDY CLOSURE

Continuing Review Requirements

There is no provision for any grace period extending the conduct of research beyond the expiration date of IRB approval. The expiration date is the same expiration date of the initial approval. All continuing reviews should be submitted to the IRB at least six weeks prior to the expiration date. If the investigator fails to provide continuing review information to the IRB, or the IRB has not reviewed and approved a research study by the continuing review date specified by the IRB, the research must stop, unless the IRB finds that it is in the best interest of individual subjects to continue participating in the research interventions or interactions. Enrollment of new subjects cannot occur after the expiration of IRB approval. When continuing review of a research protocol does not occur prior to the end of the approval period specified by the IRB, the approval expires automatically. Such expiration of IRB approval will not be reported to the OHRP.

Some minimal risk studies will not require a continuing review, however the IRB will determine such applicable studies and inform the Principal Investigator:

1. IRB approval letters and consent forms (when applicable) will document that the study qualifies for extended approval by the IRB and therefore will not expire in the future

2. Extended approval will still require modifications and amendments, if any, to be submitted for IRB approval prior to implementing any changes; events that meet prompt reporting criteria must be reported to the IRB within five (5) business days.

3. Extended approval will not be considered for studies that involve:
 - Federal Funding
 - FDA regulated components or FDA oversight
 - Medical experimentation
 - Prisoners
 - Stem Cell or protocols involving genetic testing
 - Other IRB issues

Research may be approved as exempt if it is no more than minimal risk and fits one of the exempt review categories as defined by federal regulation 45 CFR 46. Studies that may qualify for exempt status will complete an application to the IRB submission system for review. All supporting documents must be submitted with the application i.e., Protocol, Waiver of Informed Consent and Data Collection. Exempt reviews are reviewed and approved by either the IRB Chair and/or IRB Program Coordinator and are reviewed at a fully convened IRB meeting and recorded in minutes of meeting

For protocols granted a one year approval:

When the IRB grants approval for one year at the time, the IRB performs continuing review and reapproves (with or without conditions) the research within 30 days *before* the IRB approval period expires, the IRB may maintain the anniversary of the expiration date of the initial IRB approval as the expiration date of each subsequent one-year approval period. The same guidelines apply when the IRB reviews and approves research under expedited review procedures in accordance with 21 CFR 56.110.

1. If the IRB reviews and approves a protocol without any conditions at a convened meeting, continuing review will occur within 1 year of the date of the meeting;
2. When the IRB reviews a protocol at a convened meeting and approves the protocol contingent on specific minor conditions, the effective date of the initial approval is the date on which the IRB chair or his/her designee can verify fulfillment of those conditions. In such circumstances, the expiration date of the initial approval period is the date by which the *first* continuing review must occur (21 CFR 56.115 (a)).
3. If the IRB reviews a study at a convened meeting and has serious concerns or lacks significant information that requires IRB review of the study at subsequent convened meetings, continuing review will occur within 1 year of the date of the convened meeting at which the final review occurred and approval was granted.

The same conditions apply for protocols approved for a period of less than one year, however the abbreviated approval period applies to all stated timeframes.

The IRB will use the review criteria checklist for all continuing reviews

45CFR46.111

The IRB will follow expedited review applicability criteria and use the appropriate research categories when conducting continuing review of previously approved research. Please refer to the policy entitled “The Review Process”, for a complete list of the applicability criteria and research categories. The **expedited review** procedure will be used for the continuing review of previously approved research for:

1. Research previously approved by expedited review when no significant changes have occurred in the protocol
2. Research previously approved at a convened IRB meeting when:
 - a) the research is permanently closed to the enrollment of new subjects and all subjects have completed all research-related interventions, and the research remains active only for long-term follow-up of subjects or
 - b) no subjects have been enrolled at this site and no additional risks have been identified at any site where the protocol is conducted or
 - c) the remaining activities are limited to data analysis
 - d) research is not conducted under an investigational new drug application or investigational device exemption where the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

All submitted materials are preliminarily reviewed by the IRB Program Coordinator to ensure completeness. The IRB Chair or member conducting continuing review will have access to all submitted materials including the original abstract, the most recently approved protocol, and any protocol modifications previously approved by the IRB, which is provided by the IRB office and is sent with the agenda. For expedited review, investigators are required to provide the following: Protocol Progress Report/ Continuing Review Request Form, Abstract/Summary form a current consent form/HIPAA Authorization, if applicable, and all materials requiring continuing review, as applicable, such as questionnaires and surveys.

Full board review will be used for continuing review of other studies. All submitted materials are preliminarily reviewed by the IRB Program Coordinator to ensure completeness. All submitted materials are reviewed by IRB members when conducting continuing review, including the original abstract, and any protocol modifications previously approved by the IRB, which is provided by the IRB office and is sent with the agenda. Investigators are required to submit:

1. Protocol Progress Report/Request for Continuing Review and any attachments included as part of the report
2. current consent form / HIPAA Authorization
3. an Abstract/Summary form which includes a recent literature search (conducted within 30 days of submitting Progress Report) and its impact on the study

Progress Reports and Abstract/Summary Forms

Investigators are required to provide a progress report and, if continuing review is desired, a formal continuing review. The progress report is due in six weeks prior to the expiration date. Requests for renewal for sponsored pharmaceutical/device research protocols must be submitted six (6) weeks prior to the anniversary date with completed Financial Disclosure Forms. Investigators are required to provide a progress report whether patients were entered in the study or not. Investigators should also provide an abstract/summary form. In order to provide the IRB with sufficient information to determine whether the research protocol continues to fulfill the criteria for approval, the following information must be included on the Continuing Review Request and Abstract/Summary forms:

- An abstract or summary of the protocol from the original application.
- A progress report summarizing activities and events of the past period of approval which includes:
 1. Have the inclusion/exclusion criteria changed during the last year?
 2. Have there been any subject complaints during the last year?
 3. Has the risk/benefit assessment changed over the past year?
 4. Summary of adverse events that occurred at this site during the last year.
 5. Summary of adverse events that occurred at multi-center sites during the last year.
 6. Summary of any unanticipated problems involving risk to participants or others during the last year at this site.
 7. Summary of benefits to subjects participating in this protocol.
 8. Summary of interim findings/discoveries affecting the trial since the last IRB review. Please include a copy of interim analysis report, if available.
 9. Summary of amendments and modifications since the last IRB review, and relevant reports, including results obtained from multi-center sites.
 10. A statement from the Data Safety and Monitoring Board or Officer, if available.
 11. Summary of activity of this protocol for the last year at this site.

Research Financial Disclosure Forms will be updated at the time of renewal of protocols for all Investigators, or if there is a new reportable Significant Financial Interest obtained by an Investigator. New reportable financial disclosures will require Investigators to fully disclose the financial interest and Investigators indicating a disclosure of more than \$5,000 will be referred to the Financial Conflict of Interest in Research (FCOIR) Committee for review. Funded research protocols with a management plan will be reviewed annually by the (FCOIR) Committee to determine if the management plan needs to be revised. All questions on all forms must be answered in full. Incomplete forms will be returned to investigators. Failure to provide progress reports results in expiration of the protocol. Investigators will be notified by the IRB in writing that all research activities must stop, including (but not limited to) new enrollment, screening, study visits, medical record review, data analysis, presentations, and publications. The letter will also indicate that the Investigators have 30 days to submit the material, or the study would be closed. In order to continue the research after the closure, Investigators will have to submit an initial application and go through the review process.

The IRB Program Coordinator will randomly audit Investigators following closures of protocols to ensure that research activities stopped when IRB approval expired. In instances of a closure of a protocol when an Investigator leaves the Institution and does not officially close a protocol/arrange for transition to another appropriate trained Investigator within the Institution, a follow up audit will be conducted when feasible. If the IRB (or chair) finds that there is an overriding safety concern or ethical issues making it in the best interest of the participant to continue in the study, the IRB may permit research activities to continue for the brief time required to complete the continuing review process. Failure to provide progress reports may also result in loss of the privilege to use IRB services in the future.

STUDY CLOSURE

A research study can only be completed when identifiable private information is no longer required for research purposes. This includes activities such as data analysis, manuscript revision based on editorial feedback, preparation for publication/presentations, and internal and external audits. It is essential to note that the study cannot be closed if any action involving human subjects, or their data access is still pending. Adhering to this practice is critical for ensuring the confidentiality and privacy of research participants and complying with ethical and legal standards governing research studies.

SECTION XIII. PROTOCOL AMENDMENTS

Investigators are required to submit to the IRB all changes prior to their implementation by submitting a Protocol Amendment Form and when indicated, an amended consent form. Investigators are required to submit electronically in IRB's electronic submission system:

1. Protocol Amendment Form - track changed version and a clean version
2. Consent Form, if amended – track changed version and a clean version
3. Amended document - track changed version and a clean version changes
4. New proposed document
5. Supporting documentation which includes summary of changes (such as revised protocol and investigator's brochure)

Protocol Amendments are reviewed in the same manner as initial reviews, and the determination of eligibility for expedited and full board review apply. If the revision is not applicable for expedited review, it will be reviewed by the Full Board. Minor changes are reviewed and approved by expedited review by the Chair of the IRB or a designated primary reviewer. Examples of minor changes that are eligible for expedited approval include, but are not limited to:

1. Administrative or informational changes
2. Additions or deletions of investigators or study coordinators
3. Corrections of grammatical or typographical errors
4. Changes leading to clarification of a protocol
5. Minimum changes in numbers of prior, approved enrolled participants
6. Changes recommended by members of the Institutional Review Board at an adjourned meeting during which the Chair or the IRB has been designated to approve the changes by the expedited mechanism
7. Changes secondary to drug dispensation, software upgrades
8. Changes in the consent form to incorporate language recommended by the IRB
9. Revisions that include changes to the protocol that may impact research participants, but that do not affect the risks to participants
10. Advertisements for recruiting study subjects

When advertisements are taped broadcasts or videos, the IRB reviews the final audio and/or video tape and requests a copy of the final transcript. If the advertisement will include a live interview or question/answer session, the IRB requests an outline of topics to be discussed prior to the broadcast and a tape or transcript of the session following the broadcast.

Significant changes in a protocol that involve increased risk to participants undergo full IRB review and voting at a convened meeting. Enrollment may continue and the currently

approved protocol must be followed until notification by the IRB that the changes have been approved. Any changes that incorporate unanticipated added risks due to adverse events, including but not limited to informed consent documents, will be reviewed by the full board. Investigators must not use informed consent forms that do not include all known risks and side effects. Therefore, new enrollment must be suspended pending full IRB review of additional risk and approval of revised consent documents. In cases where enrollment has been suspended pending IRB review and the timing of entry of a subject into a protocol is an issue, an emergency meeting of the IRB will be called.

IRB approval is required prior to implementation of any change. However, investigators are permitted to take measures in order to eliminate apparent immediate hazards to the subjects without prior IRB approval. The investigator must report the incident to the IRB within 5 working days.

SECTION XIV SPONSORS: RESPONSIBILITIES AND OBLIGATIONS

Responsibilities and Obligations

The Institution does not allow any research involving human research participants to take place without the approval of the IRB, and as such, it is the policy of the Institution to apply all federal, state, and local laws during the review of *all* research protocols, whether or not they are funded by federal monies. All Investigators who apply for research approval assume the Investigator's Responsibility for ensuring that all safety provisions and other measures of protection will be enacted. These protections would be in place, regardless of a written agreement with the sponsor. The IRB approval is the assurance that procedures will be used to protect research participants.

Sponsor means a person or other entity that initiates a clinical investigation, but that does not actually conduct the investigation, i.e., the test article is administered or dispensed to, or used involving, a subject under the immediate direction of another individual. A person other than an individual (e.g., a corporation or agency) that uses one or more of its own employees to conduct an investigation that it has initiated is considered to be a sponsor (not a sponsor-investigator), and the employees are considered to be investigators.

Sponsor-investigator means an individual who both initiates and actually conducts, alone or with others, a clinical investigation, i.e., under whose immediate direction the test article is administered or dispensed to, or used involving, a subject. The term does not include any person other than an individual, e.g., it does not include a corporation or agency. The obligations of a sponsor-investigator include both those of a sponsor and those of an investigator.

Sponsors are responsible for selecting qualified investigators who have appropriate training and experience to investigate the scientific question, provide them with the information they need to conduct an investigation properly, ensure proper monitoring of the investigation(s), ensure that the investigation(s) is conducted in accordance with the general investigational plan and protocols, and ensuring that FDA and all participating investigators are promptly informed of significant new adverse effects or risks with respect to the test article. If a protocol is being conducted under an IND or IDE, the sponsor shall maintain an effective IND or IDE with respect to the investigations filed with the FDA.

Sponsor-Investigators

Sponsor-investigators are responsible for meeting all applicable sponsor and investigator responsibilities under FDA regulations 21 CFR 312.50-312.70, 812.1-812.19, and 21 CFR Parts 50 and 56, and all applicable DHHS regulations. A sponsor-investigator is responsible for ensuring that the test article is manufactured in compliance with the FDA's good manufacturing practices (GMPs) (21 CFR Parts 210, 211, 600, 610, and 820).

To ensure that a sponsor-investigator understands their responsibilities, the IRB Chair or IRB Program Coordinator will meet with the P.I. to discuss the applicable regulations. Investigator-initiated studies involving the use of an investigational drug or device will be audited by the IRB as necessary to monitor for compliance and safety. The Legal Services department, or authorized individual, is responsible for the review and approval of contracts between the sponsor-investigator and manufacturer of a device or drug.

For studies that involve the use of an investigational drug or device, two forms must be completed and submitted to the FDA before a study may begin: Form FDA 1571 and Form FDA 1572. For studies that involve investigational devices, an "Investigator's Agreement for Investigations with Significant Risk Devices" also must be signed and submitted by each investigator. A copy of each of these forms, when applicable, must be submitted with the IRB application.

FDA reporting requirements for sponsor-investigators includes Annual Reports, Adverse Experience Reports, and other safety report requirements. For studies involving investigational drugs, annual reports to the FDA are due each year within 60 days of the anniversary date that an IND went into effect. Adverse event reporting involves three steps: reviewing, reporting, and follow-up of adverse drug or device effects. For IND safety reporting requirements, see 21 CFR 312.32. For adverse device effect reporting requirements, see 21 CFR 812 subparts C (Responsibilities of Sponsors) and E (Responsibilities of Investigators) studies require continuing review by the IRB annually, or at shorter intervals as determined by the IRB.

Contract Information and Review

A written contract or budgetary agreement should be in place prior to submitting to the IRB, specifying the nature of the research services to be provided and the basis for payment for those services. Contracts or agreements outlining financial arrangements between the sponsor and the investigator or Institution must be submitted to the Department of Legal Services and to the Office of Grants and Contracts to review and approve contracts and agreements prior to the sponsored protocol submission to the IRB. The consent document should also be provided at the time of contract submission or as soon as possible to ensure consistency regarding payment for subject injury and medical care provisions. The IRB will receive and review the approved contract or agreement at time of protocol submission to ensure that arrangements are clear in the consent document, contract or other agreement. Changes to financial arrangements between the sponsor and the investigator or Institution must be reported to the Department of Legal Services or to the Office of Grants and Contracts and the IRB prior to their implementation.

The Department of Legal Services and Office of Grants and Contracts will ensure that payment to clinical investigators or this Institution by research sponsors will be reasonable and

based on work performed by the investigator and the investigator's staff, not on any other considerations. Any financial compensation received from trial sponsors must be commensurate with the efforts of the physician performing the research. Financial compensation should be at fair market value and the rate of compensation per patient should not vary according to the volume of subjects enrolled by the physician. When enrollment is particularly challenging, reasonable additional payments may be made to compensate the investigator or Institution for time and effort spent on extra recruiting efforts to enroll appropriate research participants. It is unethical for physicians to accept payment solely for referring patients to research studies. Therefore, payments to investigators and research staff in exchange for referrals of potential subjects (i.e., "finder fees") and payments designed to accelerate recruitment that are tied to the rate or timing of enrollment (i.e. "bonus payments") are prohibited. Payments or compensation of any sort should not be tied to the outcome of the trial. The nature and source of funding and financial incentives offered to investigators must be disclosed to potential participants as part of the informed consent process.

In addition, contracts and agreements will be reviewed for the following:

1. Sponsor payment, compensation, or reimbursement schedules for Investigators and/or the Institution.
2. Indication of who (e.g., the sponsor or Institution) will provide additional care for research-related injuries, and who will be responsible for the payment of this additional care.
3. The sponsor's obligation to promptly report to the investigator and Institution any significant new adverse effects, risks, or other findings related to the research study that could possibly affect the safety of subjects, affect the willingness of subjects to continue with participation, influence the conduct of the study, and/or alter the IRB's approval to continue the study.
4. Indication of how interim or final study results will be communicated to the subjects when the information could possibly affect their safety, medical care, and willingness to continue with participation. This includes results from other studies using the same intervention for a similar or other indication.
5. Contract provisions for medical care for research-related injuries are consistent with the consent document.

Community Based Research:

Trinity Health Of New England promotes community-based research and inclusion of under-represented populations in research:

- Research staff includes a bilingual study coordinator to oversee development of recruitment strategies and proactive enrollment of minorities in research. This work includes an ongoing study with Native Spanish speakers to develop a patient-centered tool to facilitate communication between providers and patients with serious illness. Through focus group discussions, participants from the community have used their experiences and cultural knowledge to provide feedback on content, format and cultural congruence.
- In partnership with the ministry's Center for Health Equity, the THONE IRB and research staff have developed a process to expedite translation of approved research documents. The process

leverages ministry language services resources and ensures immediate IRB review of certified translations. Moving forward, research training and education for investigators, study staff, and certified interpreters will be included. The Center for Health Equity also provides access to potential research participants through partnerships with the community and community organizations. On conjunction with organizational priorities around equity, the IRB is assisting the research development office develop a process to track enrollment of underrepresented groups in research. Per recent NIH guidelines, tracking will include all gender categories and older age.

- Initiatives such as evaluation of the New England 61 Day Challenge provide additional opportunities to engage the community and facilitate community research. The Challenge is a large health promotion program involving the New England service area. Each year, the organizers select a theme and pose a challenge to improve health behavior. More than 1,000 individuals participate annually. The IRB assisted investigators to determine the most appropriate way to distribute pre- and post-Challenge surveys, obtain consent, and protect the privacy and confidentiality of research data. In addition to targeted health outcomes, the survey includes open-ended questions about participant experience and feedback on program components. Moving forward, this work will include interviews and focus groups with participants and community stakeholders. Because this work was in the planning phase just prior to the COVID-19 outbreak, the IRB will help the researchers explore alternative methods of recruitment and data collection.
- All IRB members are educated in community-based research. The IRB has two community members that specifically focuses on the community's needs.
- The Community Health Needs Assessment is conducted annually. All THONE employees and the local community has access to the Community Health Needs Assessment.
- The Community Health Needs Assessment report is located <https://www.trinityhealthofne.org/about-us/community-benefit/community-health-needs-assessments>

**SECTION XV.
INVESTIGATIONAL NEW DRUGS AND DEVICES**

Investigational New Drugs (IND)

Investigations undertaken to develop safety and effectiveness data for investigational new drugs will be conducted according to the requirements of the investigational new drug application (IND) regulations of FDA (21 CFR Part 312). An IND is required when the investigational new drug is not approved for use by the FDA, or the drug is being tested for a new indication. If a research study will utilize an investigational new drug, the sponsor must provide the Principal Investigator with proof of an IND approval and must be included in the initial application to the IRB. The sponsor confirms that the IND or IDE number is valid. The investigator must provide verification of the IND or IDE to the IRB in terms of one of the following: commercial or sponsored protocol with the IND number, communication from the commercial sponsor, communication from the FDA. The investigator brochure is not to be used to determine validity of an IND. The IRB does not accept an investigational drug protocol without a valid IND. Therefore, recruiting, obtaining consent, and screening participants for a specific study that is subject to the IND cannot begin until the IRB receives the IND and approval by the IRB is granted. The IND goes into effect 30 days after the FDA receives the IND, unless the sponsor receives earlier notice from the FDA. If a research study does not require the use of an IND, the sponsor must provide the Principal Investigator with proof that the protocol met one of the FDA exemptions from the requirements to have an IND. This information must be included in the initial application to the IRB.

Storage, Handling and Dispensing of Investigational Drugs, Agents or Biologics in Research

The Department of Pharmacy is responsible for the storage, handling and dispensing of investigational drugs (see Policy for Investigational Drugs). When a protocol involving an investigational drug, agent or biologic has been approved by the IRB, the IRB Program Coordinator notifies the Research Pharmacist by sending a copy of the approval letter. It is the Investigators responsibility to provide the Pharmacy Department with a copy of the protocol and all subsequent protocol amendments, new protocol versions and new Investigator Brochures.

Investigational New Drug Exemptions

1. The clinical investigation of a drug product that is lawfully marketed in the United States is exempt from the requirements of 21 CFR 312 if all 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 changes 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 is conducted in compliance with the requirements for institutional review set forth in part 56 and with the requirements for informed consent set forth in part 50; and
 - (v) The investigation is conducted in compliance with the requirements of § 312.7.
2. (i) A clinical investigation involving an in vitro diagnostic biological product listed in paragraph (b)(2)(ii) of this section is exempt from the requirements of this part if (a) it is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure and (b) it is shipped in compliance with 312.160.
(ii) In accordance with paragraph (b)(2)(i) of this section, the following products are exempt from the requirements of this part: (a) blood grouping serum; (b) reagent red blood cells; and (c) anti-human globulin.
 3. A drug intended solely for tests in vitro or in laboratory research animals is exempt from the requirements of this part if shipped in accordance with 312.160.
 4. FDA will not accept an application for an investigation that is exempt under the provisions of paragraph (b)(1) of this section.
 5. A clinical investigation involving use of a placebo is exempt from the requirements of this part if the investigation does not otherwise require submission of an IND.
 6. A clinical investigation involving an exception from informed consent under 21 CFR 50.24 of this chapter is not exempt from the requirements of this part.

Investigational Device Exemption (IDE)

Any device found to pose a significant risk of harm by the sponsor, by any reviewing IRB, or by the FDA must have an Investigational Device Exemption. Investigations undertaken to develop safety and effectiveness data for medical devices will be conducted according to the requirements of the IDE regulations of the FDA (21 CFR Part 812.2(b)), and the following should be included:

- The device fulfills the requirements for an abbreviated IDE.
- The device is not a banned device.
- The sponsor labels the device in accordance with 21 CFR 812.5.
- The sponsor obtains IRB approval of the investigation after presenting the reviewing IRB with a brief explanation of why the device is not a significant risk device and maintains such approval.

- The sponsor ensures that each investigator participating in an investigation of the device obtains from each subject under the investigator's care, consent under 21 CFR 50 and documents it, unless documentation is waived.
- The sponsor complies with the requirements of 21 CFR 812.46 with respect to monitoring investigations;
- The sponsor maintains the records required under 21 CFR 812.140(b) (4) and (5) and makes the reports required under 21 CFR 812.150(b) (1) through (3) and (5) through (10);
- The sponsor ensures that participating investigators maintain the records required by 21 CFR 812.140(a)(3)(i) and make the reports required under 812.150(a) (1), (2), (5), and (7); and
- The sponsor complies with the prohibitions in 21 CFR 812.7 against promotion and other practices.

All new applications that have an IDE will be reviewed by the full board. If a research study will utilize an investigational device, the sponsor must provide the Principal Investigators with proof of an IDE application, which must be included in the initial application to the IRB. If a research study will utilize a device without an IDE, the sponsor must provide the Principal Investigators with proof that the device fulfilled the requirements for an abbreviated IDE or met one of the exemption categories this information must be included with the initial application to the IRB.

Exemption from an IDE

A device may also be exempt from the IDE requirements, and studies of devices that are IDE-exempt may be eligible for expedited review. To qualify for an exemption from an IDE, investigations must meet the criteria as stated in 21 CFR 812.2, paragraph C.

Determinations of Significant or Non-Significant Risk Device

When a sponsor or investigator claims that an investigational device is a non-significant risk (NSR), the IRB will ask the sponsor or investigator to provide the IRB with a description of the device, reports of prior investigations with the device, the proposed investigational plan, a description of patient selection criteria and monitoring procedures, whether other IRBs have reviewed the proposed study and what determination was made, the FDA assessment of the risk of the device, if such an assessment has been made, as well as any other information requested by the IRB. In the case of review by an expedited procedure, the IRB Chair will make the determination of whether a device is significant risk (SR) or NSR. Otherwise, the convened IRB will make the determination.

The IRB considers a device to be SR if it (1) Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject; (2) Is purported or represented to be for a use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject; (3) Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or (4) Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject. Otherwise, the IRB considers the device to be NSR.

If the IRB decides the study is NSR, the study is reviewed and, if approved, the sponsor and investigator will be asked to comply with “abbreviated IDE requirements”, informed consent, and IRB regulations. If the IRB disagrees with the sponsor’s assessment, the IRB will notify the sponsor of its decision in writing. The sponsor must notify the FDA that a SR determination has been made. The IRB will review the study after FDA approval of the IDE application.

In the case of review by an expedited procedure, the reviewer will document the SR/NSR determination in the protocol file. In the case of review by a convened IRB, the SR/NSR determination will be documented in the minutes. In both cases the SR/NSR determination will be noted in the letter to the investigator.

Humanitarian Use Devices

A Humanitarian Use Device (HUD) is a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects or is manifested in fewer than 4,000 individuals in the United States per year. The HUD provision of the regulation provides an incentive for the development of devices for use in the treatment or diagnosis of diseases affecting these populations.

To obtain approval for a HUD, a humanitarian device exemption (HDE) application is submitted to FDA. A HDE is similar in both form and content to a premarket approval (PMA) application but is exempt from the effectiveness requirements of a PMA. A HDE application is not required to contain the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose. The application, however, must contain sufficient information for FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury, and that the probable benefit to health outweighs the risk of injury or illness from its use, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. Additionally, the applicant must demonstrate that no comparable devices are available to treat or diagnose the disease or condition, and that they could not otherwise bring the device to market.

An approved HDE authorizes marketing of the HUD. However, a HUD may only be used in facilities that have established a local institutional review board (IRB) to supervise clinical testing of devices and after an IRB has approved the use of the device to treat or diagnose the specific disease. The labeling for an HUD must state that the device is a humanitarian use device and that, although the device is authorized by Federal Law, the effectiveness of the device for the specific indication has not been demonstrated. An approved HDE application is valid for as long as the use of the device continues to meet the conditions of the HDE application.

Use of a HUD is the only situation where federal regulations require the IRB to approve and monitor an activity that is not research. The IRB follows full board review procedures when reviewing requests to use a HUD. Submission requirements are the same as for full board review; however, the following conditions also apply:

1. A letter or document from the device sponsor must be submitted that documents the following 10 items:
 - a. the generic and trade name of the device

- b. the FDA HDE number (a six-digit number preceded by the letter H)
 - c. the date of HUD designation
 - d. indications for use of the device
 - e. a description of the device
 - f. contraindications, warnings, and precautions for use of the device
 - g. adverse effects of the device on health
 - h. alternative practices and procedures
 - i. marketing history
 - j. summary of studies using the device
2. The IRB has the discretion to determine the conditions of HUD use and whether to approve each individual use of the device. The IRB may approve the use of the device in general, or in a specific number of patients or only under specific conditions.
 3. The IRB will conduct both initial and continuing review of a HUD. Continuing review will be annually, unless otherwise specified by the IRB at the time of initial review.
 4. A letter stating that the HUD is not being used as part of a research project or clinical investigation designed to collect data to support an FDA premarket approval application must be submitted with the initial application. If the HUD is being used in a research project or clinical investigation, the IRB complies with all FDA regulations related to IRB review of research.
 5. Regulations do not require informed consent to use an HUD outside the research setting. This IRB may require that informed consent be obtained in situations that it deems appropriate. This determination will be made by the full board at the time of review.

Storage, Handling and Dispensing of Investigational Devices in Research

The Principal Investigator is responsible for the storage, handling and dispensing of investigational devices in research. IRB applications involving investigational devices must list the method for storage and inventory control to prevent the unauthorized use of the device. The monitoring plan for control of investigational devices is handled on a case-by-case basis by the IRB. Following approval of a study involving investigational devices, the IRB Program Coordinator will monitor the storage of devices for compliance and safety at intervals determined by the IRB at the time of initial review.

Expanded Access

Whenever possible, use of an approved drug, biologic, or medical device as part of a clinical trial is preferable; however, under certain circumstances physicians can use unapproved drugs, biologics, and medical devices outside of clinical trials, including emergency use of drugs, biologics, and devices. Expanded access mechanism allows access to an investigational device or drug for patients who do not meet the requirements for inclusion in a clinical trial but for whom the treating physician believes the device or drug may provide a benefit in treating and/or diagnosing their serious (albeit not life-threatening) disease or condition. This is not the same as “off-label use” of an approved drug, device, or biologics. The IRB follows full board review procedures when reviewing requests for expanded access use.

General criteria:

- The patient and a licensed physician are both willing to participate;
- The patient’s physician determines that there is no comparable or satisfactory therapy available to diagnose, monitor, or treat the patient’s disease or condition;

- That the probable risk to the person from the investigational product is not greater than the probable risk from the disease or condition;
- FDA determines that there is sufficient evidence of the safety and effectiveness of the investigational product to support its use in the particular circumstance;
- FDA determines that providing the investigational product will not interfere with the initiation, conduct, or completion of clinical investigations to support marketing approval;
- The sponsor (generally the company developing the investigational product for commercial use) or the clinical investigator (or the patient’s physician in the case of a single patient expanded access request) submits a clinical protocol (a document that describes the treatment plan for the patient) that is consistent with FDA’s statute and applicable regulations for INDs or investigational device exemption applications (IDEs), describing the use of the investigational product; and
- The patient is unable to obtain the investigational drug under another IND or to participate in a clinical trial.
- Emergency use of a device 21 CFR 56.104(c) – 21 CFR 50.23 – 21 CFR 812.35(a)(2) – 21 CFR 812.150(a)(4)
- Compassionate use of a device (21 CFR 812.35(a))

Emergency Use of Drugs and Devices

“Emergency use” means the use of an unapproved drug, biologic, or device in a life-threatening situation, or the compassionate use of an unapproved device that does not have an IDE, and in which there is not sufficient time to convene a full board IRB meeting with quorum for approval. Whenever possible the researchers must notify the IRB prior to the proposed emergency use. When emergency medical care is initiated, the patient may not be considered a research participant under 45 CFR 46. The IRB does not currently review protocols involving the pre-planned use of a test article in an emergency situation. In cases of medical emergencies, physicians will follow federal regulations for Emergency Use of Drugs and Devices (21 CFR 56.102(d) and 21 CFR 56.104(c)).

Human subject research activities subject to 45 CFR 46 may not be started, even in an emergency, without prior IRB review and approval; therefore, emergency use of a test article cannot be claimed as research, and data generated during the use of the test article cannot be reported as being obtained through a prospectively conceived research activity.

In cases of medical emergencies, physicians will follow federal regulations for Emergency Use of Drugs and Devices (21 CFR 56.102(d) and 21 CFR 56.104(c)). The emergency use provision in 21 CFR 56.104(c) is an exemption from prior review and approval by the IRB. The exemption, which may not be used unless all of the conditions described in 21 CFR 56.102(d) exist, allows for one emergency use of a test article without prospective IRB review.

Each of the following conditions must exist to justify emergency use of a drug or biologic:

- In order to use a test article in a life-threatening situation without prior IRB review:

- The participant is confronted with a disease or condition that is either life threatening or severely debilitating;
- No generally acceptable alternative treatment is available.
- There is not sufficient time to obtain IRB approval;
- The treating physician will document in the medical record that the above findings are met;
- The treating physician will report the emergency use to the IRB within five working days that the above conditions are met;
- Any subsequent use of the test article is subject to IRB review;
- The FDA has issued an IND;
- The use is not subject to DHHS regulations;
- Consent will be obtained in accordance with FDA regulations, or the circumstances meet the exception to the requirement for consent in FDA regulations. *Or all of the following are true:*

Informed consent is not required because all the following are true:

- Immediate use of the test article is, in the investigator's opinion, required to preserve the life of the participant;
- Time is not sufficient to obtain the independent determination a physician who is not otherwise participating in the clinical investigation; and
- Before the use of the test article the investigator will certify in writing all of the following:
 - The participant is confronted by a life-threatening situation necessitating the use of the test article, and immediate use of the test article is necessary;
 - Informed consent cannot be obtained from the participant because of an inability to communicate with, or obtain legally effective consent from, the participant;
 - Time is not sufficient to obtain consent from the participant's legal representative;
 - There is available no alternative method of approved or generally recognized therapy that provides an equal or greater likelihood of saving the life of the participant; and
 - The treating physician will report the emergency use to the IRB within five working days that the above conditions are met.

Unlike in the case of unapproved drugs and biologics, FDA does not consider the emergency use of an unapproved device to be clinical investigation and FDA does not require compliance with 21 CFR §50 and 21 CFR §56.

Emergency use of medical devices – the researcher and IRB must determine:

Emergency use of an unapproved device:

- There is a life-threatening disease or serious condition requiring immediate use;
- No generally acceptable alternative for treating, diagnosing, or monitoring the patient is available;
- There is no time to follow existing procedures to obtain an IDE;

- There is no IDE, or the treating physician wants to use the device in a way not approved under an existing IDE;
- The treating physician is not part of the IDE study;
- The probable risk to the patient is not greater than the probable risk from the disease;
- The treating physician has substantial reason to believe that benefits will exist;
- All institutional clearances as required by institutional policy are obtained;
- There is concurrence from the IRB chairperson;
- There is authorization from the sponsor if an IDE exists;
- A physician uninvolved with the emergency use of the device will certify in the medical record that the above findings are met.
- If there is no time to find an uninvolved physician, the physician makes and documents the above determinations in the medical record, and has the evaluation reviewed by an uninvolved physician, and the treating physician's and uninvolved physician's concurrence are reported to the IRB within 5 working days after the use.
 - Informed consent was sought from the patient or patient's legally authorized representative (does not have to follow informed consent requirements at 21 CFR 50.25)
- If no informed consent can be obtained, the treating physician, and a physician who is not participating in the clinical investigation must certify:
 - A life-threatening situation necessitating use of the device exists
 - There is no alternative therapy
 - After the use:
- If an IDE exists, the researcher must notify the sponsor; the sponsor must report to the FDA
- If an IDE does not exist, notify the FDA of the emergency use and provide FDA a written summary of the emergency use, patient protection measures, and any scientific results
 - After the use, the treating physician must report to the IRB within five days

Compassionate use of a device:

- Compassionate use is not a clinical investigation
- Prior FDA concurrence is required before compassionate use occurs
- The treating physician certifies:
 - There is a life-threatening disease or serious condition requiring immediate use
 - There are no alternatives
 - If there is an existing study, but the patient does not meet inclusion criteria for the existing study
 - The probable risk to the patient is not greater than the probable risk from the disease
- The treating physician requests authorization from the sponsor; the sponsor may agree or disagree; if the sponsor disagrees, the treating physician is not allowed to use the device; if the sponsor agrees with the use, the sponsor submits an IDE supplement requesting approval for a protocol deviation
- The treating physician should create a schedule for patient monitoring, address specific needs of the patient, and detect possible problems

- All institutional clearances must be obtained as required by institutional policy are obtained
- There is concurrence from the IRB chairperson
- The treating physician will obtain consent from the patient
- The treating physician will report any problems to the IRB and the sponsor
- The treating physician will write a summary of the use and provide to the sponsor
- The IRB must review IRB chair's documented concurrence; confirm FDA concurrence, review the consent document, receive reports after the use, receive reports of problems

For any emergency use - If a similar need is likely, the researcher must submit an IRB application within 30 days and obtain an IND or IDE.

SECTION XVI. COMMUNITY-BASED PARTICIPATORY RESEARCH

Community-based participatory research (CBPR) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each may bring. CBPR is best characterized as doing research “with” the community, not “to” the community. A fundamental concept is that the research must benefit the community and not just the researchers. CBPR requires that adequate time be taken to involve the community and to ensure community participation in all aspects of the project.

The process typically (but not always) starts with a topic of importance to the community and has the aim of combining knowledge with action with the intention of instituting change to improve community well-being. CBPR has emerged as an alternative research model which integrates education and social action to improve communities and enhance the scientific base of knowledge. It is most often associated with improving community health outcomes through transfer of evidence-based research from clinical settings to communities that can most benefit.

CBPR requires that the researcher follow the best practices for respectful and productive relationships. The following principles are in addition to those required for all human subject research:

1. Be certain that the research topic addresses a community-defined need, question or problem.
2. Recognize research as a partnership (i.e., engagement of research projects is to be led by a team of academic and community Co-Investigators as partners).
3. Respect the community partner’s interest in the research.
4. Be open to the guidance of community insights and experiences.
5. Maintain a balance in decision making between the researchers and community participants.
6. Provide continuous feedback to enhance the partnership and its outcomes.
7. Disseminate research findings to community stakeholders and participants.
8. Recognize partnerships can dissolve and a plan for closure should be developed.

Reviewers should ensure that principal investigators have submitted enough information to assess whether the study adequately meets the criteria for approval by using the checklist below:

1. Is there adequate representation of the community?
2. Consider implications for family and community: Is there a need for informed consent for family or community? And is there potential harm at the health or economic level?
3. Are there methods to share data and results with the community before release to media or scientific publication?
4. Do they address issues of prevention as well as treatment?

5. Is there consideration of children’s right to know and to privacy versus parents’ need to know?
6. Did they recognize privacy needs of individuals, families and communities?
7. Did they recognize that too much privacy (lack of transparency or sequestering information) hinders community decision making?
8. Is there support and protection of community interests?

SECTION XVII. GOOD CLINICAL PRACTICE GUIDANCE FOR RESEARCHERS ON CLINICAL TRIALS

Clinical trials should be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki and that are consistent with good clinical practice (GCP) and the applicable regulatory requirements.

When following ICH-GCP (E6), the items below should be reviewed:

- Manufacturing, handling, and storage in accordance with applicable good manufacturing practice.
- Where allowed or required, the investigator may assign some or all duties for investigational articles accountability at the trial sites to an appropriate pharmacist or another appropriate individual who is under the supervision of the investigator.
- The investigator, pharmacist, or other designated individual will maintain records of the product's delivery to the trial site, the inventory at the site, the use by each participant, and the return to the sponsor or alternative disposition of unused products. These records will include dates, quantities, batch/serial numbers, expiration dates (if applicable), and the unique code numbers assigned to the investigational products and trial participants.
- Investigators should maintain records that document adequately that the participants are provided the doses specified by the protocol and reconcile all investigational products received from the sponsor.
- When adults are unable to consent, the IRB determines:
 - A non-therapeutic clinical trial (i.e., a trial in which there is no anticipated direct clinical benefit to the participant) should be conducted in participants who personally give consent and who sign and date the written consent document.
 - Non-therapeutic clinical trials may be conducted in participants with consent of a legally acceptable representative provided the following conditions are fulfilled:
 - The objectives of the clinical trial cannot be met by means of a trial in participants who can give consent personally.
 - The negative impact on the participant’s wellbeing is minimized and low.
 - The opinion of the IRB is expressly sought on the inclusion of such participants, and the written opinion covers this aspect.
 - Such trials, unless an exception is justified, should be conducted in patients having a disease or condition for which the investigational product is intended. Participants in these trials should be particularly closely monitored and should be withdrawn if they appear to be unduly distressed.

- The researcher provides evidence of his or her qualifications through up-to-date curriculum vitae or other relevant documentation requested by the sponsor, the IRB, or the regulatory authority.
- The reviewer is provided and reviews the investigator's current curriculum vitae or other documentation evidencing qualifications.
- The researcher is familiar with the appropriate use of the investigational product, as described in the protocol, in the current investigator brochure, in the product information, and in other information sources provided by the sponsor.
- During and following a participant's participation in a clinical trial, the researcher ensures that adequate medical care is provided to a participant for any adverse events, including clinically significant laboratory values, related to the clinical trial.
- The researcher ensures the accuracy, completeness, legibility, and timeliness of the data reported to the sponsor.
- The researcher must maintain a list of appropriately qualified persons to whom they have delegated significant clinical trial-related duties.
- The researcher reports all serious adverse events (SAEs) to the sponsor except for those SAEs that the protocol or other document (e.g., investigator's brochure) identifies as not needing immediate reporting. The researcher follows regulatory requirements related to the reporting of unexpected serious adverse drug reactions to the regulatory authority and the IRB.
- The researcher provides reports to the sponsor, the IRB, and, where applicable, the organization on any changes significantly affecting the conduct of the clinical trial or increasing the risk to participants.
- If the researcher terminates or suspends a clinical trial without prior agreement of the sponsor, the researcher informs the organization, sponsor, and the IRB.
- If the IRB terminates or suspends approval of the clinical trial, the researcher promptly notifies the sponsor.
- Upon completion of the clinical trial, the researcher informs the organization; the IRB with a summary of the trial's outcome; and the regulatory authority with any reports required.
- During and following a participant's participation in a clinical trial, the researcher ensures that adequate medical care is provided to a participant for any adverse events, including clinically significant laboratory values, related to the clinical trial.
- The researcher follows the clinical trial's randomization procedures, if any, and ensures that the code is broken only in accordance with the protocol. If the clinical trial is blinded, the researcher promptly documents and explains to the Sponsor any premature unblinding.
- A qualified physician (or dentist, when appropriate), who is a researcher or a co-researcher for the clinical trial, is responsible for all clinical trial-related medical (or dental) decisions. Researchers inform participants when medical care is needed for other illnesses of which the researchers become aware.
- The researcher informs the participant's primary physician about the participant's participation in the clinical trial if the participant has a primary physician and if the participant agrees to the primary physician being informed.

- Although a participant is not obliged to give his or her reasons for withdrawing prematurely from a clinical trial, the researcher makes a reasonable effort to ascertain the reason, while fully respecting the participant's rights.
- The researchers and research staff provide all the disclosures and follow the requirements pertaining to consent

When following ICH-GCP (E6), the IRB determines that the following disclosures are included:

 - The alternative procedures or treatment that might be available to the participant, and their important potential benefits and risks.
 - That the monitor, the auditor, the IRB, and the regulatory authority will be granted direct access to the participant's medical records for verification of clinical trial procedures or data, without violating the confidentiality of the participant, to the extent permitted by the applicable laws and regulations and that, by signing a written consent form, the participant or the participant's legally acceptable representative is authorizing such access.
 - The approval of the IRB.
- Documentation of the consent process include:
 - Prior to a participant's participation in the trial, the written consent document should be signed and personally dated by the participant or by the participant's legally acceptable representative.
 - Prior to a participant's participation in the trial, the written consent document should be signed and personally dated by the person who conducted the informed consent discussion.
 - If a participant is unable to read or if a legally acceptable representative is unable to read, an impartial witness should be present during the entire informed consent discussion.
 - After the written consent document and any other written information to be provided to participants, is read and explained to the participant or the participant's legally acceptable representative, and after the participant or the participant's legally acceptable representative has orally consented to the participant's participation in the trial and, if capable of doing so, has signed and personally dated the consent document, the witness should sign and personally date the consent document.
 - By signing the consent document, the witness attests that the information in the consent document and any other written information was accurately explained to, and apparently understood by, the participant or the participant's legally acceptable representative, and that consent was freely given by the participant or the participant's legally acceptable representative.
 - Prior to participation in the trial, the participant or the participant's legally acceptable representative should receive a copy of the signed and dated written consent document and any other written information provided to the participants.

SECTION XVIII. CONFLICTS OF INTEREST IN RESEARCH POLICY

Trinity Health Of New England promotes objectivity in research and has established standards to ensure there is no reasonable expectation that the design, conduct, or reporting of research to be performed will be biased by any conflicting financial interest of an Investigator. Financial interests in human subject's research are distinct from other interests in institutional life, because their existence may entail special risks. Specifically, opportunities to profit from research may affect – or appear to affect – the judgment or decisions of an investigator. At Trinity Health Of New England, all significant financial conflicts of interest in human subjects research are regarded as potentially problematic, and therefore, require close scrutiny. It is the purpose of this policy to set forth the principle for identifying the potential for conflicts and the procedures for reviewing and addressing those potential conflicts that occur. This is done to ensure that the research may be performed in a manner consistent with preserving the safety and welfare of human subjects that participate in such research, as well as ensure the overall integrity of the research. The specific purpose of the policy is:

- To identify actual or potential conflicts of interest in research, and to eliminate, reduce or manage such conflicts;
- To maintain the integrity of research endeavors;
- To ensure compliance with federal and state laws and regulations and institutional policies regarding conflict of interest as it relates to research.

This policy applies to all individuals affiliated with the hospital in some manner who, on behalf of Trinity Health Of New England, are responsible for, or are in the position to influence, the design, conduct, or reporting of the research or other scholarly activity. This includes:

- Full or part-time employees at Trinity Health Of New England
- Members of the Medical/Dental and Nursing Staff at Trinity Health Of New England and components
- Trainees, and medical, nursing, pharmacy and dietary students

Definitions

- **Trinity Health Of New England** means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Johnson Memorial Hospital, Mercy Medical Center, Saint Mary's Hospital and their components where a research study is conducted, whether it is initiated by an investigator or by an outside entity.

- **Investigator** means the principal investigator and any other person who is responsible for the design, conduct, or reporting of a research project. For purposes of this policy, "Investigator" includes the Investigator's family members: spouse, children, and any other person living in the same household.

- **Research** means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge relating broadly to public health, including behavioral and social sciences research. The term encompasses basic and applied research and product development.

- **Significant Financial Interest Related to Research** is defined as a financial interest in the sponsor, product or service being tested, or competitor of the sponsor. This covers anything of monetary value, including, but not limited to, salary or other payments for services (e.g., consulting fees or honoraria); equity interest (e.g., stocks, stock options or other ownership interest); and intellectual property rights (e.g., patents, copyrights and royalties from such rights). For the purposes of this policy, Disclosable Financial Arrangements are:

1. Compensation made to the investigator in which the value of compensation could be affected by study outcome, or compensation of more than \$0 in the past year related to the research from entities other than the sponsor when aggregated for the immediate family.
2. A proprietary interest in the tested product, including but not limited to: a patent, trademark, copyright or licensing agreement.
3. Any equity interest in the sponsor of a covered study, i.e., any ownership interest, stock options, or other financial interest whose value cannot be readily determined through reference to public prices or other measure of fair market value.
4. Any equity interest in a publicly held company that exceeds \$0 in value, or whose value represented 0% or more interest in any one single entity.
5. Significant payments of other sorts, which are payments that have a cumulative monetary value of more than \$0 made by the sponsor of a covered study to the investigator or the investigator's institution to support activities of the investigator exclusive of the costs of conducting the clinical study or other clinical studies (e.g., a grant to fund ongoing research, compensation in the form of equipment or retainers for ongoing consultation or honoraria) during the time the clinical investigator is carrying out the study and for 1 year following completion of the study.
6. Board or executive relationship related to the research, regardless of compensation.

The term does not include:

- Salary, royalties, or other remuneration from - Trinity Health Of New England affiliates;
- Income from seminars, lectures, or teaching engagements sponsored by public or non-profit entities;
- Income from service on advisory committees or review panels for public or non-profit entities;
- An equity interest that when aggregated for the Investigator and the Investigator's family members, meets both of the following tests: Does not have value as determined through reference to public prices or other reasonable measures of fair market value, and does not represent ownership interest in any single entity;
- Salary, royalties or other payments that when aggregated for the Investigator and the Investigator's family members over the next twelve months, are not reasonably expected to exceed \$0.

- **Significant Non-Financial Interest Related to Research** is defined as an interest in the sponsor, product or service being tested, or competitor of the sponsor which excludes financial interest. For the purposes of this policy, Disclosable Non-Financial Arrangements are:
 1. Having a Board or executive relationship related to the research, regardless of compensation.
 2. Have been involved, or plan to become involved in the design, conduct, or reporting of the research.
 3. Having direct supervision of or by the researcher, participation on a research project with the researcher, or other issues that might influence decision-making

Saint Francis Hospital and Medical Center on behalf of Trinity Health Of New England will:

1) Maintain an appropriate written, enforced policy on conflict of interest that complies with state and federal guidelines and regulations, and inform each Investigator of that policy, the Investigator's reporting responsibilities, and of these regulations. If Trinity Health Of New England sites carry out research through subcontractors, or collaborators, Trinity Health Of New England must take reasonable steps to ensure that Investigators working for such entities comply with this policy, either by requiring those Investigators to comply with Trinity Health Of New England's policy or by requiring the entities to provide assurances to Trinity Health Of New England that will enable Trinity Health Of New England to comply with this policy.

2) Require that all financial disclosures be made at the time of application to the IRB of a research project, and on an annual basis thereafter, or as new reportable Significant Financial Interests are obtained.

3) Provide guidelines consistent with this policy for the designated official(s) to identify conflicting interests and take such actions as necessary to ensure that such conflicting interest will be managed, reduced, or eliminated.

Maintain records of all financial disclosures and all actions taken by Trinity Health Of New England with respect to each conflicting interest for three years.

Disclosure Procedures and Review

Research Financial Disclosure Forms will be completed for any study receiving internal or external funding and on file prior to the approval of a research project by the IRB. Forms must be completed by Principal Investigators and all Co-Investigators for each funded research project, annually, or at the time of renewal of a protocol, or if there is a new reportable Significant Financial Interest by the Investigator. Forms must be completed and on file prior to the renewal of a research project. All forms will be submitted to the IRB for review.

All Financial Disclosure Forms are reviewed initially by the office of the IRB. All forms indicating a Significant Financial Interest will require full disclosure of relevant information by the Investigator and filed with the IRB office. All forms indicating a financial interest will be referred to the Financial Conflict of Interest in Research (FCOIR) Committee for review. The FCOIR Committee will establish whether a significant financial conflict exists and review the interest to determine whether or not the conflict may adversely affect the rights or welfare of research subjects or could directly and significantly affect the design, conduct, or reporting of the proposed research. The FCOIR Committee is responsible for determining when such an interest must be managed, reduced or eliminated. If the FCOIR Committee determines that a conflict

exists, it will communicate this determination and the means it has identified for eliminating or managing the conflict, in writing, to the relevant Investigator and to the office of the IRB. Conflict of interest management plans and requests to reduce or eliminate an interest will be referred back to the IRB for review by the fully convened IRB. The determination will be utilized during the research review process by the IRB. The IRB will communicate the conditions for approval of the research protocol to the Investigator. The IRB may refer back the determination to the FCOIR Committee if changes are deemed necessary.

In accordance with Institutional Policies, investigators with a financial interest greater than \$50,000 cannot participate in the research.

At renewal if new financial interests are disclosed, they will be managed following the same procedures outlined for new protocol submissions.

Renewal of research protocols with an active management plan will be reviewed by the fully convened IRB at the time of renewal. Updated forms and a statement of any changes in the financial interest must be completed at the time of renewal of a protocol and submitted to the office of the IRB. If the financial interest has changed, the office of the IRB will refer to the FCOIR Committee to evaluate whether or not the management plan needs to be modified. The determination of the FCOIR Committee will be communicated to the Investigator and office of the IRB. The IRB has the final say with the plan. If the FCOIR Committee does not agree, then the plan gets amended and reevaluated by both the IRB and the FCOIR Committee.

Resolution and Management of Conflicts of Interest

A conflict of interest exists when the FCOIR Committee reasonably determines that a Significant Financial Interest could directly and significantly affect the design, conduct, or reporting of the proposed research. If a conflict of interest has been identified as a result of the procedures as outlined above, the FCOIR Committee will be responsible for taking the appropriate actions(s):

- 1) Determine if there are compelling circumstances which are sufficient to allow the research to proceed in the face of the conflict.
- 2) For projects that are allowed, review of the nature of the conflict at a fully convened IRB meeting, with recommendations made to manage the conflict.
- 3) Determine the appropriate strategies to properly oversee and manage potential conflict(s), taking into consideration the possible remedies as outlined below.
- 4) Inform the investigator of the actions and decisions of the IRB, including restrictions.

Restrictions that might be imposed to manage conflicts of interest include, but are not limited to:

- 1) Public disclosure of significant financial interests;
- 2) Monitoring of the research by independent reviewers;
- 3) Modification of the research plan;
- 4) Disqualification from participation in all or a portion of the research;
- 5) Divestiture of significant financial interests, or;
- 6) Severance of relationships that create actual or potential conflicts.

Sanctions

If the failure of an Investigator to comply with the conflict of interest in research policy of Trinity Health Of New England has biased the design, conduct, or reporting of the research, Trinity Health Of New England will consider the situation, and as necessary, take appropriate action. Sanctions will include, but are not limited to:

- 1) Letter of reprimand
- 2) Notification to funding agencies and/or professional journals or societies
- 3) Termination of research project
- 4) Suspension
- 5) Termination

Any financial benefit to the Investigator must be disclosed in the consent form and during the consent process. The fees and payments that the Investigators and Institution receive are negotiated by the sponsor, the Investigator and the Institution. Sponsors of research are responsible for ensuring that there is an absence of financial interest of investigators who conduct their studies, or to disclose those interests.

SECTION XIX. REVIEW OF EVENTS AND PROBLEMS

This procedure describes the process followed by the IRB to ensure prompt reporting of unanticipated problems, adverse events or protocol deviations involving risks to participants or others to the IRB, institutional officials and regulatory agencies.

Definitions

The following definitions are used in this policy:

Protocol deviation is an incident involving non-compliance with the approved protocol, but typically does not have a significant effect on subjects' rights, safety or welfare, or the integrity of the study.

Related event is an event that in the opinion of the investigator is more likely than not to be caused by or affects the research procedures.

Unanticipated problem involving risks to subjects or others is an event that includes 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; 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.

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

Unexpected adverse event is an adverse event occurring in one or more subjects participating in a research protocol, the nature, severity, or frequency of which is **not** consistent with either:

1. the known or foreseeable risk of adverse events associated with the procedures involved in the research that are described in (a) the protocol-related documents, such as the IRB-approved research protocol, any applicable investigator brochure, and 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.

Serious adverse event is any event that results in death; is life-threatening and places the subject at immediate risk of death from the event as it occurred; results in inpatient hospitalization or prolongation of existing hospitalization; results in a persistent or significant disability or incapacity; results in a congenital anomaly or birth defect; or based upon appropriate medical judgment, may jeopardize the subject's health and may require medical or surgical intervention to prevent one of the other outcomes listed in this definition.

Expected adverse event is an adverse event that does not meet the criteria for an "unexpected event."

Investigator Reporting Requirements

Investigators are required to report to the IRB the following using the **Full Unanticipated Problem and Adverse Event Report Form** when discovered during the course of research and no later than 5 working days after their occurrence:

1. Unexpected AND related adverse events (on-site or off-site)
2. The death of a research subject on site
3. Unanticipated problem that is a serious adverse event (on-site or off-site)
4. Any complaint of a participant that indicates an unanticipated risk or which cannot be resolved by the research staff
5. Any other event or other problems which in the opinion of the principal investigator was (1) previously unforeseen and (2) presents risks to research subjects or others
6. Any event that requires prompt reporting according to the protocol or the sponsor

Investigators are required to report to the IRB significant protocol deviations using the **Protocol Deviation Report Form** when discovered during the course of research and no later than 5 working days after their occurrence. Examples of significant reportable events include, but are not limited to:

1. Protocol deviations which harmed a subject or that may affect the safety of other research participants by placing them at increased risk of harm
2. Protocol deviations that have the potential to recur
3. Any change to the protocol taken by an investigator or member of the research staff without prior IRB review
4. Any publication in the literature, safety monitoring report, interim result, or other finding that indicates an unexpected change to the risks or potential benefits of the research

Events that do not meet the above reporting requirements, but which sponsors request Investigators to report to the IRB, should be logged on a **Tracking Form for Unanticipated Problems and Adverse Events** and submitted to the IRB as soon as possible. Multiple events can be reported on a single form, with the IND or manufacturer's safety report attached. If the investigator answers "yes" to the following questions, a Full Unanticipated Problem and Adverse Event Report Form must be filled out and submitted for that event:

1. Was the event unexpected?

2. Was the event related to the study drug/device or procedure?
3. Did the event that placed the subject or others at greater risk of harm than was previously known or recognized?

IRB Review of Reported Events

The Chair of the IRB or a designated member reviews all reports. If the IRB Chair determines that the event did not represent an unanticipated problem involving risks to participants or others, the Chair signs and dates the report and the report is filed.

If the IRB Chair or designated member determines that an event might represent an unanticipated problem involving risks to participants or others, and related to the investigation, the chair signs and dates the report. The IRB Program Coordinator places the item on the agenda for discussion.

If the IRB determines that an event is an unanticipated problem involving risks to participants or others, the IRB Program Coordinator will follow the procedures outlined in “Reporting of IRB Findings to Federal Agencies.”

If IRB determines that an event is an unanticipated and related problem involving risks to participants or others, it will consider the following actions:

1. No action
2. Modification of the research protocol
3. Modification of the information disclosed during the consent process
4. Additional information provided to past participants
5. Notification of current participants (required when such information may relate to participants’ willingness to continue to take part in the research)
6. Requirement that current participants re-consent to participation
7. Modification of the continuing review schedule
8. Monitoring of the research
9. Monitoring of the consent
10. Suspension or termination of the research
11. Referral to other organizational entities (e.g., legal counsel, risk management, or institutional official)

If the IRB takes any actions or imposes any requirements and/or no action taken, the IRB Program Coordinator will document in the minutes and in a letter to the Investigator.

Reporting Unanticipated and Adverse Events to Federal Agencies

The Chair or the Program Coordinator of the IRB will report to the OHRP, and if applicable, to the FDA, and inform the signatory of the FWA, within 48 hours of any unanticipated problems involving risk to human subjects or others that occur at this site. Please refer to the section entitled “Reporting of IRB Findings to Federal Agencies”.

SECTION XX
COMPLIANCE: RESPONSIBILITIES OF RESEARCHERS

Responsibilities of the Research Investigator

1. Research investigators acknowledge and accept their responsibility for protecting the rights and welfare of human research subjects and for complying with all applicable provisions of this Institution's IRB. The Principal Investigator is responsible for the compliance of all co-investigators, student investigators, and research associates with the IRB decisions, conditions, and requirements.
2. Research investigators are responsible for conducting studies in accordance with the protocol.
3. Research investigators are required to complete periodic training in the protection of human subjects, as required by Federal regulations and IRB policy.
4. Research investigators are responsible for obtaining consent and for providing a copy of the IRB-approved and signed informed consent document to each subject at the time of consent.
5. Research investigators are responsible for ensuring that only authorized research staff will conduct the consent process.
6. Research investigators will promptly report changes in previously approved human subject population or research activities to the IRB. Changes will not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
7. Research investigators are responsible for reporting progress of approved research to the IRB, as often as and in the manner prescribed by the IRB, on the basis of risks to subjects, but not less than once per year.
8. Research investigators are responsible for notifying the IRB of any change in financial relationships of any investigators that may result in a conflict of interest that was previously undisclosed.
9. Research investigators will promptly report to the IRB any injuries or other unanticipated problems involving risks to subjects or others no later than 5 working days after their occurrence.
10. Research investigators are responsible for notifying the IRB and providing a final report when a study is closed.
11. Research investigators are responsible for notifying the IRB of any gaps in investigator involvement in a study.
12. Research investigators are responsible for ensuring, whenever necessary, that the trial is properly registered with clinicaltrials.gov.
13. Research studies have the resources necessary to protect human subject participants.
14. Researchers are qualified to conduct the research.
15. Adequate time is allotted for the researchers to conduct and complete the research. There are also an adequate number of qualified staff and adequate facilities.
16. Researchers have access to populations that will allow recruitment of the necessary participants.

17. The researchers are provided with the availability of medical or psychosocial resources that participants may need as a consequence of the research.
18. Researchers will follow Good Clinical Practice guidelines.
19. Researchers must disclose significant financial interests, including those of the Researcher, and the Researcher's spouse and dependent children.

Responsibilities of the Study Coordinator

To ensure the safety of research participants and compliance with regulations, the IRB requires all interventional protocols to have a Study Coordinator. The Study Coordinators serve as impartial safety monitors. The duties of Study Coordinators are delegated by the Principal Investigator and may include the consenting of research subjects, ensuring the accuracy of the data recorded, acting as a liaison between the study sponsor and the Institution, acting as a liaison between the Principal Investigator and the IRB and other Institutional officials and committees, and general oversight of the conduct of protocols.

Compliance and Audits

As part of providing adequate oversight of studies, the IRB randomly selects protocols and conducts yearly audits to ensure compliance with the protocol, applicable Federal, State, and local regulations, and IRB policies and guidelines. Audits also are conducted when and if the IRB is concerned about the safety of a study or the process for obtaining consent. Audits are conducted by a qualified member of the IRB and/or the IRB Program Coordinator. The results of audits are summarized in a letter to the Principal Investigator, and a report is presented to IRB members at the next convened meeting. Investigators are required to address deficiencies, as requested by the IRB. It is at the discretion of IRB members to estimate the safety of participants in a given study and determine when other sources are necessary for verification of compliance by investigators. Examples of protocols that the IRB will monitor by the audit process for safety and compliance include:

1. Phase I studies
2. Phase II studies
2. Studies carried out by investigators with a record of non-compliance
3. Protocols that carry significant physical or social risks to the participants
4. Studies in which there is concern about possible material changes occurring without IRB approval
5. Studies that have been revised based upon information provided from Institutional employees, subjects enrolled or any other reliable source
6. Studies in which enrolled subjects express concerns to the IRB
7. Investigator-initiated studies that involve the use of an investigational drug or device
8. Studies eligible for full board continuing review with enrolled subjects since last continuing review period.
9. Studies eligible for expedited continuing review, where the protocol remains active with enrolled subjects since last continuing review period.

The IRB will notify Investigators, in writing, of the actions required to correct any deficiencies encountered during a routine or prompted audit, or as the result of a complaint, and a response must be received within 5 working days.

All interventional protocols require a Study Coordinator. To ensure ongoing compliance, the IRB Program Coordinator is in continued contact with Study Coordinators to review the safety of research projects, changes to protocols and monitor research activities.

Non-Compliance and Corrective Action

For the purposes of this policy, the terms used are defined as follows:

Non-compliance is the failure of investigators to comply with Federal regulations, the Policies and Procedures of the IRB, or the determinations or requirements of the IRB. Examples of non-compliance include, but are not limited to: expired CITI training, lack of submitting a study renewal, reporting adverse events or protocol deviations outside the specified timeframe and incorrectly and failure to notify the IRB of any change in financial relationships of any investigators that may result in a conflict of interest that was previously undisclosed.

Serious non-compliance is an action or omission taken by an Investigator that any other reasonable Investigator would have foreseen as compromising the rights and welfare of a research participant. Examples of serious non-compliance include but are not limited to: deliberate failure to follow the protocol as approved by the IRB, failure to report serious or on-going unanticipated problems involving risks to subjects or others, or failure to correct noted deficiencies as required by the IRB.

Continuing non-compliance is a repeated pattern that indicates the inability or unwillingness of an Investigator to comply with Federal regulations, the Policies and Procedures of the IRB, or the determinations or requirements of the IRB.

It is the responsibility of all investigators and study coordinators engaged in research to report incidents or allegations of non-compliance to the IRB. When the IRB receives written or verbal allegations of non-compliance, complaints from research subjects, or finds instances of non-compliance, the IRB administrator and/or Program Coordinator will conduct an audit to establish whether non-compliance has occurred. The Chair of the IRB and the IRB Program Coordinator will review the available information to determine whether there is serious or continuing non-compliance, and whether immediate suspension of participant enrollment is necessary to protect the rights and welfare of the participants.

If suspension is not necessary, and there is a determination that the issue was of a non-serious or non-continuing nature, the IRB Chair, IRB Program Coordinator and the Principal Investigator agree to a plan of action, and a written report is sent to the Principal Investigator and filed with the protocol. In all instances of determinations of serious or continuing non-compliance, the study is suspended, following the IRB policy titled “Suspension and Termination of Protocols”.

If the problem is of a non-serious and non-continuing nature and, in essence, a miscommunication or misunderstanding, a plan for corrective action and its timeframe is agreed upon between the IRB Chair and the program coordinator. The study is allowed to continue, and a follow-up audit conducted to ensure continued compliance.

If the IRB Chair and Program Coordinator determine that an incident indicates serious or continuing non-compliance, they will follow the IRB policy titled “Reporting of the IRB Findings to Federal Agencies” and a report is sent by the IRB Program Coordinator. Enrollment is suspended until IRB requirements have been met, as determined by the IRB Chair and IRB Program Coordinator, or by the convened IRB. Such suspensions are reported following the IRB policy titled “Reporting of the IRB Findings to Federal Agencies”. The process for management of serious or continuing non-compliance by the convened IRB must include notifying current participants when such information might relate to the participants’ willingness to continue to take

part in the research. There are several optional actions that may take place, which include, but are not limited to; modification to the protocol, modification of the information disclosed during the consent process, providing additional information to past participants, requiring current participants to re-consent to participate, monitoring the research and the consent process and a referral to other organizational entities.

When Investigators conduct any form of research (exempt, expedited, or full board) without IRB approval

Federal regulations and guidelines do not allow for review and post hoc approval of studies that have been conducted involving human participants or identifiable data that can be connected to any living individual.

Investigators are responsible for providing the IRB with sufficient information and related materials about the research (e.g., grant applications, research protocols, sample consent documents) so that the IRB can fulfill its regulatory obligations, including making the required determinations under 45 CFR 46.111. Investigators should follow institutional policies and procedures for IRB review that are required by HHS regulations at 45 CFR 46.103. Investigators must promptly report the proposed changes to the IRB and the research activity cannot proceed unless they have received IRB approval on such changes.

In these cases, the IRB and the Institutional Official will take into consideration the nature, severity, and the risk it poses to human subjects and decide on the appropriate corrective action plan that may include but is not limited to the following:

1. For data that has already been collected, if the data is intended for publication, the investigator must disclose to the publication editor or at the National Meetings that the data was collected prior to approval from the IRB
2. If they are currently collecting data without prior IRB approval, then they need to submit a protocol and application to the IRB within 7 days and cannot use any of the data collected prior to the approval
3. Re-educate the investigator and their team on Good Clinical Practice (GCP) and Belmont principles
4. Once the IRB has intervened with a corrective action plan and the investigator is found to have undertaken another study without IRB approval, then the investigator and their team will be placed on probation and will not be allowed to conduct research for a specified time and will be reported to the Office of Human Research Protections (OHRP)
5. The Department Chair will be notified of the above actions

Verification of Changes From Sources Other Than the Investigator

The IRB will vote on protocols that require verification from sources other than the investigators and will use auditing as the vehicle to verify that no changes have occurred. The following are examples of protocols that the IRB will monitor by the audit process:

1. Phase I studies
2. Phase II studies
3. Studies carried out by investigators with a record of non-compliance
4. Protocols that carry significant physical or social risks to the participants

5. Studies in which there is concern about possible material changes occurring without IRB approval
6. Studies that have been revised based upon information provided from Institutional employees, subjects enrolled or any other reliable source
7. Studies in which enrolled subjects express concerns to the IRB

For continuing review of research under expedited procedures, the IRB Chair or member assigned to review determines:

1. Whether the protocol needs verification from sources other than the researchers that no material changes had occurred since previous IRB review.

Suspension and Termination of Protocols

Suspension of IRB approval is defined as a temporary halt in IRB approval of some or all research activities and extends beyond suspension of enrollment. The IRB is authorized to suspend enrollment or terminate the approval of research that is not being conducted in accordance with the IRB's requirements, or that has been associated with unexpected serious harm to subjects (45 CFR 46.113 and 21 CFR 56.113). Suspensions and terminations represent an action by the IRB to temporarily or permanently withdraw approval for some or all research procedures. The IRB Chair, or in their absence, the Vice-Chair, has the authority to immediately suspend research when such action needs to be taken to eliminate risk of serious harm to subjects before the matter can be reviewed at the next convened meeting of the IRB, at which time the IRB must determine whether to continue, withdraw or modify the suspension. If a research protocol is suspended by someone other than the IRB (i.e., the sponsor), the IRB must be notified immediately by the PI, and the suspension will be reviewed by the convened IRB.

Protocols approved by the IRB can be suspended or terminated:

- At the discretion of the IRB in cases of continued lack of compliance or significant unanticipated adverse events;
- At the time of full-board review of suspensions, audits, or continuing review requests, if the IRB members determine there is cause.

When a study approval is terminated by the IRB, the following actions must be taken by the investigator:

- Current participants are notified that the study has been terminated. When termination is Investigator-initiated, participants are to be notified by the Investigator.
- Procedures for withdrawal of enrolled participants consider the rights and welfare of participants.
- When follow-up of participants for safety reasons is permitted/required by the IRB, the participants should be so informed.
- When follow-up of participants for safety reasons is permitted/required by the IRB, any adverse events/outcomes should be reported to the IRB and the sponsor.

When study approval is suspended, the IRB or the person ordering the suspension:

- Considers actions to protect the rights and welfare of currently enrolled participants.
- Considers whether procedures for withdrawal of enrolled participants take into account their rights and welfare (e.g., making arrangements for medical care

outside of a research study, transfer to another researcher, and continuation in the research under independent monitoring).

- Considers informing current participants of the suspension.
- Has any adverse events or outcomes reported to the IRB.

For a full description of the process the IRB uses to suspend or terminate previously approved research, please refer to the section entitled “Non-Compliance and Corrective Action”. Correspondence with investigators regarding suspensions or terminations will include a statement of the reasons for the IRB’s actions, and will be reported promptly to the investigator, appropriate institutional officials and regulatory authorities. Please refer to the section entitled “Reporting of IRB Findings”, for a description of how suspensions and terminations are communicated to the Investigator, Institutional officials, and Federal agencies. This applies to all research conducted at this Institution, regardless of the source of funding.

Appeals of IRB Decisions

Investigators may appeal to the IRB, in writing, documenting the reasons for the appeal. These will be addressed to the Chair of the IRB and discussed at a convened meeting. Based on the Investigator’s response, the IRB may approve or disapprove the protocol, or require additional information or changes, in which case voting will be deferred pending receipt of the Investigator’s response. The IRB can vote to allow the IRB Chair to approve the protocol when the IRB requirements have been satisfactorily met or require full board review at the next convened meeting. The outcomes will be communicated to the investigator in writing by the Chair of the IRB. No Institutional official or other Institutional committee may override the decisions of the IRB to disapprove a study. However, the Institution may prevent the performance of a study approved by the IRB.

Bringing Forth Concerns

Investigators may bring forth any concerns or suggestions they have regarding the functions of the Institutional Review Board or the protection of human research subjects to the IRB itself, or the Institutional Official appointed by the CEO. Investigators are invited to IRB meetings to present their new protocols, and they may also address concerns and issues directly with IRB members at that time.

Undue Influence of IRB Members

Members of the IRB and the IRB Chair are in the position where they may be subject to undue influence from investigators to provide a favorable decision. If such an incident were to occur, the IRB member should immediately report the incident to the Chair of the IRB or if it involves the Chair this matter should be taken to the signatory of the applicable FWA to discuss the appropriate course of action. Such coercion will not be tolerated and may result in the investigator’s loss of IRB privileges. If a member of the IRB is subject to undue influence by the IRB Chair, they should report the incident to the Institutional Official.

SECTION XXI. REPORTING OF IRB FINDINGS

Correspondence with Investigators

Following full or expedited review of a protocol by the IRB, the Chair corresponds with the Investigator regarding the decision of the IRB (approval, disapproval and deferral). Letters are sent to Investigators within five working days of a decision. If the IRB votes to disapprove a research activity, it shall include in its written notification a statement of the reasons for the decision and give the investigator an opportunity to respond in writing and in person at a convened meeting of the IRB. Compliance with IRB, OHRP and FDA regulations and guidelines is expected from Principal and collaborating investigators. In the approval letter, investigators are instructed to inform the office of the IRB, of all changes in protocols prior to their implementation, and terminations, should they occur prior to the renewal due date.

Reporting of IRB Findings to the Institution

Agendas for IRB meetings are available to the signatory of the Federal Wide Assurances one week prior to the meeting date. Minutes from each IRB meeting are emailed to the signatory of the Federal Wide Assurances within 7 business days after the IRB meeting.

Reporting of IRB Findings to Federal Agencies

The Chair of the IRB will report to the OHRP changes in IRB membership and the IRB Program Coordinator will report changes in FWA signatory official.

In the case of any i) unanticipated problems involving risks to subjects or others; ii) serious or continuing non-compliance with this policy or the requirements or determinations of the IRB; or iii) a suspension or termination of previously approved research, the OHRP and, if applicable, the FDA, is notified by the IRB Chair or the IRB Program Coordinator to inform them of the incident. A report is sent.

The information to be included in incident reports is as follows:

1. Name of the Trinity Health Of New England component (TRINITY HEALTH OF NEW ENGLAND, MSRH, JMH, MMC, or SMH and their components)
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. Number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement);

In addition:

A. For unanticipated problems involving risks to subjects or others:

1. A detailed description of the problem; and
 2. Actions the institution is taking or plans to take to address the problem.
- B. For serious or continuing noncompliance:
1. A detailed description of the noncompliance; and
 2. Actions the institution is taking or plans to take to address the noncompliance.
- C. For suspensions and terminations:
1. A detailed description of the reason for the suspension or termination; and
 2. The actions the institution is taking or plans to take to address the suspension or termination.

The IRB Chair approves the report. The IRB Program Coordinator sends a copy of the report to the Principal Investigator, study coordinator, the signatory of the FWA, Department Chair, and members of the IRB and other sites as appropriate, OHRP, and the FDA (if research is FDA regulated). The IRB Program Coordinator need not send a copy of the report to Federal agencies if the event has been reported through other mechanisms, such as reporting by the investigator, sponsor or another organization. The IRB Program Coordinator will ensure that the reporting requirements of this policy are completed within 5 business days of when the convened IRB has completed an evaluation of the event.