Tulane University
Policies and Standard Operating Procedures
for its
Human Research Protection Program

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1 Human Research Protection Program ("HRPP")

1.1 Policy

The Administrators of the Tulane Educational Fund (the "University," "Tulane," or "Institution") fosters a research environment that promotes the respect for the rights and welfare of individuals recruited for, or participating in, Research conducted by its employees, faculty, staff, students and any institution or individual under the auspices of the University. In the review and conduct of Research, actions by the University will be guided by the principles (i.e., respect for persons, beneficence, and justice) set forth in the Ethical Principles and Guidelines for the Protection of Human Subjects of Research (often referred to as the "Belmont Report").

The actions of the University will also conform to all applicable Federal, State, and local laws and regulations.

To fulfill this policy, the University has established a Human Research Protection Program ("HRPP") which is administered by the Human Research Protection Office ("HRPO"). The HRPP consists of this policy, a mission statement, a statement of ethical principles, supporting policies and procedures ("SOPs"), and supporting Institutional Agents and Institutional committees. The HRPP, in partnership with its research community, is responsible for ensuring the ethical and equitable treatment of all human subjects in research conducted under its auspices. The research may be externally funded, funded from University sources, or conducted without direct funding.


1.2 Mission

The mission of the HRPP is to:

- Safeguard and promote the health and welfare of Human Subjects Research by ensuring that their rights, safety, and well-being are protected;
- Provide guidance and support to the research community in the conduct of Research with Human Subjects;
- Assist the research community to ensure compliance with relevant regulations;
- Provide timely and high-quality education, review, and monitoring of Human Subjects Research; and
- Facilitate excellence in Human Subjects Research.

The HRPP includes mechanisms to:

- Establish a formal process to monitor, evaluate and continually improve the protection of human research Participants;

1The Belmont Report
• Dedicate resources sufficient to do so;
• Exercise oversight of research protection;
• Educate Institutional Review Board (“IRB”) Committee members, IRB support staff, PIs, Investigators, and research staff about their ethical responsibility to protect research Participants; and
• When appropriate, intervene in Research and respond directly to concerns of research Participants.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.E and Standard I-2)

1.3 Institutional Authority
The Tulane Human Research Protection Program operates under the authority of the University policy entitled “Human Research Protection Program” (“HRPP”) adopted on September 30, 2009. As stated in that policy, the operating procedures in these SOPs “…serve as the governing procedures for the conduct and review of all Human Subjects Research Conducted Under the Auspices of Tulane.”

The HRPP SOPs are available to all University PIs, Investigators and research staff, IRB Committee Members, IRB support staff, all components identified under the University Federal-Wide Assurance (“FWA”), and all Assurances relying upon the Tulane’s IRB. The HRPP SOPs are posted on the Tulane University HRPP Website.

The approved revisions and/or review to these SOPs are tracked on the first page of this document, and shall include an issue date, effective date, last reviewed date, and last revised date. Revisions to this document are made at least bi-annually or on a case-by-case basis.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.A)

1.4 Definitions
Terms used in these SOPs that are capitalized are considered defined terms under these SOPs with the meaning attributed to them consistent with their definition in a Section and in the Glossary found in Section27.

Clinical Trial: Per the Common Rule and NIH Policy, 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. FDA regulations refer to “clinical investigations” (see definition of “research” below).

Common Rule: The “Federal Policy for the Protection of Human Subjects” that provides for the primary source of regulation of Research. It has been adopted by several Federal agencies. Although the Common Rule is codified by each agency separately, the text is identical to Department of Health and Human Services (“DHHS”) regulations contained in 45 CFR 46 Subpart A. For the purposes of the HRPP, references to the Common Rule will cite the DHHS regulations.
Federal-Wide Assurance ("Assurance" or "FWA"): A written commitment by an institution to protect Human Subjects participating in Research. Under Federal regulations, any institution conducting or engaged in federally supported Research involving Human Subjects must obtain an Assurance in accordance with 45 CFR §46.103. This requirement also applies to any collaborating "performance site" institutions. “Engaged in Research” is defined in Section 1.9.

Generalizable Knowledge: Activities that are designed to draw general conclusions, inform policy, or generalize findings. Generalizable knowledge includes one or more of the following concepts: (1) The information contributes to a theoretical framework or an established body of knowledge; (2) The primary beneficiaries of the study are other researchers, scholars, and practitioners in the field of study; (3) Publication, presentation or other distribution of the results intended to inform the field of study; and, (4) The results are intended to be replicated in other settings.

Human Research Protection Program ("HRPP"): A comprehensive program to ensure the protection of Human Subjects participating in Research at Tulane University. The objective of this program is to assist the institution in meeting applicable ethical principles and regulatory requirements for the protection of Human Subjects in Research.

Human Subject ("Subject," “Participant,” “Human Participant,” “Human Research Subject”): A living individual about whom an investigator (whether professional or student) 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. [45 CFR 46.102(e)(1)]

For purposes of this definition, the following definitions are germane:

- **"Interaction"** means communication or interpersonal contact between Investigator and subject. [45 CFR 46.102(e)(3)];
- **"Intervention"** means both physical procedures by which information or biospecimens are gathered (example, veni-puncture) and manipulations of the subject or the subject’s environment that are performed for Research purposes. [DHHS 45 CFR §46.102(e)(2)]
- **"Private information"** means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). [45 CFR 46.102(e)(4)]
- **"Identifiable private information"** means private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information. [45 CFR 46.102(e)(5)]. Note: This definition is within the Common Rule. For a discussion of identifiable under HIPAA, please see Section 23.
- **"Identifiable biospecimen"** means a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen [45 CFR 46.102(e)(6)]
- **"Individually identifiable"** means private information or specimens that can be linked to specific individuals by the Investigators(s) either directly or through coding systems. [45 CFR 46.102(f)]
• **Obtaining**: Obtaining identifiable private information or identifiable specimens includes, but is not limited to: (1) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that have been provided to investigators from any source; and (2) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens *that were already in the possession of the investigator*.


For Research covered by FDA regulations [21 CFR Parts 50 and 56], Human Subject means an individual who is or becomes a Participant in a Clinical Investigation, either as a recipient of the Test Article or as a control. A subject may be in normal health or may have a medical condition or disease. [21 CFR §50.3(g), 21 CFR §56.102(e)]. In the case of a Medical Device, a Human Subject/Participant also includes any individual on whose tissue specimen an Investigational Device is used or tested. [21 CFR §812.3(p)]. When medical device Research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as Human Subjects.

NOTE: The FDA definition of Human Subject differs according to the applicable regulation. [See 21 CFR §812.3(p), 21 CFR §50.3(g), §312.3(b), and §56.102(e)].

**Human Subject(s) Research**: Any activity that meets the definition of Research and involves Human Subjects as defined by either the Common Rule or FDA regulations.

**Institutional Employee or Agent**: All individuals performing Institutionally designated activities or exercising Institutionally delegated authority or responsibility under Tulane’s FWA.

**Institutional Official (“IO”)**: The University Vice President for Research (“VPR”) serves as the Institution’s IO for carrying out the HRPP. The IO is responsible for ensuring that the HRPP has the resources and support necessary to comply with all Federal regulations and guidelines that govern Human Subject Research. The IO is legally authorized to represent the Institution, is the signatory official for all Assurances, and assumes the obligations of the Institution’s Assurance.

**Institutional Review Board (“IRB”)**: An independent board(s) designated by the Institution to review, approve the initiation of, and conduct periodic review of Research involving Human Subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the Human Subjects. The IRB may be assigned other review functions as deemed appropriate by the Institution. This independent board is composed of medical, scientific, and non-Scientific Members.

**Investigator**: An individual under the direction of the PI who is involved in some or all aspects in the Research project, including (1) the design of the study; (2) conduct of the study; (3) analysis and interpretation of the collected data; (4) directly involved in seeking the voluntary Informed Consent of potential subjects; and (5) writing of resulting manuscripts. Investigators can include physicians, scientists, nurses, Research staff members, administrative staff, teachers, and students. Investigators must be included on the **FDA Form 1572** and/or the Initial
**Application for Human Subjects Research** signature page. While the FDA considers an Investigator and a PI to be synonymous, this document does not. [FDA 21 CFR §50.3(d); 21 CFR §56.102(h); 21 CFR §312.3(b)]. OHRP considers the term Investigator to include anyone involved in conducting the research.

**Protocol:** A document (including subsequent amendments) that describes the objective(s), design, methodology, statistical considerations, and organization of a trial. A Protocol usually also gives the background and rationale for the trial, but this could be provided in other Protocol reference documents. [Good Clinical Practice: Consolidated Guidance (ICH-E6)(Protocol includes initial Protocol and Protocol amendments)].

**Research:** Defined by the Common Rule as a “systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge.” Activities which meet this definition constitute research whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part [the Common Rule], the following activities are deemed not to be research: (1) 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. (2) 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 an event or crisis that threatens public health (including natural or man-made disasters). (3) 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. (4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions. [45 CFR 46.102(l)]

FDA regulations define Research as meaning any experiment that involves a Test Article and one or more Human Subjects, and that either must meet the requirements for prior submission to the FDA under section 505(i) or 520(g) of the Federal Food, Drug, and Cosmetic Act (the “FDA Act”), or need not meet the requirements for prior submission to the FDA under these sections of the FDA Act, but the results of which are intended to be later submitted to, or held for inspection by, the FDA as part of an application for a Research or marketing permit. The terms Research, clinical Research, clinical study, study, and Clinical Investigation are synonymous for purposes of FDA regulations. [FDA 21 CFR §50.3(c), 21 CFR §56.102(c)].

- Experiments that must meet the requirements for prior submission to the FDA under section 505(i) of the FDA Act means any use of a Drug other than the use of an approved Drug during medical practice. [21 CFR §312.3(b)].
Experiments that must meet the requirements for prior submission to the FDA under section 520(g) of the FDA Act means any activity that evaluates the safety or effectiveness of a Device. [21 CFR §812.2(a)].

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

**Research Under the Auspices of the Institution** (or “Under the Auspices”): this includes Research conducted at this Institution, conducted by or under the direction of any employee or Institutional Agent of this Institution (including students) in connection with his or her Institutional responsibilities, using any property or facility of this Institution, or involving the use of this Institution’s non-public information to identify, contact, or study Human Subjects. See Section 1.9 for details.

**Systematic Investigation:** An activity that involves a prospective study plan, which incorporates data collection, either quantitative or qualitative, and data analysis to answer a study question. Investigations designed to develop or contribute to generalizable knowledge.

**Test Article:** The FDA defines “Test article” as any drug (including a biological product for human use), medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 and 354-360F of the Public Health Service Act [42 U.S.C. 263 and 263b-263n]. [21 CFR 50.3(j)]

Test articles covered under the FDA regulations include, but are not limited to:

- **Human drugs** – A drug is defined as a substance recognized by an official pharmacopoeia or formulary; a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; a substance (other than food) intended to affect the structure or any function of the body; a substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device. Biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process.) [FDA Glossary of Terms](https://www.fda.gov/AboutFDA/Centers-Offices/CMO-Office-Operations/Office-Medical-Systems-Operations/). The primary intended use of the product is achieved through chemical action or by being metabolized by the body.

- **Medical Devices** – A device is “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:

  i. recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them;

  ii. intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.” [FDA Medical Device Definition](https://www.fda.gov/medical-devices)
• **Biological Products** – Biologics include a wide range of products such as vaccines, blood, and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Biologics are isolated from a variety of natural sources (i.e., human, animal, or microorganism) and may be produced by biotechnology methods and other cutting-edge technologies. Gene-based and cellular biologics, for example, often are at the forefront of biomedical research, and may be used to treat a variety of medical conditions for which no other treatments are available. [FDA Glossary of Terms](#)

• **Food Additives** – A food additive is defined in Section 201(s) of the FD&C Act as any substance the intended use of which results or may reasonably be expected to result, directly or indirectly, in its becoming a component or otherwise affecting the characteristic of any food (including any substance intended for use in producing, manufacturing, packing, processing, preparing, treating, packaging, transporting, or holding food; and including any source of radiation intended for any such use); if such substance is not Generally Recognized As Safe (GRAS) or sanctioned prior to 1958 or otherwise excluded from the definition of food additives. [FDA Food Ingredient and Packaging Terms](#)

• **Color Additives** – A color additive is any dye, pigment or substance, which when added or applied to a food, drug or cosmetic, or to the human body, is capable (alone or through reactions with other substances) of imparting color. Color additives for use in food, drugs, and cosmetics require premarket approval. Color additives for use in or on a medical device are subject to premarket approval if the color additive comes in direct contact with the body for a significant period of time. [FDA Food Ingredient and Packaging Terms](#)

• **Foods** – Foods include dietary supplements that bear a nutrient content claim or a health claim.

• **Infant Formulas** – Infant formulas are liquid foods intended for infants, which substitute for mother’s milk.

• **Electronic Products** – The FDA regulates certain classes of electronic products including radiation-emitting electronic products such as microwaves and x-rays.

### 1.5 Ethical Principles

The University is committed to ensuring that all Human Subjects Research, which it is engaged in, is conducted in accordance with the ethical principles stated in the Belmont Report. These principles are:

1. **Respect for Persons** ensured by obtaining Informed Consent, consideration of Privacy, Confidentiality, and additional protections for Vulnerable Populations. Individuals will be treated as autonomous agents afforded the right to make decisions themselves. Those with decreased or diminished autonomy such as Minors, Prisoners, people who are mentally disabled or challenged are entitled to additional protections.
2. **Beneficence** assured by maximizing possible benefits and minimizing possible risks to all Human Subjects. Application of this principle involves a risk-benefit analysis in which the risks to subjects must be reasonable compared to the potential for benefit to subjects either directly or to society. Risk evaluation must include the consideration of both the probability and magnitude of harm, including psychological, physical, legal, social, and economic harm.

3. **Justice**, which is the equitable selection of subjects. The possibility for benefits and the potential burdens of the Research should be equitably distributed among the potential research subjects. Application of this principle requires the scrutiny of the enrollment process to ensure that particular classes are not selected for their compromised position or convenience to the Investigator. Such classes are welfare patients, racial and ethnic minorities or persons confined to institutions.

The University, through its HRPP and in partnership with its Research community, including researchers and research staff, IRB members and chairs, IRB staff, and the Institutional Official, employees and students, is responsible for ensuring the ethical and equitable treatment of all Human Subjects involved in Research under the auspices of the Institution “Research Under the Auspices of the Institution”.

**AAHRPP Standards for Accreditation** (Standard I-1, Element I.1.D)

Regulations & Guidance: ICH-GCP (E6) 2.1 and 2.13

**1.6 Regulatory Compliance**

The University is responsible for ensuring compliance with all applicable Federal, State, and local laws, regulations and Institutional policies (including tribal laws passed by the official governing body of an American Indian or Alaska Native tribe) with regard to Human Subjects Research. This is accomplished through, among other things, the HRPP, University Research compliance policies, and other Institutional policies.

All Human Subjects Research at the University is conducted in accordance with the following policies and regulations that fall under its authority.

1. Federal regulations for the protection of Human Research Subjects (often referred to as the “Common Rule”). [DHHS 45 CFR Part 46].2

2. When Research involves articles subject to regulation by the FDA, the FDA regulations for the protection of Human Subjects [21 CFR Part 50] and Institutional Review Boards. [FDA 21 CFR Part 56].3

3. Research supported by the Department of Defense (DoD) is reviewed and conducted in compliance with part 219 of title 32 CFR, part 980 of title 10 USC, applicable parts of title 21 CFR (50, 56, 312, 600, 812), DoD Instruction 3216.02, DoD Directive 3210.07, and applicable additional requirements from respective DoD component(s). See Tulane HRPP Policy on “Additional Department of Defense (DoD) requirements at https://research.tulane.edu/hrpo/policies).

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2 *The Common Rule*

3 For details, see21CFR Part 56
4. Research involving the use of Protected Health Information is reviewed and conducted in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 160, 162, and 164.

5. Research involving the use of student educational records is reviewed and conducted in accordance with the Family Educational Rights and Privacy Act (FERPA), 34 CFR Part 99.

6. Policies and procedures established by the Human Research Protection Program, IRB, including those incorporated in these SOPs. The current version of this reference may be found on the Tulane University HRPP Website. Compliance with all other University policies that relate to Human Subject Research also is required.

7. The provisions of the Institution’s FWA (i.e., FWA 00002055).

1.6.1 Management of pre-existing studies once the revised 2018 Common Rule goes into effect

For research subject to the Common Rule (whether due to support or organization policy), all studies initially approved, waived under .101(i), or determined exempt before January 21, 2019 will be subject to the pre-2018 Common Rule through the close of study.

1.7 International Conference on Harmonization Good Clinical Practices (“ICH-GCP”)

Tulane voluntarily applies the International Conference on Harmonization (“ICH”) Good Clinical Practices (“GCP”) Guidelines found in section E6 (sometimes referred to as “ICH-GCP” or “E6”) to certain types of Human Subjects Research conducted under its HRPP. In general, Tulane applies the ICH-GCP guidelines only to the extent that they are compatible. When a sponsor requires institutional ICH-GCP compliance, the IRB will conduct a review in accordance with ICH-GCP requirements. See the document “International Conference on Harmonization (ICH) Good Clinical Practices (GCP), Applicability to Human Subjects Research” for guidance on the applicability of the ICH-GCP requirements.

1.8 Federal-Wide Assurance (“FWA”)

The University operates under an Assurance approved by the Federal Office for Human Research Protections (“OHRP”) issued by the Secretary of the Department of Health and Human Services (“DHHS”) as Tulane FWA 00002055. The University has designated two IRBs registered as 00000324 (Biomedical IRB) and 00000339 (Social/Behavioral IRB) to review all Human Research Protocols.

While the terms of the FWA are applied only to Federal sponsored Research, the policies and procedures in these SOPs apply to all Research under the auspices of the Institution involving Human Subjects, regardless of funding source: When human subjects research is not subject to the Common Rule or FDA regulations, the University ensures that human research subjects benefit from equivalent protections by applying the Common Rule standards, with purposeful deviations that do not meaningfully diminish protections as noted within this manual.
Likewise, federal regulations require IRBs to register with DHHS if they will review human subjects research conducted or supported by DHHS or research subject to FDA regulations.

Regulations & Guidance: DHHS 45 CFR §46.103.

1.9 Research under the Auspices of the Institution and Engagement

Research under the auspices of the University includes research conducted at this University, conducted by or under the direction of any employee or agent of this Institution (including students) in connection with his or her University responsibilities, conducted by or under the direction of any employee or agent of this Institution using any property or facility of this University, or involving the use of this Institution’s non-public information to identify, contact, or study human subjects.

Employee or Agent – For the purposes of this document, “employees or agents” refers to individuals who: (1) act on behalf of the University; (2) exercise Institutional authority or responsibility; or (3) perform Institutionally designated activities. “Employees and agents” can include staff, students, contractors, and volunteers, among others, regardless of whether the individual is receiving compensation.

Engagement or Engaged – The Department of Health and Human Services (DHHS) regulations [45 CFR 46.103(a)] require that an institution “engaged” in human subject research conducted or supported by a Federal Department or Agency provide the Office for Human Research Protection (OHRP) with a satisfactory assurance of compliance with the DHHS regulations, unless the Research is exempt under 45 CFR 46.104. “In general, an institution is considered engaged in a particular non-exempt human subjects research project when its employees or agents for the purposes of the research project obtain: (1) data about the subjects of the research through intervention or interaction with them; (2) identifiable private information about the subjects of the research; or (3) the informed consent of human subjects for the research.” In general, Institutions that receive an award through a grant, contract, or cooperative agreement directly from DHHS for the non-exempt human subjects research (i.e. awardee institutions), are also considered engaged in Research even where all activities involving Human Subjects are carried out by Employees or Agents of another Institution.

FDA regulations are oriented to the responsibilities of IRBs, Investigators, and Sponsors as opposed to Institutions. In general, FDA-regulated Research conducted in the University facilities or by the University Principal or Sub-Investigators (as defined on the FDA 1572 or delegation of responsibilities log) requires review by a Tulane-designated IRB. Exceptions to this requirement may be granted on a case-by-case basis (e.g., when the Institution’s involvement in the Research is limited to the provision of a common diagnostic procedure and associated reading or analysis).

An IRB Chair or Vice Chair, with the assistance of the HRPO/HRPP Director or Designee and staff, RCO, and legal counsel as needed, will determine whether the Institution is engaged in a particular Research Study. Investigators and other Institutions may not independently determine the Institution engagement.

When the Institution is engaged in Research, the Institutional Official or Designee may choose to enter into an engagement to cede review to an eternal IRB.

To determine if the University is engaged in Research, the PI is to complete and submit a
Human Subjects Research Determination Form via the IRB electronic submission system for a determination by the IRB Chair or designee whether the proposed research meets the definition of Human Subject Research and whether the University is Engaged in Research. See Section 6 of these SOPs, “Human Subjects Research and Engagement Determination.” For additional information on determining engagement, please refer to Guidance on Engagement on Institutions in Human Subjects Research, [http://www.hhs.gov/ohrp/policy/engage08.html](http://www.hhs.gov/ohrp/policy/engage08.html).

1.10 Research Covered by the HRPP

The HRPP covers all Research involving Human Subjects that is under the auspices of the University, regardless of the funding source. The Research may be externally funded, funded from University sources, or conducted without direct funding.

1.11 Written Policies and Procedures

These SOPs describe the requirements that govern Research under the Auspices of the Institution that involves Human Subjects, as well as the requirements for submitting Research Proposals for review by the University’s IRB. This is not a static document. Instead, it is an organic document that is annually reviewed and revised by the HRPO/HRPP Director, in consultation with applicable Institutional entities (e.g., the IRB, the Office of General Counsel (“OGC”), the Research Compliance Officer (“RCO”), etc.). The IO ultimately is responsible for reviewing and approving all recommended revisions to these SOPs.

The HRPO/HRPP Director will keep the University apprised of new information that may affect the HRPP, including laws and regulations; Institutional policies and procedures; and emerging ethical and scientific issues on its Website, listservs, and through campus E-mailing lists.

These SOPs will be available on the University HRPO Website and copies will be available upon request.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.A)

Regulations & Guidance: DHHS 45 CFR §46.108 and FDA 21 CFR §56.108

1.12 HRPP Organization

The HRPP is a comprehensive system to ensure the protection of Human Subjects participating in Research. It consists of a mission statement; ethical principles; this policy; supporting SOPs; various Institutional Agents (e.g., the IO, the HRPO/HRPP Director, the RCO, Biosafety Officer, Radiation Safety Officer, University Privacy Officer, Security Officer, etc.); various Institutional committees (e.g., the Biomedical and Social/Behavioral IRB) and other committees or subcommittees addressing Human Subjects protection (e.g., the Biosafety Committee, Radiation Safety Committee, Pharmacy and Therapeutics Committee, Radioactive Drug Research Committee, Conflict of Interest Committee, etc.). The HRPP also encompasses the actions of Institutional individuals and staff (e.g., PIs, Investigators, IRB staff, HRPO staff, Research staff, and Research pharmacy staff). The objective of this system is to facilitate the Institution in its...
efforts to adhere to ethical principles and regulatory requirements for the protection of Human Subjects in Research.

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

1.12.1 **University President**

The President of the University is responsible for the overall operations at the University. The President has designated the ultimate responsibility and authority of the HRPP to the IO.

1.12.2 **Institutional Official (“IO”)**

The ultimate responsibility of the HRPP resides with the Vice President for Research, who serves as the IO of the HRPP. The IO is responsible for ensuring the Institution’s HRPP has the resources and support necessary to comply with all Institutional policies and with applicable Federal regulations and guidelines that govern Human Subject Research. The IO is legally authorized to represent the University, is the signatory of the FWA, and assumes the obligations of the FWA.

- The responsibilities and authorities of the IO are detailed in Tulane’s’ HRPP Policy, including: (1) oversight of the Institution’s IRBs and all Tulane Investigators; (2) assuring the IRB members and Investigators are appropriately knowledgeable to conduct Research in accordance with ethical standards and applicable regulations; and (3) the development and implementation of an educational plan for IRB members, staff and Investigators.

**AAHRPP Standards for Accreditation** (Standard I-1, Element I.1.B and Standard I-2)

1.12.3 **Director of the HRPO/HRPP**

The Director of the HRPO (“HRPO/HRPP”) reports to the IO and is responsible for:

1. Developing, managing and evaluating policies and procedures that ensure compliance with all Federal, State, and local regulations governing Research. This includes monitoring changes in regulations and policies related to Human Subjects Research protection and overseeing all aspects of the HRPP.

2. Advising the IO on key matters regarding Research at the University.

3. Implementing the HRPP.

4. Submitting, implementing and maintaining an approved FWA through the IO and OHRP.

5. Managing the finances of the HRPO/HRPP.

6. Providing information to the IO regarding the needs and resources required for the HRPP operation.

7. Assisting Investigators in their efforts to carry out the University’s Research mission.

8. Developing and implementing needed improvements and ensuring follow-up of actions, as appropriate, for the purposes of managing risk in the HRPP.
9. Developing a training and education program as required and appropriate for Investigators, subcommittee members and Research staff, and ensuring that training is completed in a timely manner.

10. Serving as the primary contact and liaison at the University for communications with Federal, State and local regulatory agencies with respect to Human Subject Research conducted under the auspices of the University’s IRB (e.g., OHRP and the FDA).

11. Day–to–day responsibility for the operation of the HRPO/HRPP, including supervision of HRPO staff.

12. Responding to faculty, student and staff questions.

13. Working closely with the IRBs Chairs on the development of policy and procedures, as well as organizing and documenting the review process.

1.12.4 Assistant Director of the HRPO

The Assistant Director of HRPO ("HRPO Assistant Director ") reports directly to the Director of the HRPO/HRPP. The HRPO Assistant Director advises the HRPO/HRPP Director on day-to-day operations of the HRPO. Additional duties of the HRPO Assistant Director are:

1. Assist the HRPO/HRPP Director to ensure constructive communication concerning the HRPP and IRB matters among the officials of the University, Investigators, clinical care staff, and Human Subjects as a means to maintain a high level of awareness regarding the safeguarding of the rights and welfare of the subjects.

2. Assisting Investigators in their efforts to carry out the University’s Research mission.

3. Developing and implementing needed improvements and ensuring follow-up of actions, as appropriate, for the purposes of managing risk in the HRPP.

4. Developing training requirements as necessary and appropriate for Investigators, committee members and Research staff, and ensuring that training is completed on a timely basis.

1.12.5 University Research Compliance Officer ("RCO")

The University’s Research Compliance Officer ("RCO") or designee acts to oversee and ensure that, among other things, Research conducted at the University is in compliance with Research regulations applicable to the use of Human Subjects. In this capacity, the RCO (or designee) is responsible for (1) developing and implementing policies and procedures to ensure compliance with Research regulations and requirements; (2) conducting training and education regarding Research compliance topics; and (3) conducting audits and monitoring Research activity. The RCO may conduct audit site visits or conduct record audits of any study submitted to the IRB to review, for example, subject consent forms, Research Records or IRB Records.

The RCO serves as an ex-officio guest of the IRB to facilitate the IRB’s arriving at an unbiased and independent determination on the validity of any compliance deviations and the appropriateness of recommended corrective measure(s). The RCO meets with the

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4 Throughout these SOPs, wherever RCO is referred to, RCO shall be considered to mean “RCO or designee” to all the RCO to delegate as appropriate.
HRPO/HRPP Director on at least weekly basis and the IO on a biweekly basis to discuss ongoing projects of the RCO that relate to Human Subjects Research.

The RCO reviews and investigates all credible complaints and Allegations of Non-Compliance (as discussed below in Section 10 entitled “Complaints and Non-Compliance”) that are submitted to the IRB or that the RCO is made aware of. The RCO shall investigate all credible complaints and allegations and make a report, as appropriate, to the IRB with recommendation for corrective measures as appropriate.

1.12.6 Institutional Review Board (“IRB”)

Tulane has two IRBs created by the IO on behalf of the Institution. Tulane’s IO retains the authority to create or dissolve IRBs. Members of Institutional IRBs are appointed by the IO. The IRB(s) prospectively and retrospectively reviews and makes decisions concerning all non-Exempt Research Under the Auspices of the Institution. The IRB(s) is responsible for the protection of rights and welfare of Human Subjects involved in Research Under the Auspices of the Institution. It discharges this duty by complying with the requirements of the Common Rule; Federal and State regulations; the FWA; and Institutional policies. See Section 4 for a detailed discussion of the nature, role and duties of the IRB.

1.12.7 Department Chairs

Department Chairs are responsible for ensuring that the Principal Investigator (“PI”) is qualified by training and experience to conduct the proposed Research. In addition, Department Chairs are responsible for ensuring that the PI has sufficient resources and facilities to conduct the proposed Research. For each Protocol submitted to Tulane IRB for approval, the Department Chair must certify (via the IRB electronic signature) that s/he accepts responsibility for assuring adherence to the Federal and State regulations and institutional policies governing the protection of Human Subjects involved in Research, including applicable institutional credentialing requirements.

Department Chairs are required to review all proposals before they are submitted to the IRB for review. The electronic signature of the Department Chair indicates that the study is found to be scientifically sound and can reasonably be expected to answer the proposed question.

Department Chairs are responsible for assuring that Investigators have the resources required to conduct the Research in a way that will protect the right and welfare of Participants. Such resources include but are not necessarily limited to personnel, space, equipment and time.

AAHRPP Standards for Accreditation (Standard I-2)

1.12.8 The Principal Investigator (“PI”)

The Principal Investigator (“PI”) bears the ultimate responsibility for the protection of Human Subjects who participate in Research. The PI is expected to abide by the highest ethical standards for developing a Protocol that incorporates the principles of the Belmont Report. He/she is expected to conduct Research in accordance with the approved Research Protocol and to oversee all aspects of the Research by providing supervision of support staff, including oversight of the informed consent process. All subjects must provide their Informed Consent and the PI must establish and maintain an open line of communication with all Research subjects within his/her responsibility. In addition to complying with all the policies and standards of the
governing regulatory bodies, the PI must comply with Institutional and administrative requirements for conducting Research. The PI is responsible for ensuring that all Investigators and Research staff completes appropriate training and must obtain all required approvals prior to initiating Research. When Investigational Drugs or Devices are used, the PI is responsible for providing written procedures for their storage, security, dispensing and disposal.

The PI ultimately is responsible for ensuring that no subject is enrolled before IRB approval is issued and any related sponsor agreement is fully executed.

1.12.9 Multiple PIs

If a funding agency allows multiple PIs (e.g. NIH Multiple PI Option) and issues an award with multiple PIs, the Investigators are required to follow the guidelines of the funding agency. When submitting an Initial Application to the IRB for review and approval, please include the agency’s guidelines along with supporting documents that describe the roles and responsibilities of each PI. The IRB recognizes that a single PI must be designated for compliance and oversight purposes on each approved study (see Section 20 for more details). As such, when an award is issued with multiple PIs, the multiple PIs must supply the IRB with a written and signed statement identifying which PI is responsible for Study oversight purposes, including serving as main contact for submitting and receiving all correspondence with the IRB.

1.12.10 Other Related Entities & Units to HRPP

1.12.10.1 Sponsored Projects Administration (“SPA”)

Sponsored Projects Administration (“SPA”) is responsible for, among other things, reviewing and negotiating agreements involving sponsored Research (e.g., grants, contracts and cooperative agreements) with Federal, State and local entities, as well as private and non-profit organizations. This institutional review ensures that all terms of the award are in compliance with Institutional policies. SPA also is responsible for ongoing compliance with the terms and provisions of the award issued by the sponsor, applicable Office of Management and Budget (“OMB”) circulars, and Institutional policies with respect to sponsored activity conducted at the University.

Only designated senior individuals within SPA are authorized to approve research proposals and to execute research agreements on behalf of the Institution.

As a further control, SPA maintains all sponsored agreements (include fully executed sponsored agreements and award notification for intramural and extramural funding) and internal documents submitted by the University as part of the application process for extramural funding. For additional details, refer to SPA’s policy entitled, “Establishing Sponsored Project Accounts.”

When the grant or contract agreement includes human research activities that will be conducted by Investigators who are not employees or agents of Institution, a subcontract (or similar agreement) is executed between Institution and the collaborating institution. The subcontract includes the requirement for the collaborating institution to assure compliance with federal regulations for the protection of Human Subjects in Research and to provide documentation of current and ongoing IRB approval by submission of an executed NIH Form 310 (as applicable). The collaborating institution must also ensure that Key Personnel involved in Human Subjects Research are in compliance with the NIH policy on education in the protection of human research subjects and provide documentation of education of Key Personnel to Institution.
As an additional control, as part of the negotiating process, SPA reviews sponsored agreements involving clinical trials to ensure that the informed consent document is consistent with the sponsored agreement. SPA uses a checklist to facilitate its review of draft sponsored agreements.

Upon request, SPA will forward to HRPO copies of fully executed sponsored agreements.

1.12.10.2 Research Pharmacy Services

All Investigational Drugs, Agents and/or Biological Products used in Human Subjects Research under the purview of Tulane’s IRB shall be stored, handled, and dispensed in compliance with regulations or requirements of the FDA, the Louisiana State Board of Pharmacy (“LSBP”), The Joint Commission, Federal, State and other laws and regulations, and these SOPs. Furthermore, if Research is conducted on hospital premises, such Research shall be conducted in accordance with applicable hospital and medical staff policies and guidelines.

The University is affiliated with and routinely conducts Human Subjects Research at Tulane University Hospital and Clinic (“TUHC”), and such Research may also require the provision of clinical care to Research subjects in an inpatient acute care(i.e., hospital) setting. To this end, TUHC serves as a primary site for hospital-based clinical Research conducted by University. For this reason, the University and TUHC entered into a Master Clinical Trial Affiliation Agreement (“Master CTA Agreement”) to facilitate the provision of necessary Research-support services, supplies and equipment, and the use of TUHC facilities including, without limitation, TUHC pharmacy services. The Master CTA Agreement only applies to Research conducted at TUHC’s Downtown, Lakeside, and Lakeview campuses, as well as any ambulatory clinic (i.e., outpatient) physically located within them (“TUHC Facility”).

TUHC’s Department of Pharmacy (“TUHC Research Pharmacy”) provides administrative and clinical services to PIs, Investigators and Research staff involved in Drug-related Research conducted at TUHC’s Facility under the purview of Tulane’s IRB. Furthermore, a TUHC research pharmacist (“Research Pharmacist”) will serve as a member on the Biomedical IRB to allow TUHC Research Pharmacy to have complete information about all IRB-approved Research that takes place at the TUHC’s Facility. Inclusion of the Research Pharmacist as an IRB member assures that information about all studies involving Drugs used in Research is shared with both the TUHC Research Pharmacy staff as appropriate and that TUHC’s Pharmacy and Therapeutics Committee is made aware of IRB-approved Research involving Drugs.

Refer to Section 13 for details regarding oversight of Research Pharmacy activity (both inpatient and outpatient) for Research Under the Auspices of Tulane’s IRB.

1.12.10.3 Protocol-Specific Coordination

For Research Under the Auspices of the IRB that takes place at TUHC, Protocol-specific coordination must take place. The PI must identify services to be provided by units within TUHC. The Initial Application for Human Subjects Research should include a letter of support, collaboration, permission, or approval from the designated authority for each identified service that takes place at TUHC. As part of the Application and IRB approval process, HRPO staff will ensure that all necessary TUHC approvals are included with the Application. Final IRB approval will not be given until all necessary letters are received. Refer to Section 13 for details with respect to the process for issuing project specific work orders under the Master Clinical Trials Affiliation Agreement between the University and TUHC.
1.12.10.4 Office of General Counsel

Tulane’s Office of General Counsel (“OGC”) provides advice to HRPO, the IO, and Institutional Agents, PIs, Investigators and Research staff with respect to laws, regulations and requirements applicable to Human Subjects Research. This includes interpretation and application of Federal, State and local laws where Research is conducted. When there are any conflicts between federal or national law and other applicable laws, the Associate General Counsel for Research or Designee will determine the appropriate resolution. A member of the OGC sits on the Biomedical IRB and Social/Behavioral IRB as the Institution’s legal advisor as an Ex-OfficioGuests.

1.12.10.5 Research Compliance Operations Committee (“RCOC”)

The Research Compliance Operations Committee (“RCOC”) periodically meets to ensure a dialogue is maintained between the various compliance entities at the University. The RCO or designee serves as Chair. The RCOC will act in an advisory capacity to the VPR, monitoring the effectiveness of existing research compliance programs, recommending new or revised policies as changes in requirements occur, and disseminating updated compliance information to the Research community. The IO and the RCO meet regularly to discuss the progress of the RCOC’s work.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.A)

1.12.11 Relationship Between Components

The IRB functions independently of, but in coordination with, other Institutional regulatory committees. The IRB, however, makes its independent determination whether to approve or Disapprove a Protocol based upon whether or not Human Subjects are adequately protected. The IRB has review jurisdiction over all Research involving Human Subjects conducted, supported, or otherwise subject to regulation by any Federal department or agency that has adopted the Human Subjects regulations.

The Tulane Compliance Steering Committee periodically meets to ensure a dialogue is maintained between the various compliance entities of the Organization. The Compliance Steering Committee acts in an advisory capacity to the University and to University Officials regarding monitoring the effectiveness of existing compliance programs, developing new or revised policies as required, and disseminating updated compliance information to the Tulane community. The Vice President for Research serves as the Chair of the Compliance Steering Committee. Committee membership is comprised of the Dean of the School of Medicine, the Dean of the School of Public Health, the Director of the Tulane National Primate Research Center, the Chairs of the Research Compliance Operations Committee, the Clinical Compliance Operations Committee, the Conflict of Interest Committee, and the Teaching and Administration Compliance Operations Committee.

Research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials of the Institution. However, those officials may not approve Research involving Human Subjects that has not been approved by the IRB.
1.13 HRPO Operations

In addition to the leadership structure described above, other support staff members for the HRPO include: full-time IRB Quality and Compliance Advisor, IRB Compliance and Education Coordinator, IRB Compliance Analyst(s), IRB Senior Regulatory Compliance Specialist, and Regulatory Compliance Specialist(s).

1.13.1 Human Research Protection Office (“HRPO”)

The University has established the Human Research Protection Office (“HRPO”) to administer the HRPP. The HRPO is supervised by the HRPO/HRPP Director. The HRPO/HRPP Director has expert knowledge in regulatory issues regarding Human Subjects and serves as the Human Protections Administrator. The HRPO/HRPP Director is the primary contact and liaison at the University for communications with Federal, State and local regulatory agencies with respect to Human Subjects Research (e.g., OHRP or the FDA).

The HRPO/HRPP Director oversees the HRPO staff that facilitates administration of the HRPP, activities of the IO, and the operation of the IRB(s). This includes responding to faculty, student, and staff questions about Human Subjects Research as well as organizing and documenting the IRB review process. The HRPO/HRPP Director works closely with the IRB Chair(s) in the development of policy and procedures and is not a voting member of the IRB. The duties and responsibilities for all HRPO staff are found in their respective job descriptions, and their performance is evaluated on an annual basis.

The IRBs shall be supported by an adequate number of HRPO staff with knowledge, skills and abilities necessary to carry out the function of the IRB. At a minimum, this shall include the IRB Quality and Compliance Advisor, IRB Compliance and Education Coordinator, IRB Compliance Analyst(s), Senior Regulatory Compliance Specialist and Regulatory Compliance Specialist(s) for each IRB. The HRPO staff is physically located in the HRPO. An organizational chart for HRPO may be found on the website.

AAHRPP Standards of Accreditation (Standard I-1, Element I.1.D and Standard II-1, Element II.1.B)

1.13.1.1 IRB Quality and Compliance Advisor

The IRB Quality and Compliance Advisor ensures that researchers comply with regulations, standards of ethics, and institutional procedures designed for the protection of human subjects. The position is responsible for developing and implementing a robust program of Post Approval Monitoring of ongoing research studies involving human subjects research. The IRB Quality and Compliance Advisor may also participate in for-cause audits as part of an audit team and/or as the Research Compliance Officer’s designee. Additionally, the IRB Quality and Compliance Advisor coordinates AAHRPP re-accreditation initiatives, internally audits and reviews HRPO and IRB processes and records for compliance and best practices, and provides consultation and guidance to researchers and board members on legal and procedural compliance.

1.13.1.2 IRB Compliance and Education Coordinator

The IRB Compliance and Education Coordinator will coordinate and manage all aspects of the department’s education and outreach initiatives to the university’s research faculty, staff and students, including special initiatives; be responsible for the review and drafting of all IRB
Authorization Agreements between Tulane and collaborative institutions, to fulfill the federal and NIH mandates for single IRB review (sIRB); and provide consultation and guidance to researchers and IRB board members on regulatory and procedural compliance matters. The position provides consultation to researchers and board members on regulatory and procedural compliance. The position develops and delivers compliance training programs.

1.13.1.3 IRB Compliance Analyst(s)
The IRB Compliance Analyst is responsible for facilitating the monitoring of Human Subjects Research under the auspices of Tulane’s IRBs. This responsibility includes conducting regulatory review of biomedical and social/behavioral research submissions to the HRPO/IRB, serving as the liaison between the Investigator and the IRB, provision of training and education to the research community, and provision of administrative support to IRB leadership. The IRB Compliance Analyst also ensures proper documentation of IRB correspondence and is a member of both the Biomedical and Social/Behavioral IRBs.

1.13.1.4 IRB Senior Regulatory Compliance Specialist
The IRB Senior Regulatory Compliance Specialist is responsible for all aspects of IRB communication and database management, as well as evaluation of IRB protocols and submissions for compliance and consistency with appropriate regulations prior to IRB review. The IRB Senior Regulatory Compliance Specialist reviews the IRB minutes for accuracy and ensures proper documentation of discussions and actions taken by the IRB during convened meetings. This individual also serves as a liaison between the Investigators and the IRB.

1.13.1.5 IRB Regulatory Compliance Specialist(s)
The IRB Regulatory Compliance Specialist is responsible for pre-reviewing and screening biomedical and social/behavioral submissions prior to their review by the IRB, as well as providing administrative and clerical support to the IRB, IRB Chairs and IRB Senior Regulatory Compliance Specialist. The Regulatory Compliance Specialist participates in all aspects of meeting preparation and post-meeting activities, as well as scheduling and coordinating all technical IRB functions.

1.13.2 Selection, Supervision and Evaluation of HRPO/HRPP Supporting Staff

1.13.2.1 Selection Process:
All HRPO staff that support the IRB and HRPO/HRPP are selected by the HRPO/HRPP Director or the Director’s designee.

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

1.13.2.2 Supervision:
HRPO staff are supervised by the HRPO/HRPP Director and the Assistant Director.

1.13.2.3 Evaluation:
HRPO staff are evaluated on an annual basis consistent with Institutional guidelines.

**AAHRPP Standards of Accreditation** (Standard I-1, Element I.1.E)

1.13.3 HRPO & IRB Resources

The HRPO is equipped with sufficient office space, meeting space, storage space and equipment to perform the functions required under the HRPP. The adequacy of personnel and non-personnel resources of the HRPO is assessed on an annual basis by the HRPO/HRPP Director with the aid of the Assistant Director HRPO/HRPP and is reviewed and approved by the IO.

Tulane’s IO will ensure that sufficient resources exist to support HRPO and IRB operations, including meeting and office spaces, and staff for conducting IRB business. Office equipment and supplies, including technical support, file cabinets, computers, internet access, and copy machines, will be made available to the HRPP and IRB staff.

The adequacy of personnel and resources provided to HRPO/HRPP and the IRB is assessed on an annual basis by the HRPO/HRPP Director during the annual budget review process and is reviewed and approved by the IO.

The plan to evaluate resources needed for the HRPP, including but not limited to:

- HRPP education program
- Legal counsel
- Conflict of interest
- Quality improvement plan
- Community outreach

**AAHRPP Standards of Accreditation** (Standard I-2)
2 Quality Assurance/Quality Improvement Activities

The University engages in Quality Assurance/Quality Improvement ("QA/QI") activities to measure and improve the effectiveness, quality, safety, and compliance of Research involving Human Subjects under the purview of Tulane’s IRB. These QA/QI efforts seek to comply with Institutional policies and procedures and applicable Federal, State and local laws. QA/QI efforts will be managed and implemented by the HRPO/HRPP Director or Designee.


2.1 External Monitoring, Audit, and Inspection Reports

All reports from external monitors, auditors, or inspectors must be submitted by Investigators to the IRB for Review within ten business days of receipt of the report. The IRB Chair or designee will review such reports in order to monitor for issues that could impact the rights or welfare of Human Subjects and for issues indicative of possible Serious or Continuing Non-Compliance. If such issues are identified, the report will be forwarded to the Convened IRB to determine what additional actions are necessary. See Sections 14, 15 and 16 for more details.

2.2 Investigator Compliance Reviews

The IRB Quality and Compliance Advisor is responsible for coordinating periodic (not “for cause”) compliance reviews of investigator research, as well post approval monitoring. The Research Compliance Officer is responsible for coordinating post-approval Directed (“for cause”) audits. Additionally, the IRB may appoint a subcommittee for the purpose of conducting a for-cause or not for-cause compliance review of one or more research plans under its jurisdiction. The subcommittee may be composed of IRB members and staff from within, or individuals from and outside of the organization.

Compliance reviews are conducted to assess investigator compliance with federal, state, and local law, and University policies, identify areas for improvement, and to provide recommendations based on existing policies and procedures. The results of compliance reviews will be reported to the HRPO/HRPP Director, the IRB, RCO, IO, and the Investigator. Any non-compliance will be handled according to the procedures in Section 17 Complaints and Section 16 Non-Compliance.

If it is identified that subjects in a research project have been exposed to unexpected serious harm, the reviewer will promptly report such findings to the HRPO/HRPP Director, RCO, and the IRB Chair for immediate action.

If issues are identified that indicate possible misconduct in research, the procedures in the University’s Research Misconduct Policies will be initiated. The University’s Research Misconduct Policies are available on the RCO website, https://research.tulane.edu/compliance/policies-procedures.

Compliance reviews may include:
1. Requesting progress reports from investigators;
2. Examining investigator-held research records;
3. Contacting research subjects;
4. Observing research sites where research involving human research subjects and/or the informed consent process is being conducted;
5. Reviewing advertisements and other recruiting materials;
6. Reviewing projects to verify from sources other than the investigator that no unapproved changes have occurred since previous review;
7. Assuring that the consent documents include the appropriate information and disclosures about conflicts of interest;
8. Monitoring HIPAA authorizations;
9. Conducting other monitoring or auditing activities as deemed appropriate by the HRPP or IRB.

2.3 IRB Compliance Reviews

The HRPO/HRPP Director or Designee in consultation with the IO, with, or without, the assistance of an outside organization, will periodically review the activities of the IRB to assess compliance with regulatory requirements and to identify areas for improvement; this will include a review of IRB records at least annually. Review activities may include:

1. Review of the IRB minutes to determine that adequate documentation of the meeting discussion has occurred. This review will include assessing the documentation surrounding the discussion for protections of vulnerable populations as well as risk/benefit ratio and consent issues that are included in the criteria for approval;
2. Review of the IRB minutes to assure that quorum was met and maintained;
3. Review of IRB documentation, including IRB minutes, to assess whether privacy provisions, according to HIPAA, have been adequately reviewed, discussed and documented;
4. Evaluating the continuing review discussions to assure they are substantive and meaningful and that no lapse has occurred since the previous IRB review;
5. Reviewing IRB files to assure retention of appropriate documentation and consistent organization of the IRB file according to current policies and procedures;
6. Reviewing the IRB database to assure all required fields are completed accurately;
7. Verifying IRB approvals for collaborating institutions or external performance sites;
8. Reviewing the appropriate metrics (for example, time from submission to first review) to evaluate the quality, efficiency, and effectiveness of the IRB review process;
9. Reviewing the workload of IRB staff to evaluate appropriate staffing level; and
10. Other monitoring or auditing activities deemed appropriate.

The HRPO/HRPP Director and IRB Chair will review the results of IRB compliance reviews with the IRB and the Institutional Official. If any deficiencies are noted in the review, a corrective action plan will be developed by the Director and Chair and approved by the
Institutional Official. The Director will have responsibility for implementing the corrective action plan, the results of which will be evaluated by the Institutional Official.

2.4 HRPP Quality Assessment and Improvement

The HRPO/HRPP Director meets with the IO on a regularly scheduled monthly basis to discuss all HRPO, HRPP, IRB matters, including but not limited to budgets and resources. On an annual basis, a meeting is held by the HRPO/HRPP Director, Assistant HRPO/HRPP Director, RCO, IRB Quality and Compliance Advisor, IO, and other relevant parties as appropriate to discuss whether the need for a quality improvement plan is assessed. If it is determined that a quality improvement plan is needed, it is to be carried out by an individual or committee named by the Institutional Official that assesses compliance and achieving targeted levels of quality, efficiency, and effectiveness of the HRPP (e.g., continuous investigator training; use of IRB-approved consent forms, turn-around time of exemption determinations, etc.). The plan will, at a minimum contain:

- The goals of the quality assessment/improvement plan with respect to measuring effectiveness, identifying opportunities for improvement and achieving and maintaining targeted levels of quality, efficiency, effectiveness and compliance are stated:
  - At least one objective to achieve or maintain compliance is defined
  - At least one measure of compliance is defined
  - The methods to assess compliance and make improvements are described
  - At least one objective of quality, efficiency, or effectiveness is defined
  - At least one measure of quality, efficiency, or effectiveness is defined
  - The methods to assess quality, efficiency, or effectiveness and make improvements are described

Results of the plan report is reviewed by the HRPO/HRPP Director, Assistant HRPO/HRPP Director, RCO, IRB Quality and Compliance Advisor, and the IO, in order to identify trends and to determine if systematic changes are required to prevent re-occurrence. If so, the HRPO/HRPP Director and other relevant parties such the IO, the IRB Chairs will collaborate in the development of a corrective action plan, its implementation, and evaluation of its effectiveness.

The HRPO staff, in conjunction with the Quality and Compliance Advisor is responsible for tracking internal metrics that are informative in considering IRB and investigator efficiency such as the amount of time from receipt of a submission through pre-review, assignment to the IRB, and final approval and the amount of time it takes investigators to develop and submit responses to pre-review and IRB requirements. Metric reports will be provided to the HRPO/HRPP Director, Assistant Director, and IRB Chair(s) twice per year.

Annually, the HRPO/HRPP Director or Assistant Director, or designee, in collaboration with other relevant parties, will define quality improvement goals for the year. The targeted issues, goals, and means to measure progress are reviewed and discussed in a QA/QI plan. In order to evaluate whether the defined goals are being achieved, the HRPO staff collects, records, and provides a report to the Director for tracking purposes. At the end of each
year, the Directors evaluate whether the respective goals were achieved and adjust the affected processes to correct any deficiencies.

3 Education and Training

3.1 Training / Ongoing Education of IRB Chair, Members, and Staff

Recognizing that a vital component of a comprehensive human research protection program is an education program, the Tulane HRPP is committed to providing training and an on-going educational process for IRB members and the staff of the IRB and HRPP Office, related to ethical concerns and regulatory and organizational requirements for the protection of human subjects.

The University is committed to providing initial and on-going training and education for the IRB Chair(s), IRB Vice-Chair(s), and IRB members, and HRPO staff related to Research ethics concerns, these SOPs, Federal and State regulatory requirements, and the University’s policies for the protection of Human Subjects involved in Research.

**AAHRPP Standards for Accreditation** (Standard I-1, Element I.1.E)

3.1.1 Orientation

New IRB members, including Alternate Members, will meet with the HRPO/HRPP Director or designee for an informal orientation session. At the session, the new member will be given an IRB Handbook, and the following items will be discussed:

- Tulane University Policies and Standard Operating Procedures for its Human Research Protection Program;
- Tulane’s FWA;
- Tulane’s HRPP;
- *The Belmont Report*;
- Applicable Federal & State regulations including:
  - 45 CFR Part 46 – The Common Rule
  - 21 CFR Part 50 – Protection of Human Subjects
- FDA Information Sheets Guidance;\(^5\)
- OHRP Guidance Sheets;\(^6\)
- HIPAA; and
- IRB Electronic Submission System.

New members are required to complete the Initial Education requirement for IRB members before they may serve as a reviewer.

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\(^5\) See FDA Website at: [FDA Information Sheet Guidance for Institutional Review Boards (IRBs), Clinical Investigators, and Sponsors](https://www.fda.gov/regulatory-information/)

\(^6\) See OHRP Website at: [OHRP Regulations and Policy](https://www.ohrp.org/400regulations.aspx)
3.1.2 Initial Education

IRB members, HRPP and HRPO staff must receive and successfully complete the Web-based initial education requirement, which consists of the CITI training modules for the protection of Human Subjects involved in Research for both biomedical and social behavioral Research. Additionally, new IRB Members must attend at least one IRB meeting prior to serving as a reviewer.

3.1.3 Continuing Education

To ensure that oversight of human research is ethically grounded, and the decisions made by the IRB is consistent with current regulatory and policy requirements, training is continuous for IRB members throughout their service on the IRB.

In addition to initial training requirements, IRB members, HRPP and HRPO staff must also satisfy continuing education requirements on an annual basis. Tulane HRPP uses the following activities as a means for offering continuing education to IRB members, HRPP, and HRPO staff:

- In-service training at IRB meetings;
- Annual training workshops and sessions;
- CITI trainings
- Distribution of appropriate publications; and
- Identification and dissemination by the HRPO/HRPP Director and/or HRPO staff of new information that might affect the HRPP, including laws, regulations, policies, procedures, and emerging ethical and scientific issues to IRB members via E-mail, mail, listservs, or during IRB meetings.

- Tulane will provide support to send as many HRPO staff as possible to attend appropriate national and regional conferences on Human Participants Research protections.

IRB Members and HRPO staff that are unable to attend education sessions will be provided the training information and will have the opportunity to make-up any training that they missed.

The activities for continuing education vary on a yearly basis depending on operating budget and areas of need, as determined by the Director or Designee of the Human Research Protection Office. The Director or designee determines which continuing education activities are mandatory for IRB members and staff in a given year. The HRPO staff tracks whether each individual has satisfied the requirements. Fulfillment of training requirements is included as part of the annual evaluation of the performance of IRB members/alternates.

3.2 Training / Ongoing Education of Investigators and Research Team

As stated previously, a vital component of a comprehensive human research protection program is an education program for all individuals involved with research subjects. The Tulane HRPP is committed to providing training and an on-going educational process for investigators and members of their research team related to ethical concerns and regulatory and organizational requirements for the protection of human subjects.

The University Research Compliance Officer serves a role responsible for providing consultation to researchers and board members on legal and procedural compliance, which is delivered through educational training programs.
3.2.1 Initial Education for Research Team Members

Investigators, key personnel, and other members of the research team must complete Tulane required core modules in the CITI Course in the Protection of Human Research Subjects including the module on Conflicts of Interest. Evidence of current training (date of completion within 4 years of application date) for each member of the research team must be included in every new research study application and application for continuing review.

New research plans and applications for continuing review will not be approved from investigators who have not completed the initial education requirement.

While research plans and applications for continuing review will be accepted and reviewed if the investigator holds a current certification of training, final approval will not be granted until all co-investigators and members of the research team have completed the initial education requirement and maintain an up-to-date completion certificate.

In some cases, typically large international studies, it is not possible to have all data collectors complete CITI training, as is required for key personnel on the study. These situations arise when either there is no or limited access to internet, data collection teams are large, and when data collection teams may not be fluent in languages currently offered by CITI. In these cases, a waiver can be requested (as outlined below in Section 3.2.2 Waiver of Initial Education).

However, it is still the PIs responsibility to conduct training with these team members and cover topics related to the informed consent process, privacy and confidentiality, specifically, and other topics as needed depending on the type of study. In addition, it is the PIs responsibility to certify that this training has taken place prior to the beginning of any data collection or research activities where these individuals will be involved.

For studies where this is applicable, the PI should attest to the inclusion of non-Tulane affiliated research team members in the Initial Application for Human Subjects research, and provide as much information as possible related to the training and the PIs oversight of such.

3.2.2 Waiver of Initial Education

If individuals can provide documentation verifying that they have successfully completed Human Subjects Research training equivalent to that required by the University, they may request a waiver of the requirement for Initial Education. This should be indicated in the Additional Information Section of the Initial Application for Human Subjects Research. The HRPO staff will review the documentation and determine if it satisfies organizational standards. However, all investigators or members of their research team must complete the requirements of continuing education as reviewed below.

3.2.3 Continuing Education and Recertification for Research Team members

Investigators, key personnel, and other members of the research team must meet the Tulane continuing education requirement every 4 years after certification of Initial Education for as long as they are involved in human subject research. There is no exception to this requirement.

Individuals must submit to the HRPO evidence of continuing education prior to the expiration of their training certification. New research plans and applications for continuing review will not be accepted from investigators who have not submitted satisfactory evidence of continuing education.
Investigators who are also IRB Chair, IRB members, or HRPO staff will satisfy the training requirements for IRB members and staff described in this policy under Section 3.1.3.
4 Institutional Review Board

All non-Exempt Human Subjects Research conducted Under the Auspices of the Institution must be reviewed and approved by Tulane’s Institutional Review Boards (“IRBs”) prior to the initiation of the Research. Tulane has established the following two Institutional Review Boards (“IRBs”) to ensure the protection of Human Subjects in Research Under the Auspices of the Institution:

- **Institutional Review Board #1 – Biomedical (IRB00000324) (IORG0000197)**: This IRB is delegated to review Human Subject Research for the following areas: (1) clinical trials such as Drug studies; (2) Research involving medical interventions; and (3) the prevention, treatment, or understanding of basic mechanisms of disease.

- **Institutional Review Board #2 – Social/Behavioral (IRB00000339) (IORG0000204)**: This IRB is delegated to review Human Subject Research involving the social sciences, such as sociology, psychology, anthropology, economics, political science, and history.

Tulane’s IRBs follow the same policies and procedures.

Tulane also utilizes the services of off-site IRBs, including:

- **National Cancer Institute (“NCI”) Adult Central IRB (“CIRB”)**: for applicable cooperative oncology group Protocols involving Adult subjects.

- **National Cancer Institute (“NCI”) Pediatric Central IRB (“CIRB”)**: for applicable cooperative oncology group Protocols involving Minor subjects.

- **External IRBs (Independent or Commercial)**: this option is available to Tulane investigators who conduct industry-initiated, industry-sponsored research activities, when use of independent IRB is required by the Sponsor of a particular proposed study or if such reliance benefits TU, its investigators, and/or the research participants (see Section 8.21 for more details).

The authorized off-site IRBs that serve as the IRB-of-Record for Tulane have the same authority as Tulane’s Biomedical IRB and all determinations and findings of the off-site IRBs are equally binding on all Research Under the Auspices of the Institution. Procedures for the off-site IRB are found in Section 24.

The following sections describe the authority, role and procedures of the Tulane University IRB.

**AAHRPP Standards for Accreditation** (Standard I-2 and Standard I-1, Element I.1.C)

Regulations & Guidance: [DHHS 45 CFR §46.103](https://www.codigest.com/15127320)

4.1 IRB Authority

Tulane’s IRBs derive their authority from Tulane policy and Federal Regulations. IRBs authority includes the ability to:

1. Approve, require modifications to secure approval, or disapprove human subjects research activities, including exempt research activities under 45 CFR 46.104 for which
limited IRB review is a condition of exemption (under 45 CFR 46.104(d)(2)(iii), and (d)(3)(i)(C));

2. Require that informed consent is obtained and documented in accordance with regulatory and policy requirements unless the criteria for the waiver or alteration of such requirements has been satisfied and approved by the IRB. The IRB may require that information, in addition to that specifically mentioned in the regulations, be given to the subjects when in the IRB's judgment the information would meaningfully add to the protection of the rights and welfare of subjects;

3. Regarding continuing review:
   a) **For research subject to the 2018 Common Rule:** To conduct continuing review of research requiring review by the convened IRB at intervals appropriate to the degree of risk of the research, but not less than once per year;
   b) **For research subject to other regulations (e.g., pre-2018 Common Rule, FDA, DoJ) or requirements (e.g., grant or contract terms):** To conduct continuing review of research at intervals appropriate to the degree of risk of the research, but not less than once per year;

4. Suspend or terminate approval of research not being conducted in accordance with regulatory or IRB requirements or that has been associated with unexpected problems or serious harm to subjects;

5. Observe, or have a third party observe, the consent process;

6. Observe, or have a third party observe, the conduct of the Research; and

7. Determine whether data or specimens gathered without IRB approval or in association with serious or continuing noncompliance may be published or used for research purposes.

Research that has been reviewed and Approved by the IRB may be subject to further review and Suspension and Disapproval by University officials consistent with University policy (see **Section 9**). However, such officials may NOT approve Research that has not been approved by the IRB. University officials may strengthen requirements and/or conditions or add other modifications to secure University approval or approval by another University committee. Previously approved Research Proposals and/or consent forms must be re-approved by the IRB before initiating the changes or modifications. The IRB Chair(s) makes the determination whether the changes require Convened IRB, re-Review, or Expedited Review.

The authorized off-site IRBs (e.g. the CIRBs that serve as the IRB-of-Record for Tulane’s IRB) have the same authority as the on-site IRBs and all determinations and findings of the off-site IRBs are equally binding on all Research Under the Auspices of the Institution.

Regulations & Guidance: DHHS 45 CFR 46.109; DHHS 45 CFR §46.112; DHHS 45 CFR 46.113; FDA 21 CFR §56.103; 21 CFR §56.109; 21 CFR §56.112; and 21 CFR §56.113
4.2 Roles and Responsibilities

4.2.1 Chair of the IRB

The IO, in consultation and approval with the HRPO/HRPP Director and, as appropriate, IRB members, appoints an IRB Chair and IRB Vice Chair to serve for a renewable term up to three years. Appointment is continuous unless the HRPO/HRPP Director and/or IO determine their appointment is no longer needed, based on annual evaluation, or if the IRB Chair/Vice Chair resigns from the committee.

The IRB Chair should be a highly respected individual, employed by the University, fully capable of managing the IRB, and the matters brought before it with fairness and impartiality. The task of ensuring that the IRB is a respected part of the Institutional community will fall primarily on the IRB Chair. The IRB must be perceived to be fair, impartial and immune to pressure by the Institution's administration, the Investigator whose Protocols are brought before it, and other professional and nonprofessional sources.

The criteria used to select an IRB Chair include experience with, and knowledge of, applicable Federal and State laws and regulations, and Institutional policies as well as human subjects research experience. Additional criteria include willingness to commit to the IRB; past experience as an IRB member; and demonstrable excellent communication skills, along with an understanding of Human Subjects Research. The IRB Chair must also be flexible and demonstrate a thorough understanding of ethical issues involved in Human Subjects Research.

The IRB Chair convenes and chairs the meetings of the IRB and is required to attend a majority of the convened meetings of the IRB. The IRB Chair may conduct or delegate Expedited Review of Research that qualifies for such review; review the responses ofInvestigators to contingencies of the IRB (to secure IRB approval); and to review and approve Minor Changes in previously approved Research during the period covered by the original approval. The IRB Chair may delegate such authority to the authorized IRB Vice Chair or designee, as needed.

The IRB Chair is a signatory for correspondence generated by the IRB and may delegate signatory authority to the IRB Vice Chair and/or the HRPO/HRPP Director. The IRB Chair may designate other IRB members to perform duties, as appropriate, for review and other IRB functions.

The IRB Chair advises the IO and the HRPO/HRPP Director about IRB Member performance and competence.

The performance of the IRB Chair will be reviewed on an annual basis by the HRPO/HRPP Director in consultation with the IO (as completed using the IRB Chair Evaluation Form (TU Form 202). If the IRB Chair is not functioning in accordance with the IRB’s mission, policies and procedures; has an undue number of absences; or is not fulfilling the responsibilities of IRB Chair, then he/she will be removed by the IO and replaced by a suitable alternative.

4.2.2 Vice Chair of the IRB

The Vice Chair of the IRB (“IRB Vice Chair”) is an IRB member appointed by the IO to serve as IRB Chair in the absence of the IRB Chair. The IRB Vice Chair shall meet the same criteria for selection, qualifications, authority, and duties as IRB Chair. As of the issuance date of these SOPs, there is a designated IRB Vice Chair for both the Biomedical IRB and Social/Behavioral IRB.


4.2.3 IRB Members

The role of an IRB member is to ensure that human research activities comply with federal regulations, state and local laws, and Institutional policies and procedures, by:

1. Completing member education and training, both initial and on-going (See Section 3).
2. Maintaining the confidentiality of IRB deliberations and research review by the IRB.
3. Conducting and documenting reviews of assigned research in a timely fashion.
4. Attending IRB meetings as scheduled.

Members should attend all meetings for which they are scheduled. If a member is unable to attend a scheduled meeting, they should inform the HRPO staff, IRB Chair, or IRB Vice Chair.

If an IRB member is to be absent for an extended period of time, he or she must notify the HRPO at least 30 days in advance so that an appropriate alternate/replacement can be obtained. If the member has a designated alternate, the alternate can serve during the primary member’s absence.

1. Recusing self from final deliberations and vote when s/he has a conflict of interest (Refer to Section 4.6 and 21.6 for IRB member conflict of interest policies).
2. Participating in subcommittees of the IRB if requested and available.
3. Conduct themselves in a professional and collegial manner.

IRB members’ performance will be reviewed on an annual basis by the IRB Chair(s) and HRPO/HRPP Director, with feedback from such review shall be provided to the IRB member under review (use the **IRB Committee Member Performance Evaluation Form** (TU Form 203)). IRB members who are not acting in accordance with the IRB(s) mission, the HRPP or IRB policies and procedures, or who have an undue number of absences will be removed.


4.2.4 Alternate members

The appointment and function of Alternate Members is the same as that of regular IRB members and the alternate’s expertise and perspective are comparable to those of the regular member. The area of expertise of the alternates should match that of the regular member such that the Federal policy requirements are met if a regular member cannot attend an IRB meeting. The role of the Alternate Member is to serve as a voting member of the IRB when the regular member is unavailable to attend a convened meeting. When an Alternate Member substitutes for a primary member, the Alternate Member will receive and review the same materials prior to the IRB
meeting that the regular member received or would have received. The minimum attendance requirement does not apply to alternate members.

The IRB roster identifies the regular member(s) for whom each Alternate Member may substitute. The Alternate Member will not be counted as a voting member unless the regular member is absent. The IRB minutes will document when an Alternate Member has replaced a regular member. The length of term of the alternate will be the same as the term of the voting member.

Experienced alternate members may be designated by the Chair to conduct expedited reviews.

4.2.5 Subcommittees of the IRB

The IRB Chair(s), in consultation with the HRPO/HRPP Director, may designate one or more IRB Subcommittees of the IRB to perform duties, as appropriate, to review and undertake other IRB functions, and to make recommendations to the IRB for Research that is not Expedited or Exempt. If the IRB Chair creates one or more IRB Subcommittees, the Chair shall also appoint a Chair of the IRB Subcommittee (“IRB Subcommittee Chair”). The number and composition of the IRB Subcommittee members shall depend on the authority delegated by the IRB Chair(s) to such IRB Subcommittee (e.g., merely making recommendations versus decision-making authority). If the IRB Subcommittee has decision-making authority, then its members and composition must comply with the requirements specified in Section 4.5 of these SOPs. Members of the IRB Subcommittee must be experienced in terms of seniority on the IRB and must be matched as closely as possible with their field of expertise to the study assigned to the IRB Subcommittee.

If the IRB Chair(s) create one or more IRB Subcommittees, they shall also indicate whether it is a standing or ad hoc IRB Subcommittee.

4.3 IRB Membership

IRB members are selected based on appropriate diversity, including consideration of race, gender, and cultural backgrounds; varied community involvement and affiliations; knowledge and experience with Vulnerable Populations; and with multiple, diverse professions or specialties, including both Scientific Members and Non-Scientific Members. The structure and composition of the IRB must be appropriate to the nature of the Research that is reviewed. Every effort is made to have member representation that has an understanding of the areas of specialty that encompasses the types of Research performed at the University. The University has procedures (See Section 4.3) that specifically outline the requirements for Protocol review by individuals with appropriate scientific or scholarly expertise beyond or in addition to that available through the IRB members.

In addition, the IRB will include members who are knowledgeable about and experienced in working with subjects vulnerable to coercion or undue influence (e.g., children, prisoners, individually with impaired decision-making capacity, or economically or educationally disadvantaged persons) that typically participate in University Research.

The IRB must promote respect for its advice and counsel in safeguarding the rights and welfare of Human Subjects and possess the professional competence necessary to review specific Research activities. Ideally, a single member of the IRB could exhibit a profile that fulfills multiple specific requirements for IRB composition.
Individuals from SPA and the Office of Development may not serve as members of the IRB or carry out day-to-day operations of the review process. Individuals from these offices may provide information to the IRB and attend IRB meetings as guests. An IRB Member from the Technology Transfer Office can serve on the IRB but is required to recuse him/herself from the vote and discussion for any studies that he/she is or had some type of involvement.


Regulations & Guidance: DHHS 45 CFR §46.107; FDA 21 CFR §56.107

4.4 Definitions

**Affiliated IRB Member:** is an employee or agent of Tulane University (or a member of that person’s immediate family). Affiliated members include, but are not limited to individuals who are: Full- or part-time employees; current students; members of any governing panel or board of the institution; paid or unpaid consultants; health care providers holding credentials to practice at the institution; and, volunteers working at the institution on business unrelated to the IRB.

**Alternate Member:** is an individual who has the experience, expertise, background, professional competence, and knowledge comparable to that of the primary IRB member(s) whom the alternate would replace.

**Non-Scientific Member:** is any IRB Member who has formal education and training in a discipline generally considered to be non-scientific (e.g. humanities, law, business) and/or is engaged in an occupation or role that is generally considered to be non-scientific (e.g. law enforcement, minister).

**Scientific Member:** is an individual who has formal education and training in scientific areas, such as a physician, other medical professional, physical scientist, biological scientist, or social behavioral scientist.

4.5 Composition of the IRB

1. The IRB will have at least five members with varying backgrounds to promote complete and adequate review of Research activities commonly conducted by the Institution.

2. The IRB will be sufficiently qualified through the experience, expertise of its members, and the diversity of the members, including consideration of race, gender, cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of Human Subjects.

3. In addition to possessing the professional competence necessary to review specific Research activities. The IRB will be able to ascertain the acceptability of proposed Research in terms of Institutional policies and regulations, applicable law, and standards of professional conduct and practice. The IRB will therefore include persons knowledgeable in these areas.

4. The IRB will include members who are knowledgeable about and experienced working with subjects vulnerable to coercion or undue influence (e.g., children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons) that are regularly included in the research under its review. When
Protocols involve populations who are vulnerable to coercion or undue influence, if the IRB Reviewer feels it is necessary, the review process will include consulting with one or more individuals who are knowledgeable about or experienced in working with these Participants, either as members of the IRB or as consultants (see Section 8.4.7.3 and Section 12).

5. Every nondiscriminatory effort will be made to ensure that the IRB does not consist entirely of men or entirely of women, including the Institution's consideration of qualified persons of both sexes, so long as no selection is made on the basis of gender. The IRB shall not consist entirely of members of one profession.

6. The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in non-scientific areas.

7. The IRB includes at least one member who is not otherwise affiliated with Tulane and who is not part of the immediate family of a person who is affiliated with Tulane.

8. The IRB includes at least one member who represents the general perspective of Participants.

9. One member may satisfy more than one membership category.

10. HRPO staff members with the requisite qualifications for IRB membership may be voting members of the IRB.

Composition of the IRB are periodically reviewed and adjusted as appropriate and on an annual basis, the IRB Chair and the HRPO/HRPP Director review the membership and composition of the IRB to determine if they continue to meet regulatory and Institutional requirements (using the IRB Committee Member Performance Evaluation Form (TU Form 203). Members receive documented feedback on their performance as reviewers following this annual review.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.F and Standard II-3),

Regulations & Guidance: DHHS 45 CFR §46.107; FDA 21 CFR §56.107

4.5.1 Appointment of New IRB Members

The IO, in consultation with the IRB Chair(s) and HRPO/HRPP Director, is responsible for selecting individuals from the pool of appointees to serve as a new IRB member (and indicate whether regular member or alternate member). The IO, in consultation with the IRB Chair(s) and HRPO/HRPP Director, is responsible for removing individual IRB Members before the end of their term of appointment, as appropriate.

Appointments are for an up to three-year period of service, after which the IO may elect to extend the member’s appointment for another up to three-year period. The term can be extended with the agreement of the IO and the IRB Member. Extensions can be for another entire term or for a shorter term. Removal by the Chair, IRB Director, or IO requires written notification. Members may resign by written notification to the IRB Chair, HRPO/HRPP Director, and IO.

On an annual basis, the IRB Chair and the HRPO/HRPP Director shall review the membership and composition of the IRB to determine if they continue to meet regulatory and Institutional requirements.
4.5.2 Documentation and Information for New IRB Members

The following items are required from each member of the IRB at initial appointment and as directed and will be made available as appropriate, upon request for audit:

1. Current *curriculum vitae* (“CV”) initially and upon reappointment;
2. Attendance of at least half of the regularly scheduled IRB meetings unless otherwise approved by the HRPO/HRPP Director during the course of a year (upon reappointment). However, this minimum attendance requirement does not apply to alternate members. The member is to contact the HRPO of any potential absence as far in advance as possible;
3. Participation in the required initial training and new IRB member orientation must occur prior to review of any Research; and
4. Documentation of current Institutional certification in compliance education in the conduct of Human Subjects Research (e.g., CITI Training).

Documents supporting final appointments along with records of continuing education will become part of the permanent membership records maintained by HRPO. The IRB membership will be reviewed at least annually. Required changes will be reported to the OHRP.

**AAHRPP Standards for Accreditation** (Standard II-1, Element II.1.A)

4.5.3 IRB Registration Updates

Changes in IRB membership will be reported to FDA and OHRP by the HRPO/HRPP Director or Designee as follows:

1. A University decision to disband a registered IRB that it is operating will be reported in writing within 30 days after permanent cessation of the IRB’s review of DHHS-conducted or –supported Research.
2. If an FDA-regulated IRB decides to review additional types of FDA-regulated products (e.g., to review device studies if it only reviewed drug studies previously) or to discontinue reviewing clinical investigations regulated by FDA, it must report this within 30 days of the change.
3. Within 90 days after changes regarding the contact person who provided the IRB registration information or the IRB Chair;
4. To register any additional IRB before it is designated under an FWA and reviews Research conducted or supported by DHHS or regulated by FDA.
5. Within 90 days of a change in the membership roster if that IRB is designated under an FWA.

4.6 IRB Member Conflict of Interest

The University has established policies and procedures for review, management and oversight of any potential Conflict of Interest (“COI”) and/or Institutional Conflict of Interest (“ICOI”). The University policies on Conflict of Interest (available at Tulane University Conflict of Interest Policies) and Institutional Conflict of Interest (available at Tulane University Conflict of Interest Policies)
Policies are to be followed in all aspects of review, oversight, and conduct of Human Subject Research under the auspices of the University. These policies apply to Research Oversight Officials responsible for research oversight under the auspices of the University.

4.6.1 Definitions

Conflict of Interest: a set of circumstances in which the professional interests or duties of an individual, such as professional obligations or judgment owed to the University and its constituencies by a faculty member, staff member, or affiliated Investigator, are compromised by, or could reasonably be perceived as being compromised by, his or her leadership role(s), financial interest(s), research leadership role(s), or research financial interest(s). [Tulane University COI Policy, Part A(V)].

Institutional Research Conflict of Interest: An Institutional Research Conflict of Interest exists whenever the financial interests of the University, or of University Research Official acting within his or her authority on behalf of the University, could directly and significantly affect or reasonably appear to affect University processes for the design, conduct, reporting, review or oversight of research. [Tulane University ICOI Policy, Section II].

Research Oversight Officials: include all faculty and staff of any institutional office or body (for instance, all IRB, IACUC, and IBC members) at the University who perform research oversight functions in which they exercise professional or administrative-level discretion. [Tulane University COI Policy, Part D(I)].

4.6.2 Policy

No IRB Member may participate in the review (initial, continuing, or modification) of any Research project, including review by the expedited procedure, review of unanticipated problems involving risk to subjects or others, and review of non-compliance, in which the member has a Conflict of Interest (“COI”) or Institutional Conflict of Interest (“ICOI”), except to provide information as requested. It is the responsibility of each IRB member to disclose any COI and/or ICOI for a study submitted for review and recuse him/herself from the deliberations and vote by leaving the room.

Matters concerning financial COI and ICOI involving IRB members are governed by the Institution’s COI Policy Part D “Policy for Conflicts of Interest of Research Oversight Officials” and ICOI Policy (both available at Tulane University Conflict of Interest Policies). IRB members may find themselves in any of the following COI and/or ICOI when reviewing a Research project:

1. Where the member or consultant is involved in the design, conduct, and reporting of the Research project being reviewed;
2. Where an immediate family member of the member or consultant is involved in the design, conduct, and reporting of the Research project being reviewed;
3. Where the member holds significant Financial Interests (See Section21 for a definition) related to the Research project being reviewed; and
4. Any other situation where an IRB member believes that another interest conflicts with his or her ability to deliberate objectively on Research project being reviewed.
It is the responsibility of each IRB member to disclose any COI and/or ICOI with a Research project submitted for review, and recuse him/herself from the deliberations and vote on the Research project by leaving the room, which departure is noted in the minutes.

The IRB Chair, will poll IRB members at each convened meeting to determine if a COI or ICOI exists regarding any Research project to be considered during the meeting and reminds the committee that members with conflicts should recuse themselves by leaving the room during the discussion and vote of a specific Research project. IRB members with a conflicting interest are excluded from being counted towards Quorum for the discussion and vote on a Research project. All recusals by members with COI or ICOI are recorded in the minutes with an indication that a conflict of interest was the reason for the absence. If requested to do so by the IRB, a recused IRB member may be called back into the meeting room to answer questions if desired by the members present; however, the recused IRB member will then exit the meeting room for the remainder of the discussion and vote.

If the Conflict of Interest status of an IRB member changes during the course of a study, the IRB Member is required to declare this to the IRB Chairs and/or HRPO/HRPP Director of the HRPO.

AAHRPP Standards for Accreditation (Standard II-1, Element II.1.D)

Regulations & Guidance: DHHS 45 CFR §46.107(e); FDA 21 CFR §54; 21 CFR §56.107(e)

4.7 Use of Consultants

A “Consultant” is an individual with competence in a special area that the IRB has invited to assist in the review of issues which require expertise beyond or in addition to the availability on the IRB. These individuals do not count for IRB quorum purposes and cannot vote on any issue before the IRB [45 CFR §46.107(f)].

When necessary, the IRB Chair or the HRPO/HRPP Director may solicit advice or otherwise engage individuals to assist the IRB in its review of issues or IRB Proposals, which require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB.

The need for an outside reviewer is determined in advance of the IRB meeting by the HRPO/HRPP Director, HRPO Assistant Director or IRB Chair by reviewing the IRB Proposals scheduled to be reviewed at the convened meeting. The HRPO will ensure that all relevant materials are provided to the outside reviewer prior to the convened IRB meeting.

Outside reviewers or consultants can be obtained either within or outside the University community. In the event that additional scientific or scholarly expertise cannot be obtained for a Research Proposal the IRB Chair, HRPO/HRPP Director or HRPO Assistant Director will defer the Proposal to the next IRB meeting in order that appropriate review may be obtained.

The HRPO/HRPP Director or designee will review the COI Policy for IRB members (see Section 4.6) with consultants. Consultants must verbally confirm to the HRPO/HRPP Director or designee that they do not have a COI prior to review. Individuals who have a COI or whose spouse or family members have a COI in the Research will not be invited to provide consultation.
The consultant’s findings will be presented to the Convened IRB for consideration either in person or in writing. If in attendance, these individuals will provide consultation but may not participate in or observe the vote.

Ad hoc or informal consultations requested by individual members (rather than for Convened IRB Review) will be requested in a manner that protects the Researcher’s confidentiality and is in compliance with the IRB COI policy (unless the question raised is generic enough to protect the identity of the particular PI and Research Proposal).

To the extent that written statements or recommendations are provided by a consultant, a copy will be kept in IRB Records. Key information provided by consultants at meetings will be documented in the minutes. Written reviews provided by the outside reviewer will be filed with the Protocol.

AAHRPP Standards for Accreditation (Standard II-1, Elements II.1.B and II.1.D)

Regulations & Guidance: DHHS 45 CFR §46.107(f); FDA 21 CFR §56.107(f)

4.8 Insurance Coverage for Research Oversight Activity

The University maintains insurance that covers IRB members, the IRB Chairs, the IO, the HRPO/HRPP Director, Institutional Agents, the RCO, and HRPO staff with respect to their acts and omissions taken within their scope of their employment/service or authorized activity taken under this document. The University’s Risk Management Department should be timely notified of any potential or actual claims as per the University’s Risk Management Department Guidelines.

4.9 Reporting and Investigation of Allegations of Undue Influence

If an IRB Chair, IRB member, or HRPO staff person feels that the IRB or IRB member has been unduly influenced, then he/she shall make a confidential report to the RCO and/or HRPO/HRPP Director. Additionally, an IRB Chair, IRB member, or HRPO staff person may report concerns of undue influence via the University’s hotline, whereby any complaints, concerns, or comments can be submitted anonymously: 1-855-546-9283 or www.MyComplianceReport.com (Access I.D. is “TUL”).

The allegations shall be investigated by the RCO (who shall consult with the HRPO/HRPP Director, IRB Chair(s), General Counsel, and others as appropriate) to consider whether undue influence exists and, if so, determine what recommended corrective action should be taken. Such findings and recommendations will be reported to the IO for a final decision.
5 IRB electronic submission system

5.1 Background Regarding IRB Electronic Submission System
Tulane has adopted an electronic online system to administer and manage IRB matters. The system offers electronic management of Protocols and documents; on-line submissions; web-based Protocol sharing and collaboration; automatic notifications; the furnishing of electronic signatures; event tracking; IRB Meeting Agendas, IRB Meeting Minutes, and IRB Member reviews of submissions to the IRB, and other important electronic features to facilitate oversight of Human Subjects protections at the Institution. The University uses an electronic system to reduce manual and paper-based procedures, streamline and standardize Protocol submission, and review processes throughout the Research lifecycle. IRB decisions are communicated through the electronic system. The electronic system generates decision letters pursuant to the IRB Chair's electronic signature and approval.

The actual signature by the IRB Chair(s) is not required for this document to be effective. This process is consistent with Federal Regulations and Tulane Standard Operating Policies with respect to the IRB and Human Research Protection Office, which consider electronically generated documents as official notices to sponsors and others of approval, disapproval or other IRB decisions.

5.2 Mandatory Electronic Submissions
All submissions to be reviewed by the Tulane IRB must be submitted electronically via the electronic system. All Protocols (including revisions and renewals) must be submitted electronically via the electronic system, and all review decision notifications will be issued electronically via the system.

5.3 IRB electronic submission system User Guide and Training
When the new system is implemented there will be weekly training sessions for the research community to learn the new system. Once those trainings are completed, a user guide will be created and available to assist researchers with the electronic system. The User Guide will be available online on the Tulane Research personnel are to contact the HRPO with all questions or concerns regarding the system or the User Guide.
6 Human Subjects Research and Engagement Determination

The responsibility for an initial determination as to whether an activity constitutes Human Subjects Research rests with the PI. The PI should make this determination based on the definitions of Human Subject and Research contained in Section 1.4. Since the University and Sponsor will hold the PI responsible if the determination is not correct, PIs are required to request a determination from the HRPO that an activity does not constitute Human Subjects Research.

To utilize this service, the PI must submit a Human Subjects Research Determination Form via the IRB electronic submission system for a determination if the proposed research meets the definition of Human Subjects Research. The HRPO staff will review the submitted information and determine if it does or does not meet the definition of Human Subjects Research. The PI will then receive an official letter containing the outcome of the Human Subject Research determination, generated within the IRB electronic submission system.

Determinations as to whether an activity constitutes Human Subjects Research will be made according to the definitions in Section 1.4 and using the Does My Project/Research Need IRB Approval? (TU Form 703). HRPO determinations regarding activities that are either clearly or clearly not Human Subjects Research, based on this guidance document (TU Form 703), will be made by the Chair (or their designee). Determinations regarding less clear-cut activities will be referred to the Chair, who may make the determination or refer the matter for Convened IRB Review. If a clear determination cannot be made, then, out of an abundance of caution, the activity should be deemed to constitute Human Subjects Research for further review (e.g., Exempt, Expedited or Convened IRB Review).

Note: With the implementation of the revised Common Rule, the requirement of the Newborn Screening Saves Lives Reauthorization Act of 2014 that federally funded "research on newborn dried blood spots shall be considered research carried out on human subjects" is eliminated. Whether such research involves human subjects shall now be considered using the same standards as are used for other research involving human biospecimens (e.g., whether the identity of subjects may be readily ascertained, whether the specimens are coded and who has access to the key, whether the research involves the evaluation of the safety or effectiveness of an FDA-regulated device, etc.).

Documentation of all determinations made of whether activity constitutes Human Subjects Research are recorded and maintained by the HRPO. Formal submissions will be responded to in writing and a copy of the submitted materials and determination letter will be kept on file.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.A)

Regulations & Guidance: DHHS 45 CFR §46.101(a); FDA 21 CFR §56.101
7 Exempt Studies

While all Research using Human Subjects must be approved by the Institution, certain categories of Research (i.e., “Exempt Research”) do not require Convened IRB Review and approval. Exempt Research is subject to Institutional review and must be determined and approved by either the IRB Chair, HRPO/HRPP Director, HRPO Assistant Director (or their designee). The designee may be a voting member of the IRB or an HRPO staff member (regardless of voting status). Designees may also include non-Tulane employees. Individuals involved in making the determination of an IRB Exempt status of proposed Research cannot be involved in the proposed Research. Reviewers cannot have any conflict of interest. Note: For Exemptions 2(iii) and 3(i)(C) limited IRB review, i.e., by an IRB member or the convened IRB, is required for privacy and confidentiality protection under 45 CFR 46.111(a)(7).

Unless otherwise required by law or by Federal department or agency heads, exempt studies are exempt from the requirements of the Common Rule (i.e., IRB approval and full research consent are not required) other than as specified within the regulations (e.g., the conditions that permit exemption, and when limited IRB review is required). Exempt research is not exempt from ethical considerations, such as honoring the principles described in the Belmont Report. The individuals making the determination of exemption will determine whether to require additional protections for subjects in keeping with ethical principles (e.g., requiring disclosure/consent, etc.).

Any Exempt study may be referred to a Convened board if the Reviewer feels it is necessary.


Regulations & Guidance: DHHS 45 CFR §46.104

7.1.1 Limitations on Exemptions

Children: Exemption #2(i) and (ii) for research involving survey or interview procedures or observations of public behavior does NOT apply to research in children, except for research involving observations of public behavior when the investigator does not participate in the activities being observed. Exemption #2(iii), where identifiable information is obtained and the IRB conducts a limited IRB review, is NOT applicable to research in children. Exemption #3 does NOT apply to research involving children. [45 CFR 46.104(b)(3)]

Prisoners: Exemptions do not apply except for research aimed at involving a broader subject population that only incidentally includes prisoners. [45 CFR 46.104(b)(2)]

7.1.2 Categories of Exempt Research

With the above-referenced limitations and any other limitations or restrictions due to applicable law, regulation, or agency policy, research activities not regulated by the FDA (see Section 1.4, 7.13, and 13 for FDA Exemptions) in which the only involvement of human subjects are determined to be in one or more of the following categories may be determined exempt:

Reminder: Such Research is Exempt from IRB review, but still requires Institutional review.
1. Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students’ opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
   
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 .111(a)(7): When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

3. (i) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:
   
   A. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
   B. Any disclosure of the human subjects’ responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, educational advancement, or reputation; or
   C. 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 .111(a)(7): When appropriate, there are
adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(ii) 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.

(iii) 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.

4. Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

   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, subparts A and E, for the purposes of “health care operations” or “research” as those terms are defined at 45 CFR 164.501 or for “public health activities and purposes” as described under 45 CFR 164.512(b); or

   iv. The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for non-research 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. 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. 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.

Note: Exempt categories 7 & 8 have not been adopted by this institution at this time.

7.1.3 FDA Exemptions

The following categories of Clinical Investigations are Exempt from the FDA requirements of IRB review; they are not, however, exempt from HRPO review or from responsible and ethical conduct and require an exemption determination by the HRPO before exempt research can proceed as outlined in this section:

1. **Emergency use of a Test Article:** provided that such Emergency Use is reported to the IRB within 5 working days. Any subsequent use of the Test Article at the Institution is subject to IRB review. [FDA 21 CFR §56.104(c)] See Section 13 for a detailed discussion of this Exemption.

2. **Taste and Food Quality Evaluations and Consumer Acceptance Studies,**

   a. if wholesome foods without additives are consumed; or

   b. if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or
below the level found to be safe, by the FDA or approved by the EPA or the Food Safety and Inspection Service of the U.S. DOA. [FDA 21 CFR §56.104(d)]

7.1.4 Additional Protections

Although Exempt Research is not covered by the Federal regulations, this Research is not Exempt from the ethical guidelines of the Belmont Report. The individual making the determination of Exemption will determine whether to require additional protections for subjects in keeping with the guidelines of the Belmont Report.

7.1.5 Procedures for Exempt Review

In order to obtain an Exemption determination, Investigators must submit the following:

1. A completed Initial Application for Human Subjects Research;
2. All recruitment materials (e.g., recruitment script, flyer, etc.);
3. Biomedical Consent Form (TU Form 402) and Social/Behavioral Consent Form (TU Form 403) when appropriate;
4. All surveys, survey questionnaires, survey instruments, etc.;
5. Letters of permission from each non-Tulane performance site;
6. If the Research is sponsored, one copy of the application(s) submitted to the sponsor and/or award document (e.g., grant, contract or collaborative); and
7. Verification of current human research protection training (e.g., CITI or CITI- equivalent as approved by the HRPO) for all members of the research team (i.e., Investigators, Key Personnel and Other Study Personnel).

The IRB Chair, HRPO/HRPP Director, HRPO Assistant Director (or designee) reviews all requests for Exemption and determines whether the request meets the criteria for Exempt Research.

To document the reviewer’s determination of the request for Exempt Research, he/she completes the Exempt Reviewer Worksheet (TU Form 508). The reviewer verifies on the Form whether the submission meets the definition of Human Subjects Research. If the request meets the definition of Human Subjects Research, the reviewer indicates whether the request for exemption was approved or denied, and, if approved, the rationale for the determination and category under which it was permitted. The Reviewer has the authority to make the determination that any protocol submitted under Exempt Review must be reviewed by the IRB.

When the research requires limited IRB review or a HIPAA determination (i.e., waivers or alterations of the requirement for HIPAA authorization), the review may be conducted using expedited review procedures by the IRB Chair or an experienced Chair-designated member of the IRB. As with all other research subject to IRB review requirements, when conducting limited IRB review the IRB has the authority to approve, require modifications in (to secure approval), or disapprove all research activities; and to suspend or terminate IRB approval. Actions of disapproval may only be made by the convened IRB. [45 CFR 46.109(a), 45 CFR 46.110]

Proposed modifications to the aspects of research subject to limited IRB review must be submitted to and approved by the IRB prior to implementation, except when necessary to eliminate apparent
immediate hazards to the subject(s), in which case the change must be promptly reported to the IRB (i.e., no more than 10 business days). [45 CFR 46.108(a)(3)(iii)]

Continuing review is generally not required for research determined to be exempt, even when that research is subject to limited IRB review. However, the IRB may determine that continuing review is required for a particular study subject to limited IRB review, in which case it shall document the reasons for its determination in the IRB record and communicate the requirement to the investigator in the IRB determination letter. [45 CFR 46.109(f)(ii), 45 CFR 46.115(a)(3)]

Investigators will be provided feedback by email as to the qualification of the application for exempt status. Once institutional review is completed, the PI will receive a notification via the IRB electronic submission system of the results of the review.

Investigators must submit a request for any proposed modification to the research during the course of the exempt study for a determination of whether or not the modified activity still qualifies for exemption. The Investigator must complete a Study Closure Form (TU Form 602) once the project is finished, so that the University can maintain an accurate database of active research.

8 IRB Review Process

8.1 Policy
All Human Subjects Research conducted Under the Auspices of the Institution must meet the criteria for one of the following methods for review:

- Expedited review (“Expedited” or “Expedited Review”); or
- Full review by a convened IRB (“Convened IRB Review” or “Convened IRB”).

The IRB will ensure that the Research meets all required ethical and regulatory criteria for Initial and Continuing Review and any modifications of approved Research. IRB electronic submission system notifications are the primary source of communication regarding IRB matters.

Any study may be referred to a Convened board if the Reviewer feels it is necessary.

The following describe the procedures required for the review of Research by the IRBs (i.e., where Tulane has not deferred to another IRB). See Section 8.20 and 24 for a description of the procedures for review of Research to the extent that Tulane has deferred to another IRB.

8.2 Definitions

*Enrolled participants*: individuals who are eligible for participation (i.e., meet the inclusion criteria for the study and do not meet any of the exclusion criteria), have given informed consent and participated in some or all of the study procedures (excluding screening procedures where applicable). An individual who fails screening procedures is not considered to be enrolled.

*Minimal Risk (or “Minimum 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.

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

- The level of risks to subjects;
- The Research design or methodology (i.e., adding procedures that are not eligible for Expedited Review (see Section 8.5 for details) would not be considered a Minor Change);
- The number of subjects enrolled in the Research (i.e., not greater than 10% of the total requested in the initial application);
- The qualifications of the research team;
- The facilities available to support safe conduct of the Research;
- Any other factor which would warrant review of the proposed changes by the convened IRB.
**Screen failures:** individuals who have given informed consent and participated only in screening procedures to determine eligibility, but who were determined to be ineligible to take part in the study. Screen failures are not considered to have enrolled in a study.

**Screened participants:** individuals who have given informed consent and participated in screening procedures to determine eligibility. Note that informed consent is required before any data can be collected for screening purposes. A screening process where persons are simply informed of inclusion/exclusion criteria and allowed to self-identify as eligible for enrollment does not require informed consent because no data about the individuals are collected.

**Quorum:** A quorum of the IRB consists of a majority (more than half) of the voting membership, including at least one member whose primary concern is in a non-scientific area. When research involving an investigational new drug is on the agenda for review, a physician should be included in the quorum.

**Suspension of IRB approval:** A suspension of IRB approval is a directive of the IRB to temporarily stop some or all previously approved research activities. Suspended Research studies remain open and require Continuing Review. Investigators must continue to provide reports on Adverse Events and Unanticipated Problems to both the IRB and Sponsors just as if there had never been a Suspension (i.e., all events that need to be reported during a Study need to continue to be reported during the Suspension period). If a Suspension is lifted and IRB approval of the suspended Research Study has expired, a Continuing Review is required before the study may resume.

**Termination of IRB approval:** A termination of IRB approval is a directive of the Convened IRB to permanently stop all activities in a previously IRB approved Research Study. Terminated Research studies are closed and no longer require Continuing Review.

### Expedited Review

Expedited Review (“Expedited Review”) is used by the IRB for either of both of the following:

- Some or all of the Research appearing on the list of categories of Research eligible for Expedited Review and found by the reviewer(s) to involve no more than Minimal Risk; and/or
- Minor Changes in previously approved Research during the period (of one year or less) for which approval is authorized. [DHHS 45 CFR §46.110; FDA 21 CFR §56.110(b)].

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

- The level of risks to subjects;
- The research design or methodology (i.e., adding procedures that are not eligible for Expedited Review (see Section 8.5 for details) would not be considered a Minor Change);
- The number of subjects enrolled in the Research (i.e., not greater than 10% of the total requested in the initial application);
- The qualifications of the research team;
• The facilities available to support safe conduct of the Research;

• Any other factor which would warrant review of the proposed changes by the convened IRB.

Expedited Review does not mean that Institutional review is less rigorous or happens more quickly than Convened IRB Review. OHRP has published decision trees that are available online to help in determining whether a Research Proposal fits the criteria for Expedited Review (see HRPO Website regarding Criteria for Expedited Review (TU Form 702); Decision Trees—Humans Subjects Regulations (TU Form 707); and Types of IRB Review (TU Form 706)).


This Section addresses categories of Research that are eligible for Expedited Review. Inclusion on this list merely means that the activity is eligible for review through the Expedited Review procedure when the specific circumstances of the proposed Research involve no more than Minimal Risk to Human Subjects. The categories in this list below in Paragraphs one (1) through nine (9) apply regardless of the age of subjects, except as noted. The activities listed below should not be deemed to be of Minimal Risk simply because they are included on this list. [63 FR 60364-60367, November 9, 1998].

The Expedited Review procedure may not be used for the following:

• 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 Risk.

• The Expedited Review procedure may not be used for Human Subjects Research that has been classified by the U.S. Government.

• Self-Sponsored (or “Investigator-Initiated,” “Investigator-Sponsored,” or “Unsponsored”): refers to a situation in which the individual Investigator is a Tulane Investigator and is the holder of the IND or IDE and therefore assumes the duties of the Sponsor of the clinical Investigator under the applicable FDA regulations.

The standard requirements for Informed Consent (or its waiver, alteration, or exception) apply regardless of the type of review (i.e., Expedited Review or Convened IRB Review) used by the IRB. However, it should be noted that, while Research that involves Paragraphs one (1) through seven (7) below pertains to both Initial Review and Continuing Review, Paragraphs eight (8) and nine (9) below only pertains to Continuing Reviews.

1. Clinical studies of Drugs and Medical Devices only when condition (a) or (b) is met:
   a. Research on Drugs for which an IND [21 CFR Part 312] is not required. (NOTE: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the produce is not eligible for Expedited Review.)

7 The decision tree can also be found online at: OHRP Decision Charts.
b. Research on Medical Devices for which (i) an IDE [21 CFR Part 812] is not required; or (ii) the Medical Device is cleared/approved for marketing and the Medical Device is being used in accordance with its cleared/approved labeling.

2. Collections of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:

   a. From healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8-week period and collection may not occur more frequently than 2 times per week; or

   b. From other adults and Children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8-week period and collection may not occur more frequently than 2 times per week.

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

   a. Hair and nail clippings in a non-disfiguring manner;

   b. Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;

   c. Permanent teeth if routine patient care indicates a need for extraction;

   d. Excreta and external secretions (including sweat);

   e. Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gum base or wax or by applying a dilute citric solution to the tongue.

   f. Placenta removed at delivery;

   g. Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor;

   h. Supra-and sub-gingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques;

   i. Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings;

   j. Sputum collected after saline mist nebulization.

4. Collection of data through non-invasive 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, ophthalmoscopy, ultrasound, diagnostic infrared imaging, Doppler blood flow, and echocardiography;
e. Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

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

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

7. Research on individual or group characteristics or behavior (including, but not limited to, Research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. [NOTE: Some Research in this category may be Exempt from the DHHS regulations for the protection of Human Subjects. See Exempt Categories and 45 CFR §46.101(b)(2) and (b)(3). This listing refers only to Research that is not Exempt.]

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

Of note, category (8) identifies three situations in which Research that is greater than Minimal Risk and has been initially reviewed by a Convened IRB may undergo subsequent Continuing Review by the Expedited Review procedures.

For a multi-center Protocol, an Expedited Review procedure may be used by the IRB at a particular site whenever the conditions of category (8)(a), (b), or (c) are satisfied for that site. However, with respect to category 8(b), while the criterion that “no subjects have been enrolled” is interpreted to mean that no subjects have been enrolled at a particular site during the approval period, the criterion that “no additional risks have been identified” is interpreted to mean that neither the Investigator nor the IRB at a particular site has identified any additional risks from any site or another relevant source.
9. Continuing Review of Research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply by the IRB has determined and documented at a convened meeting that the Research involves no greater than Minimal Risk and no additional risks have been identified.

Under Category (9), an Expedited Review procedure may be used for Continuing Review of Research not conducted under an investigational new drug application or investigational device exemption where categories (2) through (8) do not apply but the IRB has determined and documented at a convened meeting that the Research involves no greater than Minimal Risk and no additional risks have been identified. The determination that “no additional risks have been identified” does not need to be made by the Convened IRB.

Regulations & Guidance: 63 FR 60364-60367, November 9, 1998

8.3.1 Expedited Review Procedures

Under an Expedited Review procedure, the review may be carried out by the IRB Chair or by one or more reviewers designated by the IRB Chair from among IRB members. IRB members who serve as designees to the IRB Chair for Expedited Review will be matched as closely as possible with their field of expertise to the study under review.

On an annual basis, the IRB Chairs will designate a list of IRB members eligible to conduct Expedited Reviews. The designees must be experienced voting members of the IRB. The Chair (or designee) HRPO/HRPP will select expedited reviewers from that list. Selected reviewers must have the qualifications, experience, and knowledge in the content of the Protocol to be reviewed, as well as be knowledgeable of the requirements to approve Research under Expedited Review. IRB members with a COI in the Research (see Section 4.6) will not be selected to serve as expedited reviewers.

When reviewing Research under an Expedited Review procedure, the IRB Chairs, or designated IRB member(s), should receive and review all documentation that would normally be submitted for Convened IRB Review including the complete Protocol. This includes review of the following: (1) the complete Protocol, (2) for Continuing Review, a Secondary Application for Human Subjects Research that summarizes Research activities since the previous annual review (including modifications and Unanticipated Problems); (3) notes from pre-screening conducted by the HRPO staff; and (4) the current consent documentation. If the Research is subject to the ICH-GCP Guidelines, refer to the HRPO policy entitled “International Conference on Harmonization (ICH) Good Clinical Practices (GCP), Applicability to Human Subjects Research.”

If the Research meets the criteria allowing review using the Expedited Review procedure, the reviewer(s) conducting the Initial or Continuing Review must complete the appropriate Reviewer Sheet (Expedited and Full Board Initial Submission Reviewer Sheet, Expedited and Full Board Continuing Review Reviewer Worksheet, or the Expedited and Full Board Amendment Reviewer Worksheet) to determine whether the Research meets the criteria allowing review using the expedited procedure, and if so, whether the Research meets the regulatory criteria for approval. If the Research does not meet the criteria for Expedited Review, then the reviewer will indicate that the Research requires Convened IRB Review and the
Protocol will be placed on the agenda for the next IRB meeting. The Reviewer has the authority to make the determination that any protocol submitted under Expedited Review must be reviewed by the IRB.

In reviewing the Research, the reviewers will follow the Review Procedures described in Sections 8.5 and 8.6 and may exercise all of the authorities of the IRB except that the reviewers may not disapprove the Research. A Research activity may be disapproved only after review in accordance with the non-Expedited procedure set forth below.

Reviewers will indicate approval, required modifications or referral to Convened IRB on the Expedited and Full Board Initial Submission Reviewer Sheet, Expedited and Full Board Continuing Review Reviewer Worksheet, or Expedited and Full Board Amendment Reviewer Worksheet and return it to the HRPO. If modifications are required, the HRPO staff will inform the Investigator by E-mail via the IRB Electronic System.

In the event that Expedited Review is carried out by more than one IRB member and the expedited reviewers disagree, the IRB Chair may make a final determination. Upon the discretion of the IRB Chair, the Protocol will be submitted to the IRB for Convened IRB Review.

Simple in nature amendments to research protocols may be reviewed and approved by appropriate HRPO/IRB staff who are voting members of the IRB. For purposes of this section, examples of “simple in nature” amendment submissions include, but are not limited to: updated telephone numbers, changes to non-Investigator study personnel, editorial revisions to the recruitment materials, and other non-substantive changes that do not require analysis in accordance with Common Rule or other research regulations.


**Regulations & Guidance:** DHHS 45 CFR §46.110; FDA 21 CFR §56.110; Categories of Research that May Be Reviewed by the IRB through an Expedited Review Procedure—FDA & DHHS; OHRP Guidance on Written IRB Procedures; OHRP Guidance on Use of Expedited Review Procedures; OHRP Guidance on Continuing Review; FDA Guidance on Continuing Review

All members of the IRB will be apprised of all Expedited Review approvals by means of a list in the agenda at the next scheduled meeting. Any IRB member can request to review the full Protocol by contacting the HRPO.

**8.4 Convened IRB Review**

Convened IRB Review (or “Convened IRB”) means review by a fully convened IRB. Except when Exempt or Expedited Review procedure is used, the IRB will conduct Initial and Continuing Reviews of all Research at convened meetings at which a Quorum (see Section 8.4.6 below) of the members is present.

**AAHRPP Standards for Accreditation** (Standard II-2, Elements II.2.D, and II.2.E)

**Regulations & Guidance:** FDA; DHHS 45 CFR 46.108(c)

**8.4.1 IRB Meeting Schedule**

The IRB meets on a regular basis throughout the year. The schedule for the IRB may vary due to holidays, lack of Quorum, or the need for an emergency meeting. The schedule for IRB meetings is found on the Tulane University HRPP Website. Special meetings may be called at any time by the IRB Chair and/or HRPO/HRPP Director or Designee.
8.4.2 Preliminary Review

All submissions by PIs to the IRB are electronically date stamped to confirm the day and time of submission.

The HRPO Staff will perform a preliminary review of all materials submitted to the IRB for determination of completeness and accuracy. Only complete submissions will be placed on the IRB agenda for review.

The Investigator will be informed by the IRB electronic submission system of missing materials and the necessary date of receipt for inclusion on the next agenda. The PI is responsible for providing the HRPO with an active E-mail address and current contact information. In the case of a PI who is submitting a Protocol for the first time or an Investigator who may not be well-versed in the Protocol submission procedures, individualized HRPO consultations can be arranged.

Specific questions regarding the HRPP policies and procedures; determining whether a particular Protocol is Human Subjects Research or not; and which forms are required for a particular study, can be submitted in writing to the HRPO for further information and/or clarification. Individual appointments with the IRB Chair, HRPO/HRPP Director, HRPO Assistant Director and/or HRPO staff can also be arranged and are strongly recommended for first-time submissions.

AAHRPP Standards for Accreditation (Standard II-1, Element II.1.A)

8.4.3 Primary & Secondary Reviewers

After it has been determined that the Protocol submission is complete, the IRB Staff, with the assistance of the HRPO Chair and Vice-Chair, assigns Protocols for review based on the scientific content of the Protocol, the potential reviewer’s area of expertise, and requirements for representation of Vulnerable Populations involved in the Research. For Protocols submitted to the Tulane Biomedical IRB, a primary and secondary reviewer will be assigned only for Biomedical Initial Submissions that qualify for Convened IRB Review. All other submissions will have one primary reviewer. For Protocols submitted to the Tulane’s Social/Behavioral IRB, a Primary Reviewer will be assigned to each Initial Submission/Protocol.

Reviewers may be assigned several Protocols or other research items for review. Reviewers are assigned to all Protocols requiring Initial Review, Continuing Review, and Modifications.

When the IRB is presented with a Protocol which, in the opinion of the IRB Chairs, may be outside of the knowledge base or representative capacity of all the IRB members, an outside consultant will be sought (see Section 4.7 above). Protocols for which appropriate expertise cannot be obtained for a given meeting will be deferred to another meeting when appropriate expertise can be achieved.

Primary and secondary reviewers are responsible for:

1. Having a thorough knowledge of all details of the proposed Research;
2. Performing an in-depth review of the proposed Research and supporting documents;
3. Leading the discussion of the proposed Research at the convened meeting, presenting both positive and negative aspects of the Research, and leading the IRB through the regulatory criteria for approval (see Sections 8.5 and 8.6);
4. Making suggestions for changes to the proposed Research, where applicable. 

**Reviewer Forms** are used as guidance documents in order to facilitate the discussion, suggest changes, and citing regulatory information.

If the primary reviewer will be absent from the meeting, the secondary reviewer may act as the primary reviewer or a new reviewer may be assigned. The primary and secondary reviewers will submit their comments to the IRB.

In the event that there is only one primary reviewer (as in the Social/Behavioral IRB) the Chair or the Chair’s designee will serve as the primary reviewer. In addition, all IRB members have access to all information available to reviewers.

If both the primary and secondary reviewer are absent from the IRB meeting, a new reviewer may be assigned, provided the new reviewer has reviewed the materials prior to the meeting. Typically, the IRB Chair may serve as the primary reviewer in the event that the primary reviewer is absent. Alternatively, an absent reviewer can submit his/her written comments for presentation at a Convened IRB meeting, as long as there is another reviewer present at the convened meeting, who can serve as the primary reviewer. It should be noted that all of the IRB members receive and are expected to review all studies listed on the IRB agenda, not just the ones they are responsible for reviewing.

**AAHRPP Standards for Accreditation** (Standard II-1, Element II.1.A)

**8.4.4 IRB Agenda**

The meeting agenda for the IRB(s) will be prepared by the HRPO Staff under the supervision of the HRPO/HRPP Director, HRPO/HRPP Assistant Director, or Designee and in consultation with the IRB Chair. The IRB agenda will be distributed to the IRB members prior to the scheduled meeting.

**8.4.5 Pre-Meeting Distribution of Documents to IRB Members**

All IRB members receive their IRB materials for review which include the IRB agenda, the prior meeting minutes, applicable business items and audits, appropriate Continuing Review education materials and Protocol review materials no later than five (5) business days before the scheduled meeting to allow sufficient time for the review process. An exception exists in the case of an emergency meeting of the IRB in which the materials should be furnished with as much lead time as reasonable.

All items for Convened IRB Review are available via the IRB electronic submission system to IRB members prior to the meeting. The IRB agenda and minutes from the last meeting are available electronically for viewing.

Each IRB member receives and reviews the following documentation, as applicable, for all Protocols on the agenda:

- Complete Protocol;
- Proposed Consent/Parental Permission/Assent Form(s);
- Recruitment Materials/Subject Information;
- Data Collection Instruments (including all surveys and questionnaires);
At least one Primary Reviewer and/or Secondary Reviewer must receive and review the following:

- Sponsor’s Protocol (if applicable);
- Investigator’s Brochure (if applicable);
- DHHS-approved sample Informed Consent Document (if applicable);
- DHHS-approved Protocol (if applicable);

IRB members have electronic access to all materials provided to the primary and secondary reviewers.

If an IRB member requires additional information to complete the review, they may contact the Investigator directly or may contact the HRPO Staff to make the request of the Investigator.

Protocol Reviewers will use the Expedited and Full Board Initial Submission Reviewer Sheet (TU Form 502, 509, and 510) as a guide to completing their review.

AAHRPP Standards for Accreditation (Standard II-1, Element II.1.E and Standard II-2, Element II.2.E)

Regulations & Guidance: ICH-GCP 8.2.10

**8.4.6 Quorum**

A quorum (“Quorum”) consists of a simple majority (more than half of the voting membership), including at least one member whose primary concern is in a non-scientific area. If a regular IRB member and his/her alternative are present at a Convened IRB meeting, only one counts towards the Quorum and the IRB member (not the alternate) is the only one entitled to vote.

Additional Quorum requirements include the following:

1. If Research involving an FDA-regulated article is involved, a licensed physician must be included in the Quorum; and
2. When reviewing a Protocol in which a Prisoner is a subject or potential subject, at least one IRB member present at the meeting shall be a Prisoner, or a Prisoner advocate/representative with appropriate background and experience to serve in that capacity.
3. For Research that involves mentally disabled persons or persons with impaired decision-making capacity, IRB membership must include at least one member who is an expert in the area of the Research.

At meetings of the IRB, a Quorum must be established and maintained for the deliberation and vote on all matters requiring a vote. The IRB Chair, with the assistance of the HRPO staff, will confirm that an appropriate Quorum is present before calling the meeting to order. The IRB Chair, with assistance of the HRPO Staff, will be responsible to ensure that the IRB meeting remains appropriately convened. If a Quorum is not maintained, the Proposal or pending action item must be deferred or the meeting terminated. The HRPO staff and HRPO/HRPP Director document the time of arrival and departure for all IRB members and notify the IRB Chair if a Quorum is not present. A Quorum Worksheet (TU Form 901) is completed by the IRB Staff.
and/or IRB Chair in advance of the IRB meeting to determine if a Quorum exists to convene an IRB meeting. A Sign-In Sheet (TU Forms 902, 903) is maintained for each convened meeting. Although all members are listed on the Sign-In Sheet, only those members present at the particular IRB meeting sign his/her name to the Sign-In Sheet.

It is generally expected that at least one unaffiliated member and at least one member who represents the general perspective of participants (the same individual can serve in both capacities) will be present at all IRB meetings. Although the IRB may, on occasion, meet without this representation, individuals serving this capacity must be present for more than a majority of the IRB meetings.

IRB members are considered present and participating at a duly convened IRB meeting when either physically present or participating through electronic means (e.g., teleconferencing or video conferencing) that permits them to listen and speak during IRB deliberations and voting. When not physically present, the IRB member must have received all pertinent materials prior to the meeting and must be able to participate actively and equally in all discussions.

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

HRPO staff contact IRB members by E-mail, telephone, IRB electronic submission system, and/or Outlook calendar approximately 7–10 days before a scheduled IRB meeting date to confirm their planned attendance to ensure a Quorum exists.

AAHRPP Standards for Accreditation (Standard II-2, Elements II.2.D and II.2.E)

8.4.7 IRB Meeting Procedures

The IRB Chair, Vice-Chair or designee in the event that the IRB Chair is absent will call the IRB meeting to order, once it has been determined that a Quorum exists.

The IRB Chair or Vice-Chair (designee) will remind IRB members to recuse themselves from the discussion and vote by leaving the room where there is a conflict.

The IRB will review and discuss the IRB meeting minutes from the previous meeting and determine if there are any revisions/corrections to be made. If there are no changes to be made, the minutes will be accepted as presented and considered final. If it is determined that revisions/corrections are necessary, the minutes will be amended and presented at the next IRB meeting.

The IRB reviews all submissions for initial and continuing review, as well as requests for modifications. The Primary and Secondary Reviewer present an overview of the Research and assist the Chair in leading the IRB through the completion of the regulatory criteria for approval in the Expedited and Full Board Initial Submission Reviewer Sheet (TU Form 502, 509, and 510). In order for the Research to be approved, it must receive the approval of a majority of those voting members present at the meeting.

It is the responsibility of the Regulatory Compliance Specialist(s) to record the proceedings of the session. In addition, the Senior Regulatory Compliance Specialist and the Regulatory Compliance Specialist are responsible for taking Minutes at each IRB meeting.

AAHRPP Standards for Accreditation (Standard II-2, Elements II.2.D and II.2.E)
8.4.7.1 Initial & Continuing Review & Requests for Modification

The IRB reviews all submissions for Initial Review and Continuing Review, as well as requests for modifications. The primary reviewer (and a secondary reviewer for initial submissions to the Biomedical IRB) present an overview of the Research and lead the IRB through the completion of the regulatory criteria for approval within the Reviewer Sheets.

In order for the Research to be approved, it must receive the approval of a majority of those voting members present at a duly constituted IRB meeting. It is the responsibility of the HRPO staff to record the proceedings of the session. In addition, the HRPO staff is responsible for taking Minutes at each IRB meeting.

All members attending the meeting are provided electronic access to the study materials to be discussed at the meeting. Members are given the option to access these materials electronically (laptop, tablet, etc.) or can request to be provided with printed versions for the meeting. The criteria for approval worksheet is distributed to each member and the chair refers to it at the beginning and during each meeting.

AAHRPP Standards for Accreditation (Standard II-2, Elements II.2.D, II.2.D and II.2.E)

Regulations & Guidance: DHHS 45 CFR §46.103(b)(4); 45 CFR §46.108(b); 45 CFR §46.109; 21 CFR §56.108; 21 CFR 56.109; OHRP Guidance on Written IRB Procedures; OHRP Guidance on Continuing Review; FDA Guidance on Continuing Review

8.4.7.2 Children

When reviewing a Protocol involving Children, if the IRB Reviewer feels it is necessary, the review process will include consulting with one or more individuals who are knowledgeable about or experienced in working with pediatric populations. Non-voting consultants may be invited to assist with the review if additional expertise is needed.

8.4.7.3 Consultant Advice—Vulnerable Populations

When reviewing studies with other Vulnerable Populations, including Pregnant Women, Fetuses, Neonates, handicapped persons, and cognitively impaired, the IRB will request review by expert consultant, as needed. If the IRB regularly reviews Research involving a vulnerable category of subjects, one or more individuals who are knowledgeable about and experienced in working with these subjects should be included as IRB members (refer to policy on Vulnerable Subjects for more detail Section 12). For Research that involves mentally disabled persons or persons with impaired decision-making capacity, IRB membership must include at least one member who is an expert in the area of the Research.

AAHRPP Standards for Accreditation (Standard II-4, Element II.4.A)

8.4.7.4 Prisoner Representatives

When reviewing a Protocol in which a Prisoner is a subject:

- A majority of the IRB (exclusive of Prisoner members or Prisoner advocates) must have no association with the prison(s) involved, apart from their membership on the IRB.
• At least one IRB member present at the meeting shall be a Prisoner, or a Prisoner advocate/representative with appropriate background and experience to serve in that capacity. Prisoner/prisoner representative must be present and a voting member.

8.4.8 Guests & Ex Officio Guests

At the discretion of the IRB, the PI (or designee such as a sub-investigator) may be invited to the IRB meeting to answer questions about their proposed or ongoing Research. The PI may be present for portions of the discussion in which the overview of the protocol is presented and initially discussed. The PI should not be present for the final deliberation and vote of the study or action under review by the IRB.

Other invited guests may be permitted to attend and observe IRB meetings at the discretion of the IRB Chair and/or HRPO/HRPP Director. Invited guests may not speak unless requested by the IRB and must sign a confidentiality agreement prior to the convened meeting.

Ex-officio members are individuals who, by virtue of their position and their role in the HRPP, regularly attend IRB meetings. Ex-officio members include but are not limited to: the HRPO/HRPP Director, General Counsel Representatives, the Research Compliance Office Representatives, University Privacy Office Representatives, and Sponsored Projects Administration Representatives. Ex-officio members may fully participate in the IRB discussion and deliberation but may not vote.

8.5 Criteria for IRB Approval of Research

In order for the IRB to approve Human Subjects Research, either through the Expedited Review or by the full IRB, it must determine that the following requirements are satisfied:

1. Risks to subjects are minimized:
   a. By using procedures which are consistent with sound Research design and which do not unnecessarily expose subjects to risk; and
   b. 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 (e.g., the possible effects of the Research on public policy) as among those Research risks that fall within the purview of its responsibility.

3. Selection of subjects is equitable. In making this assessment, the IRB should take into account the purpose 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 the Federal Regulations 45 CFR §46.116.

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

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

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

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

These criteria must be satisfied for each review (Initial, Continuing, and Modifications) for both Expedited Review and Review by the Convened IRB.

Regulations & Guidance: DHHS 45 CFR §46.111; FDA 21 CFR §56.111

8.5.1 Risk-Benefit Assessment

The goal of a risk-benefit assessment is to ensure that the risks to Research subjects posed by participation in a Research study are justified relative to the anticipated benefits for the subjects or society. The IRB must:

- Judge whether the anticipated benefit, either of new knowledge or of improved health for the Research subjects, justifies asking any person to undertake the risks; and
- Disapprove Research in which the risks are judged unreasonable in relation to the anticipated benefits.

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

- **Identify the risks** associated with the Research, as distinguished from the risks of therapies the subjects would receive even if not participating in Research;
- **Determine whether the risks to subjects will be minimized** to the extent possible.
- **Identify the probable benefits** to be derived from the Research;
- **Determine whether the risks to subjects are reasonable in relation to the benefits** to subjects, if any, and assess the importance of the knowledge to be gained.
- **Ensure that potential subjects will be provided with an accurate and fair description** of the risks or discomforts and the anticipated benefits (see Section 26.11 for Research related to deception and incomplete disclosure in Research);
- **Note**: If the Research is subject to the ICH-GCP Guidelines, refer to the HRPO policy entitled “International Conference on Harmonization (ICH) Good Clinical Practices (GCP), Applicability to Human Subjects Research.”
Risks to subjects are minimized:

1. By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk; and

2. Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

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

In addition to evaluation of the risks in the research, the IRB determines, based on the materials submitted by the investigator, that research studies have the resources necessary to protect participants, such as adequate time for the researchers to conduct and complete the research, adequate number of qualified staff, adequate facilities, access to a population that will allow recruitment of the necessary number of participants, availability of medical or psychosocial resources that participants might need as a consequence of the research.

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

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

Based on this assessment, risk associated with the Research will be classified as either Minimal Risk or greater than Minimal Risk, which will be based on the interpretation of Minimal Risk.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.F and Standard II-5, Element II.5.A)

Regulations & Guidance: DHHS 45 CFR §46.111(a); FDA 21 CFR §56.111(a)

8.5.1.1 Scientific Merit

In order to assess the risks and benefits of the proposed Research, the Department Head/Department Chair/student faculty advisor, must determine that:

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

The IRB is not responsible for making scientific merit determinations. Scientific review, as confirmed by the PI’s Department/Unit Head/student faculty advisor, is a critical first step in ensuring the merit of a study submitted for approval. Such review must determine that:

- The study is appropriately designed for the intended purpose and has scientific merit;
- The Investigators are appropriately trained and competent to perform the study;
• Adequate funding space and personnel are available to perform the project; and
• The study is appropriate for the subject population to be studied.

Scientific review is documented in the IRB electronic submission system by the electronic signature of the administrative official responsible for the PI’s Department/Unit or student faculty advisor with regards to the initial Protocol applications.

If the PI is a Department Head, then the signature of the Dean of the school is required. If the PI is a Dean, the signature of the Vice President of Research is required. If the PI is a student, a Faculty Advisor must be appointed, and the faculty advisor must electronically sign the event/study through the IRB electronic submission system. If the Faculty Advisor holds an adjunct appointment at the University, the Department Head/Dean must also electronically sign the event/study through the IRB electronic submission system.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.F)

Regulations & Guidance: DHHS 45 CFR §46.111(a)(1); FDA 21 CFR §56.111(a)(1)

8.5.2 Equitable Selection of Subjects

The IRB determines by viewing the IRB Proposal that the selection of subjects is equitable with respect to gender, age, class, etc. The IRB will not approve a study that does not provide adequately for the equitable selection of subjects or has not provided an appropriate scientific and ethical justification for excluding classes of persons who might benefit from the Research. In making this determination, the IRB evaluates: the purpose of the Research; the setting in which the Research occurs; scientific and ethical justification for including Vulnerable Populations such as Children, Prisoners, Pregnant Women, mentally disabled persons, or economically or educationally disadvantaged persons; the scientific and ethical justification for excluding classes of persons who might benefit from the Research; and the inclusion/exclusion criteria.

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

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.C)

Regulations & Guidance: DHHS 45 CFR §46.111(a)(3); FDA 21 CFR §56.111(a)(3)

8.5.3 Recruitment of Subjects

The PI will provide the IRB with all recruiting materials to be used in identifying Participants including recruitment methods, advertisements, and payment arrangements. See Section 8.6.9 for a discussion of IRB review of advertisements, and Section 8.6.9 for a discussion of IRB review of payments/compensation to subjects.

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.C.1)


8.5.4 Informed Consent

The IRB will ensure that informed consent (“Consent” or “Informed Consent”) will be sought from each prospective subject or the subject’s Legally Authorized Representative, in accordance
with, and to the extent required by 45 CFR §46.116 and 21 CFR §50.20. See Section 11. In addition, the IRB will ensure that Consent will be appropriately documented in accordance with, and to the extent required by 45 CFR §46.117 and 21 CFR §50.27 (see Section 11.9 below).

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.F)

Regulations & Guidance: DHHS 45 CFR §46.111(a)(4) & (a)(5); FDA 21 CFR §56.111(a)(4) & (a)(5)

**8.5.5 Data and Safety Monitoring**

For all Research that is more than Minimal Risk, the Investigator must submit a safety monitoring plan. The initial plan submitted to the IRB should describe the procedures for safety monitoring, reporting of Unanticipated Problems Involving Risks to Subjects or Others, descriptions of interim safety reviews and the procedures planned for transmitting the results to the IRB. This description should include information regarding an independent Data and Safety Monitoring Board (“DSMB”), if one exists, or an explanation why an independent data safety monitor is not necessary.

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

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

1. Monitoring is commensurate with the nature, complexity, size and risk involved.
2. Monitoring is timely. Frequency should be commensurate with risk. Conclusions are reported to the IRB.
3. For low risk studies, continuous, close monitoring by the study Investigator or an independent individual may be an adequate and appropriate format for monitoring, with prompt reporting of problems to the IRB, sponsor and regulatory bodies as appropriate.
4. For an individual Safety Monitor, the plan must include:
   - Parameters to be assessed
   - Mechanism to assess the critical efficacy endpoints at intervals in order to determine when to continue, modify, or stop a study.
   - Frequency of monitoring
   - Procedures for reporting to the IRB
5. For a DSMB, the plan must include:
   - The name of the Data Safety Monitoring Board
   - Where appropriate, is independent from the sponsor
• Availability of written reports

• Composition of the monitoring group (if a group is to be used): experts in all scientific disciplines needed to interpret the data and ensure patient safety. Clinical trial experts, biostatisticians, bioethicists, and clinicians knowledgeable about the disease and treatment under study should be part of the monitoring group or be available if warranted.

• Frequency and content of meeting reports

• The frequency and character of monitoring meetings (e.g., open or closed, public or private).

In general, it is desirable for a DSMB to be established by the study Sponsor for Research that is blinded, involves multiple sites, involves Vulnerable Subjects, or employs high-risk interventions. For some studies the National Institutes of Health (“NIH”) require a DSMB. The IRB has the authority to require a DSMB as a condition for approval of Research where it determines that such monitoring is needed. When DSMBs are utilized, IRBs conducting Continuing Review of Research may rely on a current statement from the DSMB indicating that it has and will continue to review study-wide Unanticipated Problems, interim findings, and any recent literature that may be relevant to the Research, in lieu of requiring that this information be submitted directly to the IRB.

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.B)

Regulations & Guidance: DHHS 45 CFR §46.111(a)(6); FDA 21 CFR §56.111(a)(6)

8.5.6 Privacy and Confidentiality

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

AAHRPP Standards for Accreditation (Standard II-3, Elements II.3.D and II.3.E)

8.5.6.1 Definitions

Confidentiality: methods used to ensure that information obtained by Researchers about their Research subjects is not improperly divulged. Do not confuse this Research term with HIPAA Privacy requirements.

Identifiable Information: for research privacy purposes, this means information where the identity of the subject is or may readily be ascertained by the Investigator or associated with the information. This term should not be confused with IIHI used with HIPAA.

Individually Identifiable Private Information: is information where, for Research purposes, the identity of the subject is or may readily be ascertained by the Investigator or associated with the information.

Obtain (or “Obtaining”): means to receive or access Individually Identifiable Private Information (or identifiable specimens) for Research purposes. This includes an Investigator’s use, study, or analysis for Research purposes of Individually Identifiable Private Information (or identifiable specimens) already in the possession of the Investigator.

Privacy: means having control over the extent, timing, and circumstances of sharing oneself (i.e., physically, behaviorally, or intellectually) with others.
**Private Information:** for research privacy purposes, this means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (e.g., a medical record). [45 CFR §46.102(f)]. Do not confuse this Research term with HIPAA Privacy requirements.

**Sensitive Information:** data or information, on any storage media or in any form or format, which requires protection due to the risk of harm that could result from inadvertent or deliberate disclosure, unauthorized access, misuse, alteration, or loss or destruction of the information (e.g., could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subject’s financial standing, employability, or reputation).

### 8.5.6.2 Privacy

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

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

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

**AAHRPP Standards for Accreditation** (Standard II-3, Element II.3.D)

### 8.5.6.3 Confidentiality

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

At the time of Initial Review, the IRB ensures that the Privacy and Confidentiality of Research subjects are protected. The IRB assesses whether there are adequate provisions to protect subject Privacy and maintain Confidentiality. The IRB does this through the evaluation of the methods used to obtain information:

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

The PI will provide information regarding the Privacy and Confidentiality of Research subjects at the time of Initial Review through the completion of Application for review, any necessary HIPAA Forms (TU Form 405), the research Protocol, and/or other submitted, applicable materials. The IRB will review all information received from the PI and determine whether or not the Privacy and Confidentiality of Research subjects is sufficiently protected. In some cases, the IRB may also require that a Certificate of Confidentiality be obtained to additionally protect Research data (See Section 26.1).

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

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.E)

Regulations & Guidance: DHHS 45 CFR §46.111(a)(7); FDA 21 CFR §56.111(a)(7)

8.5.6.4 Vulnerable Populations

At the time of Initial Review, the IRB will consider the scientific and ethical reasons for including Vulnerable Subjects in Research. The IRB may determine and require that, when appropriate, additional safeguards are put into place for Vulnerable Subjects, such as those without decision-making capacity.

For an extensive discussion about the IRB’s review and approval process for individual populations of Vulnerable Subjects, please refer to Section 12.

AAHRPP Standards for Accreditation (Standard II-4, Element II.4.A)

Regulations & Guidance: DHHS 45 CFR §46.111(b); 45 CFR 46 Subpart B, Subpart C & Subpart D; 21 CFR §56.111(b)-(c); 21 CFR 50 Subpart D

8.6 Additional Considerations during IRB Review and Approval of Research

8.6.1 Determination of Risk

At the time of Initial Review and Continuing Review, the IRB will make a determination regarding the risks associated with the Research Proposals. Risks associated with the Research will be classified as either “Minimal Risk” or “greater than Minimal Risk”. The meeting minutes will reflect the IRB’s determination regarding risk levels.

8.6.2 Period of Approval (for studies requiring Continuing Review)

At the time of Initial Review and at Continuing Review, the IRB will make a determination regarding the frequency of review of the Research Protocols. All Protocols will be reviewed by the IRB at intervals appropriate to the degree of risk but no less than once per year. In some circumstances, a shorter review interval (e.g. semi-annually, quarterly, or after accrual of a
specific number of Participants) may be required (see below). The meeting minutes will reflect
the IRB’s determination regarding review frequency.

Regulations & Guidance: DHHS 45 CFR §46.109(e); FDA 21 CFR §56.109(f)

8.6.3 Review More Often Than Annually

Unless specifically waived by the IRB, Research requiring continuing review that meets any of
the following criteria will require review more often than annually:

1. Significant risk, as determined by the IRB, to Research subjects (e.g., death, permanent or
   long-lasting disability or morbidity, severe toxicity) without the possibility of direct
   benefit to the subjects;
2. The involvement of especially Vulnerable Populations likely to be subject to coercion
   (e.g., terminally ill); or
3. A history of serious or Continuing Non-Compliance on the part of the PI.

The following factors also will be considered when determining which studies require review
more frequently than on an annual basis:

1. The probability and magnitude of anticipated risks to subjects;
2. The likely medical condition of the proposed subjects;
3. The overall qualifications of the PI, Investigators, Key Personnel and Other Study
   Personnel;
4. The specific experience of the PI Investigators, Key Personnel and Other Study
   Personnel in conducting similar Research;
5. The nature and frequency of Unanticipated Problems observed in similar Research at this
   and other Institutions;
6. The novelty of the Research making Unanticipated Problem more likely; or
7. Any other factors that the IRB deems relevant.

In specifying an IRB approval period of less than one year, the IRB may define the period with
either a time interval or a maximum number of subjects either studied or enrolled. If a maximum
number of subjects studied or enrolled is used to define the approval period, it is understood that
the approval period in no case can exceed one year unless the study does not require continuing
review.

If an approval period of less than one year is specified by the IRB for research that is subject to
continuing review the reason for more frequent review must be documented in the minutes.

8.6.4 Independent Verification That No Material Changes Have Occurred

The IRB recognizes that protecting the rights and welfare of subjects sometimes requires that the
IRB independently verify, utilizing sources other than the Investigator, that no material changes
occurred since previous IRB review. Independent verification from sources other than the
Investigator may be necessary at times (e.g., in cooperative studies, or other multi-center
Research).
The IRB will determine the need for verification from outside sources on a case-by-case basis. The following factors will be considered when determining which studies require independent verification:

1. The nature, probability, and magnitude of anticipated risks to subjects;
2. The degree of uncertainty regarding the risks involved;
3. Whether the research involves novel therapies or procedures;
4. The vulnerability(ies) of the subject population;
5. The projected rate of enrollment;
6. The experience and expertise of the investigators;
7. The IRB’s previous experience with the investigators or the sponsor (e.g., compliance history, complaints from subjects, etc.);
8. The probable nature and frequency of changes that may ordinarily be expected in the type of research;
9. Whether the research undergoes routine independent monitoring;
10. Whether concerns about possible material changes occurring without IRB approval have been raised based on information provided in continuing review reports or from other sources; and
11. Any other factors that suggest independent verification is warranted.

In making determinations about independent verification, the IRB may prospectively require that such verification take place at predetermined intervals during the approval period, or may retrospectively require such verification at the time of Continuing Review, review of amendments and/or Unanticipated Problems.

If any material changes have occurred without IRB review and approval, the IRB will decide the corrective action to be taken.

**AAHRPP Standards for Accreditation** (Standard II-2, Element II.2.F)

**8.6.5 Consent Monitoring**

In reviewing the adequacy of subject informed consent procedures for proposed Research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (i.e., a consent monitor) is required to reduce the possibility of coercion and undue influence.

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

See **Section 11.14** for a detailed discussion of consent process monitoring.

**AAHRPP Standards for Accreditation** (Standard II-3, Element II.3.F)

8.6.6 Investigator Qualifications

The IRB reviews credentials, curriculum vitae, resumes, or other relevant materials to determine whether Investigators and members of the Research team are appropriately qualified to conduct the Research. The IRB may rely upon other University processes (e.g., credentialing) to inform this determination.

8.6.7 Investigator Conflicts of Interest

The Research application asks Protocol-specific questions regarding COIs for Investigators and key Research personnel. As part of its review process, the IRB notifies the University’s Office of Conflict of Interest (“COI”) of the potential conflict. If a conflict of interest exists, final IRB approval of a Protocol cannot be given until an approved conflict management plan that adequately protects the Human Subjects in the Protocol is in place. See Section 21 for more details regarding Conflicts of Interest Regulations & Guidance.

AAHRPP Standards for Accreditation (Standard I-6, Element I.6.B)

42 CFR §50.603; 42 CFR §50.606(a); 21 CFR §54.1; 21 CFR §54.2; 21 CFR §54.4; 21 CFR §312.64(d); 21 CFR §812.110(d)

8.6.8 Institutional Conflicts of Interest

As with individual conflict of interest, the IRB has final authority to determine whether the Institutional Conflict, the Financial Interest, and the management plan, if any, allow the study to be approved. See Section 21 “Conflicts of Interest in Research” for more details regarding Institutional Conflicts of Interest.

AAHRPP Standards for Accreditation (Standard I-6, Element I.6.A)

8.6.9 Significant New Findings

During the course of Research, significant new knowledge or findings about the medication or Test Article and/or the condition under study may develop. The PI must report any significant new findings to the IRB and the IRB will review such findings with regards to potential impact on the subjects’ rights and welfare. Since the new knowledge or findings may affect the risks or benefits to subjects or subjects’ willingness to continue in the Research, the IRB may require, during the ongoing review process that the PI contact the currently enrolled subjects to inform them of the new information. The IRB will communicate this to the PI. The Informed Consent should be updated, and the IRB may require that the currently enrolled subjects be re-consented, acknowledging receipt of this new information and for affirming their continued participation.

AAHRPP Standards for Accreditation (Standard II-2, Element II.2.I)

Regulations & Guidance: OHRP Guidance on Written IRB Procedures; OHRP Guidance on Continuing Review; FDA Information Sheets: Continuing Review After Study Approval

8.6.10 Advertisements/Recruitment Materials

The IRB must approve any and all recruitment materials and/or advertisements prior to posting and/or distribution for studies that are conducted under the purview of the Tulane IRB. The IRB will review:

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

This information should be submitted to the IRB with the Initial Application for Human Subjects Research (TU Form 102) or as an amendment request to the Protocol along with the submittal.

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

1. Statements implying a certainty of favorable outcome or other benefits beyond what was outlined in the consent document and the Protocol;
2. Claims, either explicitly or implicitly, that the Drug, Biological Product or Device was safe or effective for the purposes under investigation;
3. Claims, either explicitly or implicitly, that the Test Article was known to be equivalent or superior to any other Drug, Biological Product or Device;
4. Using terms like “new treatment,” “new medication,” or “new drug;” without explaining that the test article was investigational.
5. Promising “free medical treatment” when the intent was only to say Participants will not be charged for taking part in the investigation;
6. Emphasis on payment or the amount to be paid, such as bold type or larger font on printed media; or
7. Offers for a coupon good for a discount on the purchase price of an investigational product once it has been approved for marketing; or
8. The inclusion of exculpatory language.

Recruitment materials should be limited to the information the prospective subjects need to determine their eligibility and interest.

The following items are required:

1. A clear statement that this is Research and not treatment;
2. The location of the Research and the person or office to contact for further information;
3. The name, address, and telephone number of the PI and/or Research facility

When appropriately worded, the following items are suggested:

4. The condition being studied and/or the purpose of the Research;
5. In summary form, the criteria that will be used to determine eligibility for the study;
6. The time or other commitment required of the subjects;
7. A brief list of potential benefits (e.g. no cost of health exam); or
8. Advertisements will not include compensation for participation in a trial offered by a sponsor to involve a coupon good for a discount on the purchase price of the product once it has been approved for marketing.
Once approved by the IRB, an advertisement cannot be altered or manipulated in any way without prior IRB approval.

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.C.1)


8.7 Social Media

Social media is an interactive platform for electronic communications used by groups of people to create, share and exchange information. In the context of research involving human subjects, social media may only be used as a research subject recruitment and retention tool, and it must not be used for data collection. Since materials provided to potential subjects are part of the informed consent process, the IRB must review the materials and the plans for their use prior to implementation. Therefore, the Investigator must include information about any proposed uses of social media in the research protocol, informed consent form and any other study related materials submitted to the IRB. If social media is being used to create a data set, see Section 26.13 on research repositories.

8.7.1 Social Media for Recruitment Purposes

1. Recruitment materials made available through social media platforms should follow all guidelines applicable to traditional recruitment methods, such as paper advertisements.

2. Recruitment is the first step in the informed consent process; as such, all materials presented to potential subjects must be reviewed and approved by the IRB in the form in which they will appear to potential subjects. If changes are made to existing materials during the course of the research or new materials are developed, those materials should be submitted to the IRB for review as a protocol amendment.

3. Recruitment materials should include the word “research”, investigator contact information, information about the purpose of the study, any eligibility criteria, potential benefits to the subject, and time commitment required for participation in the study.

4. Materials should never promise free medical treatment, imply unanticipated benefits, use the word “new treatment” without explaining that the treatment is investigational, or emphasize any payment that is made to subjects for participation in the study.

5. Websites and recruitment materials for clinical trials and FDA-regulated research must not make claims that are inconsistent with approved FDA labeling, must indicate when drugs and/or devices are investigational, must not state or imply that any investigational test article (drug, biologic, or device) is safe and effective for the purposes under study, must not state or imply that any investigational test article is known to be equivalent or superior to any other drug, biologic, or device, and may not offer post-approval discounts on drug/device costs in return for participation in the study.

6. Recruitment materials should not be placed on third party websites or social media sites if the nature of the site or the terms of service for the site indicate an expectation of freedom of solicitation unless authorization has been obtained from the operator of the website for
such placement. For example, many patient support group websites do not permit advertisements absent an authorization from the support group in question.

7. Recruitment materials should not be placed as comments or postings on a third party’s social media page, such as posting on an individual’s Facebook page.

8. If the social media site permits the posting of comments or other two-way communication, the site must be monitored on a routine basis by the Investigator and study team staff for any reporting of adverse events and for inappropriate comments. Inappropriate comments should be removed by the study staff immediately. Subjects should be informed at the time of enrollment in the research study that social media is not an appropriate mechanism for reporting adverse events to study staff.

### 8.7.2 Other Uses of Social Media

1. No information regarding a research subject’s participation in a research study should be posted on a portion of a social media site where it may be visible to other people, be they the public at large or the subject’s “friends” or “contacts.” (For example, no information about the research study should be posted on an individuals’ Facebook “profile” or “wall.”) The informed consent process must clearly describe any anticipated contact via social media or other electronic forum.

2. Subjects must provide consent to be contacted via social media, including each specific means through which the subjects may be contacted.

3. The consent should state clearly what types of information may be shared with subjects via social media.

4. If contact via social media and other electronic means is anticipated, the HIPAA authorization should clearly request authorization for such contact.

5. In order to reasonably safeguard the Subject’s privacy, the amount of information disclosed via Social media platforms, to include disclosures through the private messaging functionality of such platforms, should be limited to the minimum amount necessary to accomplish the intended purposes. While social media may be used with the Subject’s Authorization to communicate administrative or care coordination related information necessary for recruitment and/or retention, such as appointment reminders and availability of test results, Social media may not be used to communicate Treatment related information such as test results (as defined by 45 C.F.R. § 164.501).

6. Any solicited or unsolicited communication received via social media from a past, current or prospective Subject which seeks Treatment related information should be directed to an approved communication channel (i.e. secure messaging portal, in person consultation or voice call).

7. Investigators who are acting as workforce members of a Covered Entity must adhere to any social media policy and/or procedure in effect at such Covered Entity.

### 8.7.3 Privacy and Confidentiality Concerns When Using Social Media

It is important to remember that no social media site can provide absolute anonymity, confidentiality or privacy. Since investigators are responsible for minimizing the risks to human
subjects posed by use of the internet or social media, as well as for maintaining subject privacy and confidentiality, it is the responsibility of the Investigator to understand the various privacy and data security plans of the intended social media site to be used including how the data is transmitted and how it is maintained. The investigator must understand the privacy provisions set forth in the policies of a given social media website and be able to explain that information to both the IRB and the potential research subjects.

8.8 Payment to Research Subjects

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

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

1. Substantiate that proposed payments are reasonable and commensurate with the expected contributions of the subject;

2. State the terms of the subject participation agreement and the amount of payment in the Consent Form Templates (TU Forms 402; 403; and 407); and

3. Substantiate that subjects’ payments are fair and appropriate, and that they do not constitute (or appear to constitute) undue pressure on the subject to volunteer for the Research study.

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

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

The Consent Form Templates (TU Forms 402; 403; and 407) must describe the terms of payment and the conditions under which subjects would receive partial payment or no payment (e.g., if they withdraw from the study before their participation is completed).

Unless the study is confidential, the University requires identifying information to issue checks, cash, or gift certificates to subjects. The Consent Form Templates (TU Forms 402; 403; and 407) should inform subjects that they will be asked to provide their Social Security Number and verification of U.S Citizenship or Permanent Resident Status to receive payment, as applicable. For confidential studies, only names and addresses are required by SPA, but the PI must keep an identity key in a secure place.

8.9 Non-Monetary Gifts and Incentives

Similar to financial incentives, non-monetary gifts or incentives can also present problems of undue influence or coercion that impacts a potential subject’s ability to fully and freely consider participation in Research.
If Subjects will be provided with non-monetary gifts or tokens of appreciation, such as totes, books, toys, or other such materials, the approximate retail value must be described to the IRB and the IRB will be provided with a description, photo, or sample product to review.

The IRB will review all gifts and incentives being particularly sensitive to the influence of power or authority, whether perceived or actual, over free-decision-making. Overt coercion (e.g., threatening loss of credit, or access to services or programs, to which the potential subjects are otherwise entitled) is never appropriate. Moreover, it must be clear that choosing to not participate will not adversely affect an individual’s relationship with the Institution or its staff or the provision of services in any way (e.g., loss of credits or access to programs).

Investigators should carefully structure incentives and methods of disbursement so that while the incentives may serve as a factor in a subject’s decision to participate, that they have not served to unduly influence or coerce participation.

8.9.1 Recruitment Incentives

Payment arrangements among Sponsors, organizations, Investigators, and those referring Research Participants may place Participants at risk of coercion or undue influence or cause inequitable selection. Payment in exchange for referrals of prospective Participants from Researchers (physicians) (“finder’s fees”) is not permitted and may be considered illegal under Federal or State law. Similarly, payments designed to accelerate recruitment that is tied to the rate or timing of enrollment (“bonus payments”) also is not permitted. PIs are strongly encouraged to consult with Tulane’s OGC if they have any questions or concerns about recruitment incentives.

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.C.1)

8.9.2 Tulane Employees:

University employees who participate in Research under the purview of Tulane’s IRB must be aware of the following:

1. Employees must disclose to the Research staff their employment status;
2. Attendance of study visits must be during off time, during annual time or on lunch (i.e., break time may not be used); and
3. Disclosure of the employees’ participation in a clinical trial may be made to your Department/Unit Head or Manager.

8.10 Compliance with all Applicable Laws and Regulations

The IRB follows and adheres to all applicable Federal, State and local laws in the jurisdictions where the Research is being carried out. The HRPO and Tulane’s IRB rely on the University’s OGC for interpretation and application of Federal and State law and the laws of any other jurisdiction where Research is conducted as they apply to Human Subject Research.

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

8.11 Possible IRB Actions

The IRB or reviewer(s) may arrive at the following decisions:

- Approval (or “Approve” or “Approved”) – see Section 8.12.1;
- Conditions Required for Approval – see Section 8.12;
• Deferred for Modifications—see Section 8.12.3;
• Disapproval (or (“Disapprove” or “Disapproved”)—see Section 8.12.4;
• Approval in Principle—see Section 8.12.5;

With the exception of disapproval, the actions listed above may be used for either expedited or convened board review, including limited IRB review. An action of disapproval can only be taken at a convened IRB meeting.

• Suspension or Termination—see Section 9.1; and
• Investigator Hold—see Section 9.1.1.

The following Sections provide clarification with respect to each of these decision options.

8.11.1 Approval

Approval – the study is approved as submitted.

Approved (or “Approved,” “Approval,” or “IRB Approval”): means the determination by the IRB that the investigation and Protocol, as submitted, have been reviewed and may be conducted at an institution within the constraints set forth by the IRB and other institutional and Federal regulations. The Research may begin as of the IRB approval date. [DHHS 45 CFR §46.102(h); FDA 21 CFR §56.102(m)]. IRB Approval letters are generated by the IRB electronic submission system.

NOTE:
Research activities may commence; however, Research activities may not commence at any local participating study sites that have not provided the appropriate letters of support/approval, and the determination letter will indicate such, if applicable.

For example: if a PI proposes to conduct Research at five local school sites and has only provided letters of support from three of the schools, and informs the IRB that letters of support from the two remaining schools are in progress, but the PI would like to begin Research at the three schools for which the appropriate approvals have been provided, the IRB will approve the Research and the PI may not begin any Research activities at the two schools for which approval letters have not been provided, until the IRB has record of their support.

If there are any pending approvals from any other institutions the research cannot commence at those respective study sites until all such approvals have been obtained, and the PI is to provide to the Tulane IRB via the IRB electronic submission system a copy of all approval letters as received. Language to this effect is included on approval letters, and the PI is to comply with the language on said approval letters.

If there are any pending approvals from any other research oversight committees such as: Tulane Institutional Biosafety approval (when applicable), Tulane Radiation Safety Committee approval (when applicable), and any other committee approval required by the University, the research cannot commence until all such approvals have been obtained. However, the approval letters from the respective committees do not have to be provided to the IRB.

The University’s Biosafety Policies are available on the Biosafety website, https://research.tulane.edu/biosafety/biological-safety-policies-and-manuals.
8.11.2 Conditions Required for Approval:

Conditions Required for Approval: is a situation where the IRB may approve the Research with conditions if, given scope and nature of the conditions, the IRB is able, based on the assumption that the conditions are satisfied, to make all of the determinations required for approval (i.e., approval criteria, waiver/vulnerable population determinations, etc.). Any time the IRB cannot make one or more of the determinations required for approval, the IRB may not approve the research project.

The authority to approve research with conditions extends to the initial review of research, continuing review of research, and review of modifications. This authority applies to IRB review of research at a Convened IRB meeting or under an Expedited review procedure (typically when IRB staff/others are authorized to make the confirmatory verification).

The IRB may require the following as conditions of approval of research:

- Confirmation of specific assumptions or understanding on the part of the IRB regarding how the research will be conducted (e.g., confirmation that research excludes children);
- Submission of additional documentation (e.g., certificate of training);
- Precise language changes to study, consent, or other study documents; or
- Substantive changes to the study, consent, or other study documents along with clearly stated parameters that the change must satisfy.

When the IRB approves research with conditions, the conditions that the IRB requires to be satisfied by the PI will be documented in the IRB minutes for Research reviewed at a Convened IRB meeting or in the Reviewer Worksheet for Research reviewed under an Expedited review procedure.

When the IRB approves Research with conditions, the IRB Chair (or other designated individual/s) will receive materials/responses from the PI as required by the IRB, and verify whether the conditions of approval have been satisfied. If the requested changes have not been made or are only partially responsive, the Research must either obtain full compliance by the PI or it will be returned to the Convened IRB for further action.

After verification, the following will be documented in IRB records and written communication to the PI:

- The date when verification was made that all IRB conditions have been satisfied (i.e., the “effective date”);
- For initial approval, the date when approval becomes effective (i.e., the date on which the PI’s response has been accepted as satisfactory), and;
- The date by which Continuing Review must occur (not more than one year from the date of the effective date when verification was made).

The IRB will be informed of the outcome of the review of the PI’s response in the minutes of the next meeting.
For more information on this topic, please refer to the OHRP “Guidance on IRB Approval of Research with Conditions” document at: OHRP Policy on Conditional Approval.

8.11.3 Deferred for Modification(s):

**Deferred for Modification(s):** is a situation where the IRB cannot approve the Research as submitted because (1) the Protocol and/or **Consent Form Templates** (TU Forms 402; 403; and 407) require substantive modification or clarification; or (2) insufficient information is provided to adequately judge the Protocol application (e.g., the risks and benefits cannot be assessed with the information provided). IRB approval of the proposed Research will not be granted until a subsequent review of the material submitted by the PI, is deemed to be satisfactory by the convened IRB.

This action is taken when substantial modification or clarification is required (of the nature or amount that the IRB cannot make specify the exact changes or parameters), or insufficient information is provided to judge the study application adequately (e.g., the risks and benefits cannot be assessed with the information provided). For example, a justification for use of placebo and withholding currently available treatment is required or a greater than minimal risk research plan has no description of how the safety of the study will be monitored. IRB approval of the proposed Research will not be granted until a subsequent review of the material submitted by the PI, is deemed to be satisfactory by the convened IRB. In order to receive approval for a study Deferred for Modifications:

- For Convened IRB Review, the PI’s response must be submitted for review at a subsequent, convened meeting of the same IRB. The HRPO provides the IRB with the PI’s response, the revised materials and the previously submitted materials. The item is placed on the agenda for re-review at the next available meeting.

Approval of the study application will not be granted, and certification will not be issued until all conditions are corrected to the satisfaction of the Convened IRB.

The outcome of the IRB’s deliberations will be communicated to the PI in writing through a letter via the IRB electronic submission system.

The IRB will be informed of the outcome of the review of the PI’s response (for example, in the minutes of the next meeting).

8.11.4 Disapproved

The IRB action of Disapproved means that it cannot approve the Protocol as written. The IRB has determined that the Research cannot (1) be conducted on Institutional or TUHC premises, or other facilities; (2) cannot involve University or TUHC patients; (3) be conducted on or by Institutional employees or Institutional Agents; and/or be conducted under the auspices of Tulane’s IRB. Written notice of Disapproval will be issued by the IRB through the IRB electronic submission system.

8.11.5 Approved in Principle

**Approval in Principle** is IRB approval, as requested by a Sponsor, without the IRB having reviewed all of the study procedures and consent documents. [DHHS 45 CFR §46.118]

There are two circumstances in which the IRB may grant approval required by a sponsoring agency without having reviewed all of the study procedures and consent documents. [45 CFR §46.118]
One is if study procedures are to be developed during the course of the Research, but Human Subject approval is required by the sponsoring agency. The other is if the involvement of Human Subjects depends on the outcomes of work with animal subjects. The IRB may then grant approval without having reviewed the undeveloped recruitment, consent, and intervention materials. However, if the Proposal is funded, the PI must submit such materials for approval at least 60 days before recruiting Human Subjects into the study, or into any pilot studies or pre-tests. Approval in Principle is granted to satisfy sponsoring agency requirements or to allow Investigators to have access to funding to begin aspects of the project that do not involve Human Subjects. Approval in Principle may be done via Expedited Review.

8.12 Continuing Review

(For studies receiving initial approval on or before 1/20/19, please refer to SOP’s available at https://research.tulane.edu/hrpo/policies for content of this section).

For research subject to the Common Rule, the IRB will conduct continuing review of ongoing research requiring review by the convened IRB at intervals that are appropriate to the level of risk of the research, but not less than once per year, except as described below. The date by which continuing review must occur will be recorded in the IRB electronic submission system and on initial and continuing review approval letters.

Unless an IRB determines otherwise, continuing review of research subject to the Common Rule is not required in the following circumstances:

- Research eligible for expedited review in accordance with 45 CFR 46.110;
- Research reviewed by the IRB in accordance with the limited IRB review described in Section 10.7;
- Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:
  - Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
  - Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

Tulane IRB may determine that continuing review is required for any research protocol that falls within the above criteria. For example, the IRB may determine that continuing review is required when:

1. Required by other applicable regulations (e.g., FDA);
2. Required by the terms of a grant, contract, or other agreement
3. The research involves topics, procedures, or data that may be considered sensitive or controversial;
4. The research involves particularly vulnerable subjects or circumstances that increase subjects’ vulnerability;
5. An investigator has minimal experience in research or the research type, topic, or
6. An investigator has a history of noncompliance

When the Tulane IRB determines that continuing review is required for such research, it will
document the rationale in the IRB record and communicate the requirement to the investigator in
the IRB determination letter.

**Studies that fall into these categories and are determined to not require continuing review
are still subject to prompt reporting requirements** (e.g., proposed amendments, unanticipated
problems involving risk to subjects or others, protocol deviation/violations/non-compliance).
**They will also require submission of an annual progress report** that will collect information
regarding status of the research activity. Investigators will receive courtesy reminder e-mail
notices for completion of the progress report. ORC staff will review the report for compliance
with institutional policies (verification of human subjects training, COI review, etc.). Failure to
submit an annual progress report as required will constitute non-compliance with Tulane’s HRPP
policy and may result in suspension of the study until compliance with this policy is confirmed.

There is no exception to the requirement for continuing review in FDA regulations. The IRB
will conduct continuing review of ongoing FDA-regulated research, and any research where it is
required by applicable regulations, policy, or other requirements (e.g., as a condition of funding
or contractually), at intervals that are appropriate to the level of risk of the research, but not less
than once per year, as long as the research remains active. The date by which continuing review
must occur will be recorded in the IRB electronic submission system and on initial and
continuing review approval letters.

**AAHRPP Standards for Accreditation (Standard II-2, Element II.2.F)**

Regulations & Guidance: DHHS 45 CFR §46.109(e) and (f); FDA 21 CFR §56.109(f)

**8.12.1 Approval Periods for Research Requiring Continuing Review**

At Tulane, determination of the approval period and the need for additional supervision and/or
participation is made by the IRB on a Protocol-by-Protocol basis for research requiring continuing
review (including research subject to the Common Rule that is reviewed by the convened IRB; see
Section 8.12 above). For example, for an Investigator who is performing particularly high-risk
Research, or for an Investigator who has recently had a Protocol Suspended by the IRB due to
regulatory concerns, an on-site review by a subcommittee of the IRB might occur or approval
might be subject to an audit of study performance after a few months of enrollment, or after
enrollment of the first several subjects.

For each initial or continuing approval, the IRB will indicate an approval period with an approval
expiration date specified. IRB approval is considered to have lapsed at midnight on the expiration
date of the approval. For a study approved by the convened IRB, the approval period starts on the
date that the IRB conducts its final review of the study; that is, the date that the convened IRB
approved the Research or the date the convened IRB Deferred the Research for minor issues. For
a study approved under Expedited Review, the approval period begins on the date the IRB Chair
or IRB member(s) designated by the IRB Chair gives final approval to the Protocol.
The approval date and approval expiration date are noted on initial approvals and subsequent Continuing Review approvals sent to the P.I. and must be strictly adhered to. Investigators should allow sufficient time for development and review of renewal submissions.

Review of a change in Research ordinarily does not alter the date by which Continuing Review must occur. This is because Continuing Review is review of the full Protocol, not simply a change to it.

The regulations make no provision for any grace period extending the conduct of Research beyond the expiration date of IRB approval. Therefore, Continuing Review and re-approval of Research must occur by midnight of the date when IRB approval expires. If the IRB receives the completed Secondary Application for Human Subjects Research within 30 days prior to the IRB expiration date, and the submission is deemed complete, the IRB may retain the anniversary date as the date by which the subsequent Continuing Review must occur.

8.12.2 IRB Timeline

An IRB review timeline is posted on the HRPP’s website that describes critical Investigator deadlines and IRB meeting dates. It is important for Investigators to note that a submission is not deemed complete until HRPO staff have completed their review and forwarded/referred the request to the IRB for consideration. When this occurs, the IRB electronic submission system will automatically alert the study team confirming that the submission has been forwarded to a reviewer or referred to the Full Board.

8.12.3 Continuing Review Process

To assist PIs, the IRB electronic submission system generates courtesy reminders to Investigators 60 days, 45 days, and 30 days in advance of the study expiration date so that they timely submit Continuing Reviews. PIs must submit Continuing Reviews electronically via the IRB electronic submission system. It is the PI’s responsibility to ensure that the Continuing Review of ongoing Research is approved prior to the expiration date. By Federal regulation, no extension to that date can be granted. When submitting the Secondary Application for Human Subjects Research, please be aware of the submission deadlines for scheduled IRB meetings. If a Secondary Application for Human Subjects Research is submitted after the submission deadline for a scheduled IRB meeting, the Secondary Application for Human Subjects Research may not be placed on the upcoming meeting agenda.

Investigators must submit the following for Continuing Review:

- The Secondary Application for Human Subjects Research;
- The current Consent Form Templates (TU Forms 402; 403; and 407);
- Any newly proposed Consent Form document with redline edits (i.e., changes are to be highlighted, deletions are to be lined through) to reflect any changes from the prior submission; For documents that cannot be tracked via redline edits, a detailed summary of changes and the locations of those changes must be submitted;
- The full Protocol or a Protocol summary containing the relevant information necessary to determine whether the proposed Research continues to fulfill the criteria for approval;
- A status report on the progress of the Research that includes:
A summary since the last IRB review of:

- Unanticipated Problems Involving Risks to Participants or Others;
- Unanticipated Problems, untoward events, and adverse outcomes experienced by Participants.
- Participant withdrawals;
- The reason for withdrawals;
- Complaints about the Research;
- Amendments or modifications;
- Any relevant recent literature; and
- Any interim findings.

- Any relevant multi-center trial reports;
- The consent form of the last two Subjects that were enrolled in the study with identifying information removed or blacked out.
- The Investigator’s current risk-potential benefit assessment;
- The gender and minority status of those entered into the Protocol, including:
  - Number of Participants considered as members of specific Vulnerable Populations; and
  - An assurance that all serious and unexpected Unanticipated Problems and Adverse Events have been reported as required.

In conducting Continuing Review of Research not eligible for Expedited Review, all IRB members are provided and review all of the above materials. At the meeting, the primary reviewer leads the IRB through the completion of the regulatory criteria for approval in the Expedited and Full Board Continuing Review Reviewer Worksheet.

The complete Protocol files are available at meetings of the Convened IRB for each Protocol on the agenda. The HRPO staff will retrieve any additional materials should the IRB members or reviewer(s) request.

In the case of Expedited Reviews, the IRB members may request the HRPO staff to provide them with additional materials required for the review.

Review of currently approved or newly proposed consent documents must occur during the scheduled Continuing Review of Research by the IRB. However, informed consent documents should be reviewed whenever new information becomes available that would require modification of information in the IRB-approved informed consent document. Changes to consent documents are amendments and will be reviewed according to the procedures in Section 8.14.

Continuing Review of a study must continue until:

- The Research is permanently closed to the enrollment of new Participants;
- All Participants have completed all Research-related interventions; and
- Collection and analysis or private identifiable information has completed
8.12.4 Approval Considerations

In order to re-approve Research at the time of Continuing IRB Review, the IRB must determine that the criteria for approval continue to be satisfied. Since the Research was previously found to satisfy the criteria for approval, the IRB focuses its considerations at the time of Continuing IRB Review on whether any new information is available that would affect the IRB’s prior determination that the criteria for approval are satisfied. The IRB pays particular attention to four aspects of the Research:

1. Risk assessment and monitoring;
2. Adequacy of the informed consent process;
3. Local investigator and institutional issues; and
4. Research progress

8.12.5 Convened IRB Review

In conducting Continuing Review of Research not eligible for Expedited Review, all IRB members are provided with access to all of the material and are responsible for reviewing the project summary, the current consent document, the progress report, and, if applicable, the data and safety monitoring report, multi-center study progress reports, and any proposed amendments to the research plan, protocol, or consent. The Primary Reviewer is responsible for reviewing the complete materials submitted for Continuing Review including the complete research plan and is given access to the complete IRB file and relevant IRB meeting minutes. At the meeting, the Primary Reviewer leads the IRB through the completion of the regulatory criteria for approval in the Expedited and Full Board Continuing Review Reviewer Worksheet.

Review of currently approved or newly proposed consent documents must occur during the scheduled Continuing Review of Research by the IRB, but consent documents should be reviewed whenever new information becomes available that may require modification of information in the consent document.

8.12.6 Expedited Review of Continuing Review

In conducting Continuing Review under Expedited Review, the reviewer(s) shall have access to all of the above materials specified in Section 8.4. The reviewer(s) complete the Expedited and Full Board Continuing Review Reviewer Worksheet to determine whether the Research meets the criteria allowing Continuing Review using the Expedited Review procedure, and, if so, whether the Research continues to meet the regulatory criteria for approval. If the research no longer requires continuing review under the Common Rule and the IRB reviewer determines that continuing review is required, the reviewer shall document the rationale in the reviewer worksheet.

Generally, if Research did not qualify for Expedited Review at the time of Initial Review, it does not qualify for Expedited Review at the time of Continuing Review, unless it has progressed to the point that it involves only one or both of the following:

- Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
- Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care;
and except in limited circumstances described by Expedited Review Categories (8) and (9) found in Section 8.3.1 (Expedited Review Categories). [See 63 FR 60364-60367]. It is also possible that Research activities that previously qualified for Expedited Review in accordance with 45 CFR §46.110, have changed or will change, such that Expedited Review would no longer be permitted for Continuing Review.

8.12.7 Possible IRB Actions after Continuing Review

As with Initial Review, at the time of Continuing Review, the Convened IRB or IRB Member(s) conducting expedited review may take any of the following actions (see Section 8.12 for a detailed description of these actions):

1. Approval
2. Conditions Required for Approval
3. Deferred for Modifications

Additionally, if the IRB has significant concerns, the IRB may vote to suspend or terminate the Research (see Section 9 for a detailed discussion of suspensions and terminations).

If a Research study receives Conditions Required for Approval at the time of the Continuing Review, the IRB will specify any restrictions or requirements that must be adhered to until the contingencies of approval have been satisfied. For example, if at the time of Continuing Review, the IRB determines that an additional screening procedure is necessary, the IRB could approve the Research with contingencies and specify that no new subjects may be screened and enrolled until the PI submits the revised research plan and the contingency has been determined to be satisfied. Additionally, the IRB may specify a time period, such as 1, 2, or 3 months, for the condition to be satisfied.


8.12.8 Lapse in Continuing Review Approval

The regulations permit no grace period or approval extension after expiration of approval. Research that continues after the approval period has expired is research conducted without IRB approval. If re-approval does not occur within the time set by the IRB, all research activities must stop, including recruitment (media advertisements must be withdrawn), enrollment, consent, interventions, interactions, and data collection. This will occur even if the investigator has submitted the continuing review materials before the expiration date. Therefore, investigators must submit their continuing review materials enough in advance of expiration to allow sufficient time for IRB review before the expiration date.

When the IRB approves research with conditions at the time of continuing review before the expiration date of the preceding IRB approval period, IRB approval does not lapse if the investigator needs additional time – beyond the date on which the preceding IRB approval would have expired – to satisfy some or all of the IRB’s conditions. However, the investigator and the IRB should make every effort to resolve any conditions and finalize approval in as timely a manner as possible.
In the event that study approval does expire, the IRB via the IRB electronic submission system sends a courtesy notification to the investigator noting the expiration of approval and instructions that all research activities must stop. If the investigator fails to respond to the notification, and does not submit continuing review materials or a closure report within 30 days, the HRPO staff will refer the matter to the IRB Chair or designee to evaluate as possible noncompliance (See Section 16).

The lapse of IRB approval due to a failure to complete continuing review and obtain re-approval prior to expiration of the prior approval does not ordinarily constitute a suspension or termination of IRB approval, for federal reporting purposes; however, the failure to meet continuing review obligations may be grounds for suspension or termination of the research. If the IRB notes a pattern of noncompliance with the requirements for continuing review (e.g., an investigator repeatedly or deliberately neglects to submit materials for continuing review in a timely fashion or the IRB itself is not meeting the continuing review dates), the IRB should determine the reasons for the noncompliance and take appropriate corrective actions. When research is subject to federal reporting mandates, the IRB must report to FDA/OHRP any instance of serious or continuing noncompliance with FDA regulations or IRB requirements or determinations.

8.13 Management of Enrolled Subjects During Lapse

While enrollment of new subjects cannot occur after the expiration of IRB approval, the IRB recognizes that temporarily continuing participation of already enrolled subjects may be necessary or appropriate, for example, when the research interventions hold out the prospect of direct benefit to the subjects, or when withholding those interventions or safety monitoring procedures would place subjects at increased risk. In these instances, the investigator must, at the earliest opportunity, contact the IRB office and submit a request to continue those research activities that are in the best interests of subjects. Such a request should specifically list the research activities that should continue, provide justification, and indicate whether the request applies to all or only certain subjects. The IRB Chair or designee will review the request and provide a determination regarding what activities, if any, may continue during the lapse. Such a determination may include a time limit or other conditions or restrictions. If the IRB decides that already enrolled subjects should continue to receive the interventions that were being administered to subjects under the research project, data collection (especially safety information) should also continue for such subjects.

When there is insufficient time to obtain an IRB determination (e.g., the study regimen includes daily administration of an investigational agent), the investigator may make an initial determination in consultation with the subjects' treating physician, if appropriate. In such cases, the investigator must, as soon as possible, contact the IRB office and submit a request for confirmation that the IRB agrees with the determination. The IRB Chair or designee will review the request and provide a determination. In the event that the IRB does not agree with the investigator's determination, or only agrees in part (e.g., agrees that some but not all of the activities are in the best interests of subjects), the IRB will notify the investigator who must then comply with the IRB's requirements or request a re-review of the determination by providing additional justification or information that the IRB may not have considered.
8.14 Amendment of an Approved Protocol

PIs who wish to modify or amend their approved applications must seek IRB approval before making any changes in approved Research. This requirement exists even though the changes are planned for the period for which IRB approval has already been given. (One noteworthy exception is for changes necessary to eliminate an immediate hazard to the subject, in which case the IRB must then be notified at once).

Amendments may be approved if they are within the scope of what the IRB originally authorized. For example, if a Researcher wishes to add a population to an existing study, but not alter the study procedures or purpose, an amendment request is usually appropriate. Likewise, amending a procedure without changing the study's purpose or study population may also be appropriate. If, however, the Researcher wishes to add a population and revise study procedures, he or she will need to submit a new application for Human Subjects approval.

Investigators must submit documentation to inform the IRB about the changes in the status of the study. To this end, Investigators are required to submit the changes through the modification/Amendment package in the IRB electronic submission system:

- Completed Secondary Application for Human Subjects Research;
- Revised Sponsor’s Protocol (if applicable);
- Revised approved Consent (TU Forms 402, 403)/Assent (TU Form 401) documents (if applicable) or other documentation that would be provided to subjects when such information might relate to their willingness to continue to participate in the study;
- Revised or additional recruitment materials; or
- Any other relevant documents provided by the Investigator

HRPO staff or HRPO/HRPP Director will determine whether the proposed changes may be approved through an Expedited Review process, if the changes are minor, or whether the amendment warrants Convened IRB Review. The reviewer(s) using the Expedited procedure has the ultimate responsibility to determine that the proposed changes may be approved through the Expedited Review procedure and, if not, must refer the Protocol for Convened IRB Review for review of whether each change was consistent with ensuring the participant’s continued welfare.

Regulations & Guidance: OHRP Guidance on Written IRB Procedures.


When a modification makes it necessary to change the informed consent document, regardless of whether any Participants are enrolled, two copies of the revised consent document are to be submitted to the IRB. One “marked up” copy should show all changes from the previous version (i.e., highlighting all additions and striking through all deletions). The one clean copy will contain the IRB – approval stamp that is to be used to enroll subjects.

8.14.2 Expedited Review of Amendments/Modifications

An IRB may use Expedited Review procedures to review Minor Changes in ongoing previously-approved Research during the period for which approval is authorized. An Expedited Review may be carried out by the IRB Chair and/or designee(s) among the IRB members. Minor Changes (see
Glossary for definition) to a convened review study are determined by the Chair or Designee. See Section 8.14 for the process to submit a request for an amendment review.

The reviewer(s) complete the Expedited and Full Board Amendment Reviewer Worksheet to determine whether the modifications meet the criteria allowing review using the Expedited procedure, and if so, whether the Research with the proposed modifications continues to meet the regulatory criteria for approval.

The reviewer will also consider whether information about those modifications might relate to Participants’ willingness to continue to take part in the Research and if so, whether to provide that information to Participants.

8.14.3 Convened IRB Review of Amendments/ Modifications

When a proposed change in a Research study is not minor (e.g., procedures involving increased risk or discomfort are to be added), then the IRB must review and approve the proposed change at a convened meeting before the change can be implemented. The only exception is a change necessary to eliminate apparent immediate hazards to the Research subjects. In such a case, the IRB should be promptly (no longer than 30 days) informed of the change following its implementation and should review the change to determine that it is consistent with ensuring the subjects' continued welfare.

All documents provided by the PI are accessible to all IRB members for review via the IRB electronic submission system.

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

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

8.15 Protocol/Research Plan Exceptions

Protocol/Research Plan exceptions are circumstances in which the Investigator wishes to deviate from eligibility criteria or one or more of the specific procedures called for in a Research Plan. Unlike modifications that apply to all subsequent Subjects in the Research, a Protocol/Research Plan exception only applies to a specific Subject or group of Subjects.

Exceptions are planned, and the Investigator gets approval from the sponsor and the IRB ahead of time. For Sponsored Research, prior approval from the Sponsor is generally required. Depending on the nature of the exception, an Expedited Review is possible. In order to be approved under Expedited Review exceptions must not increase risk or decrease benefit, change the risk/benefit analysis, negatively affect the participant’s rights, safety, welfare, or negatively affect the integrity of the resultant data. Review of exceptions that represent more than minor changes or risks levels greater than minimal must be done at a Convened Meeting of the IRB.
Procedures for exceptions are the same as for a Protocol Modification. The Investigator must submit an Events Reporting Form along with any revised documentation to be presented to the subject(s) and documentation of Sponsor approval, if applicable.

The only time a Protocol/Research Plan exception would not require prior Sponsor or IRB approval is when the exception is necessary to avoid an immediate hazard to the participant. In such cases, the exception must be submitted to the IRB as soon as possible.

8.16 Closure of Protocols

The completion or Termination of a study, whether premature or not, is a change in activity and must be reported by the PI to the IRB on the Study Closure Form (TU Form 602). Although subjects will no longer be “at risk” under the study, a final report to the IRB allows it to close the study in the IRB electronic submission system as well as providing information that may be used by the IRB in the evaluation and approval of related studies.

Studies may be closed when the involvement of Human Subjects ceases (interventions, interactions, observations, and the gathering, use, study, and analysis of identifiable private information (including specimens) are all complete). For example, when the only remaining research activity involves the analysis of data without individual subject identifiers, or aggregate data sets, a study may be closed.

For multi-center research, the study may be closed once all local research activities (as above) are complete. If the PI is serving as the lead PI or Tulane is the coordinating center, please note that the study must remain open as long as the coordinating center is still receiving, studying, using, or analyzing identifiable private information from other sites (even if local interventions, interactions, observations, and data gathering is complete).

The PIs should submit the Study Closure Form (TU Form 602) through the IRB electronic submission system. The PI must submit a final report (summary of the research activity and any findings) with the closure application. IRB staff will review the closure application for completeness utilizing the Administrative Reviewer Sheet for Study Closures (TU Form 514).

Investigators may maintain the data that they collected, including Individually Identifiable Private Information, if this is consistent with the IRB-approved Protocol. However, Investigators may not conduct any additional analysis of this data without obtaining IRB approval. Investigators must continue to protect the confidentiality of the data as described to the IRB and honor any other commitments that were agreed to as part of the approved Research including, for example, future use of data or specimens, provision of Research results to subjects, and provision of any outstanding payments or compensation.

PIs will be notified of the option to close the Protocol prior to the time of Continuing Review. The IRB will review study closure reports, typically by Expedited Review, and either approve the closure of the study or request additional information or confirmation of facts from the PIs.

8.17 Notice to PI of IRB Actions

Barring extraordinary circumstances, all IRB action letters are prepared by HRPO staff and are published via the IRB electronic submission system for review by the Principal Investigator (PI), Investigators, Key Personnel and Other Study Personnel within ten (10) working days. The
Electronic system generates decision letters pursuant to the IRB Chair's electronic signature and approval. The actual signature by the IRB Chair(s) is not required for this document to be effective. This process is consistent with Federal Regulations and Tulane Standard Operating Policies with respect to the IRB and Human Research Protection Office, which consider electronically generated documents as official notices to sponsors and others of approval, disapproval, or other IRB decisions.

For an approval, along with written notification of approval, a copy of the approved Consent Form Templates (TU Forms 402, 403)/Assent (TU Form 401) document(s) containing the stamped approval with the dates of the IRB approval and expiration on each sheet will be uploaded. For required modifications or deferrals, the notification will include the information that is required, the basis for requiring those modifications, and a deadline for response submission. For a disapproval, Termination or Suspension, the notification will include the basis for making that decision.

All correspondence between IRB and Investigators are retained in the IRB electronic submission system.

The IRB reports its findings and actions to the Institution in the form of its minutes, which are stored in the IRB electronic submission system, and the HRPO staff, RCO, and IO have access to them.

8.18 Failure to Respond

Failure to submit a response to IRB requirements within 90 days of the IRB date of determination may result in Administrative Closure of the IRB file (for new study submissions). When Research has IRB approval, and an Investigator fails to respond to requirements related to a subsequent submission (e.g., a request for modification), the IRB Chair or Designee will review the circumstances, including any potential impact on Human Subjects, and will contact the Investigator to try to secure a response. If the Investigator continues to be unresponsive, the failure of the Investigator may be considered non-compliance and will be reviewed in accordance with the procedures in Section 16. The Investigator will receive notification, including an explanation. An extension beyond 90 days may be granted by the IRB or HRPO staff if sufficient cause is provided by the Investigator.

8.19 Investigator Appeal Process

In cases where there is disagreement between the IRB and the PI regarding IRB determinations, the PI may make an appeal to the IO for a resolution of the matter. The PI is to make such an appeal to the IO within 10 business days from the date of the written notification of the IRB’s determinations. A PI may include as part of the appeal additional relevant information and/or potential mitigating circumstances that might not have previously been considered by the IRB.

While the IO may provide input and make recommendations to the IRB for resolution of the matter, the final determination remains under the purview of the IRB.
8.20  Research Previously approved by another IRB

When an Investigator transfers research to the University that was previously approved by another IRB, the Investigator must submit the Research for review under the procedures covered by this section. No Research activity may take place under the Institution auspices without the appropriate review and approval.

Research approved as Exempt at the previous Institution will be reviewed according to the procedures in Section 7, Exempt Studies. All other Research must be submitted as if it were undergoing initial review and will be reviewed under Expedited Review or by the Convened IRB. Research that solely involves the analysis of existing identifiable data may be considered under Expedited Review Category 5.

For Research transfers where stopping Research interventions might harm Subjects, the Investigator can request permission from the IRB to continue Research interventions under the oversight of the prior Institution’s IRB until final University approval is obtained.

8.21  Use of the National Cancer Institute Centralized Institutional Review Board

8.21.1  General Background on Use of the National Cancer Institute Centralized Institutional Review Board

Tulane and the National Cancer Institute (“NCI”) have initiated an authorization agreement where Tulane defers to NCI’s Adult, and Pediatric Central Institutional Review Board (“CIRB”).

Studies reviewed by the NCI Adult CIRB include all Phase III Adult Cooperative Group treatment trials approved by Cancer Therapy Evaluation Program (CTEP) - ACOSOG, GOG, NSABP, RTOG AND SWOG. The NCI Adult CIRB may review other CTEP-approved Phase III clinical trials that are approved by CTEP, even if the sponsor is not a Cooperative Group. The NCI Adult CIRB also may review Phase II studies for rare tumors that appear on the CTSU menu.

Studies reviewed by NCI Pediatric CIRB include all pilot, Phase II, and Phase III Children’s Oncology Group (COG) treatment trials approved by CTEP and/or Division of Cancer Prevention (DCP). The NCI Pediatric CIRB may review other trials approved by DCP, and also other federally funded trials (i.e., via R01 grants). The NCI Pediatric CIRB may review other CTEP- approved clinical trials as directed by CTEP, even if the sponsor is not a Cooperative Group.

Tulane’s HRPO submits the necessary documentation to maintain Institutional registration with the NCI CIRB, including the “Authorization Agreement/Division of Responsibilities”, the listing of Key Personnel, and the “Annual Signatory Institution Worksheet About Local Context.”

Tulane maintains responsibility to conduct any reviews necessary under HIPAA. Additionally, the NCI CIRB relies on institutions to identify potential conflicts of interest and to develop conflict management plans. Tulane Investigators should refer to Tulane’s HRPP Section 21 for details regarding submitting disclosures of conflicts of interest.

Investigators must submit any Tulane-approved conflict management plans for themselves or members of the local research team to the NCI CIRB utilizing the “Annual Principal Investigator Worksheet About Local Context” or the “Study-Specific Worksheet About Local Context”.

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Research open under the NCI CIRB remains subject to Tulane and HRPO policies and procedures including, but not limited to, internal and external audits, training requirements, and privacy-related matters. See Section 25.9, Procedures for Requesting a Facilitated Review where Tulane defers to/relies upon an External IRB, for submission requirements to the Tulane IRB.

8.21.2 Tulane Responsibilities After Study Approval by the NCI CIRB

Once a Study is approved by the NCI CIRB, the Tulane IRB is responsible for:

1. Complying with the NCI CIRB’s requirements and directives;
2. Maintaining an FWA and designate the NCI CIRBs under its FWA;
3. Maintaining compliance with applicable state, local or Institutional requirements related to the protection of Human Subjects;
4. Ensuring that local Investigators receive proper initial and continuing education on the requirements related to Human Subjects protections;
5. Providing updates to the NCI CIRB whenever a PI is no longer the responsible party for a study under the purview of the NCI CIRB;
6. Notifying the NCI CIRB when a regulatory deficiency has been observed in a Tulane audit that occurred during the time that the NCI CIRB was responsible for a study;
7. Maintaining a registration file for each study under NCI CIRB purview.

8.21.3 Investigator Responsibilities After Study Approval by the NCI CIRB

Once NCI CIRB approval has been given for research activities to be performed at a Tulane research site, the Investigator is responsible for providing Tulane via the IRB Electronic System with further documentation as follows:

a. Principal Investigator and personnel changes
b. Updated training records (CITI or accepted alternative) for each member of the local research team
c. HIPAA Authorization forms, data collection plans involving privacy related information, and revisions to such
d. Informed consent subject injury language for industry sponsored research, and revisions to such
e. Any new potential conflicts of interest or changes in previously reported conflicts of interest, including institutional and potential financial interests, that could affect or be affected by the research
f. Conflict of interest disclosures on an annual basis or within 30 days of a change in significant financial interests or circumstances that could represent a conflict of commitment
g. Local Unanticipated Problems
h. Potential Serious- or Continuing Noncompliance reports
i. Local subject complaints or unresolved concerns
j. Study closures
For reviews of HIPAA and privacy-related matters (e.g., HIPAA Authorizations, requests to modify or waive HIPAA Authorization, etc.), the University Privacy Officer serves as Tulane’s Research Privacy Officer and is responsible, as Tulane does not defer such decisions to the NCI CIRB. Tulane’s HIPAA policies found in Section 23 apply to such reviews as well as the standard HIPAA Authorization Form (TU Form 405), which is available in the IRB electronic submission system or the HRPP website. Preparatory to Research, applications for use of PHI to identify and/or screen potential candidates should be submitted consistent with Section 23.

8.22 Use of External IRBs

External IRBs (e.g. Independent or Commercial IRBs) are not associated with an entity engaged in the conduct of Human Subject Research; rather, such IRBs can be retained by an entity Engaged in Research to conduct IRB review and oversight of that entity’s Human Subject Research (e.g. Advarra IRB, Western Copernicus Group IRB (WCGIRB), Copernicus IRB, etc.). The Tulane University Human Research Protection Program may decide to retain an External IRB, to supplement either of Tulane University’s IRBs, at its discretion.
9 Study Suspension, Termination and Investigator Hold

9.1 Suspension or Termination

IRB approval may be Suspended or Terminated if Research is not being conducted in accordance with IRB or regulatory requirements or has been associated with unexpected problems or serious harm to subjects. (See Section 15 for a discussion of Unanticipated Problems, Section 16 for a discussion of non-compliance, and Section 18 on Reporting to Regulatory Agencies and Institutional Officials). The IRB’s authority to suspend or terminate research applies to all research subject to IRB approval, including exempt research with limited IRB review and research for which continuing review is no longer required.

Suspension of IRB approval is a directive of a convened IRB, IRB Chair(s) or HRPO/HRPP Director to temporarily stop either some or all previously approved Research activities to ensure protection of the rights and welfare of study Participants or for non-compliance. Suspension directives made by the IRB Chair or HRPO/HRPP Director must be reported to a meeting of the convened IRB. Suspended Protocols remain open, and the PI is required to timely submit a Secondary Application for Human Subjects Research to avoid closure of the study. See Section 8.13 - Continuing Review.

AAHRPP Standards for Accreditation (Standard II-2, Element II.2.H)

Termination of IRB approval is a directive of the convened IRB to permanently stop some or all activities in a previously approved Research Protocol. If all Research activities are Terminated, the Research no longer requires Continuing Review. Terminations of Protocols approved under Expedited Review must be made by the Convened IRB.

The IRB shall notify the PI in writing of such Suspensions or Terminations and shall include an explanation of the reasons for the IRB’s actions. The terms and conditions of the Suspension must be explicit. The PI shall be provided with an opportunity to respond in person or in writing.

When a study is Suspended or Terminated, the convened IRB or authorized individual will:

1. Have any Unanticipated Problems reported to the IRB;
2. Consider actions to protect the rights and welfare of subjects;
3. Consider whether procedures for withdrawal of enrolled subjects take into account their
rights and welfare; and

4. Consider informing current subjects of the Suspension or Termination.

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

The PI must continue to provide reports on Adverse Events and Unanticipated Problems to both the IRB and Sponsor just as if there had never been a suspension (i.e., all events that need to be reported during a study need to continue to be reported during the suspension period.)

Suspension or Termination of Research approved that involves an IRB-approved Protocol also can be issued by University officials acting outside of an unrelated matter to the HRPP (i.e., not necessarily related to protecting the rights and welfare of study Participants). Such University actions can be made by the University President, Provost, or Deans. Such University actions may be made for any reason in furtherance of the Institution’s interest provided, however, that the aggrieved PI is entitled to all rights and procedures afforded to him/her under university grievance policies. The PI must report any Suspension or Termination of the conduct of Research by organization officials to the IRB. The IRB will then determine if Suspension or Termination of IRB approval is warranted.

AAHRPP Standards for Accreditation (Standard II-2, Element II.2.H)

Regulations & Guidance: DHHS 45 CFR §46.113; FDA 21 CFR §56.113

9.1.1 What is the impact of a Suspension or Termination on the performance of activities described in the study protocol?

When IRB approval of a study is Suspended or Terminated, effective immediately, all activities that meet the Federal definition of Human Subject Research must STOP. The PI is responsible for informing all members of the PI’s study team to immediately cease all Human Subject Research activity until further written notice from the PI. Sections 1.4, Definitions (above) and 9.1.2 (below) provide information regarding the scope of prohibited research activities under the Federal definition of Human Subject Research.

In the case of a Termination, cessation of specified Terminated Human Research activities is permanent. In the case of a Suspension, Human Subjects Research is temporary but must not be resumed until the IRB has notified the PI in writing that the Suspension has been lifted and IRB approval restored for the Study.

9.1.2 What activities involve Human Subjects Research?

If a study is Suspended or Terminated, it is the PI’s responsibility to make sure all members of the PI’s study team understand the scope of activities that constitutes Human Subject Research under DHHS regulations, the “Federal Policy for the Protection of Human Subjects,” also known as the Common Rule (45 CFR Part 46).
The full text of the Common Rule regulations, 45 CFR Part 46, are available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML.


The Common Rule’s definition of “human subject” is in 45 CFR 46.102(e) and is also provided in Section 1.4, Definitions, above. Importantly, under the Common Rule, the definition of “human subject” includes both living persons and obtaining, using, analyzing or generating identifiable information and biospecimens. DHHS/OHRP has provided guidance on the definitions used in the Common Rule’s definition of human subject. PIs are encouraged to read the guidance in full, but key definitions are provided below:

**Investigator:** “OHRP considers the term *investigator* to include anyone involved in conducting the research.”

**Individually identifiable:** “In general, OHRP considers private information or specimens to be *individually identifiable* as defined at 45 CFR 46.102(f) when they can be linked to specific individuals by the investigator(s) either directly or indirectly through *coding* systems.”

**Obtaining:** “*Obtaining* identifiable private information or identifiable specimens includes, but is not limited to: (1) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that have been provided to investigators from any source; and (2) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens *that were already in the possession of the investigator.*”

It is important that the PI and the PI’s Study team understand that under the Common Rule any use of identified or identifiable (including coded) data or biospecimens that were collected as part of the study constitutes human subject research and is prohibited during the period of Suspension or Termination (unless the IRB determines there are exceptions due to subject safety concerns, as described in Section 9.1.6, below).

Examples of Human Subject Research activity that is prohibited during the Suspension of the Study includes, without limitation, the following activities: screening or enrollment of new subjects; collection of information or specimens from currently enrolled subjects; all access to Study data (electronic or hardcopy); analysis of Study data and/or specimens; and use of Study data for preparation of publications or presentations.

**9.1.3 Who will be notified of the Suspension or Termination of IRB approval?**

Notification of a Suspension or Termination will be provided to relevant Federal agencies (e.g., Sponsor, OHRP, FDA) as required, Tulane administrative units involved in the oversight of Human Subject Research and/or use of Federal grants supporting Human Subject Research and any sub-recipients involved in study subject to the Suspension or Termination. Below is a list of persons/entities who will be notified by Tulane of a Suspension or Termination of a study:

- Department of Health and Human Services’ (DHHS) Office of Human Research Protection (DHHS/OHRP)
- Federal sponsor
• Vice President for Research/Institutional Official (IO)
• PI’s Dean and Department Head
• Dean’s Chief Financial Officer (CFO)
• Research Compliance Office (RCO)
• Grants and Contracts Accounting (GCA)
• Sponsored Projects Administration (SPA)
• IACUC and/or IBC (as applicable)
• General Counsel’s office
• Subrecipients’ IRBs

The IO will notify DHHS/OHRP of the Suspension or Termination of the Study. SPA will notify the Federal sponsor and any sub-recipients of the Suspension or Termination of the study. The PI will be copied on notifications issued by the IO and SPA.

9.1.4 What is the Impact of a Suspension or Termination on Federal Grants Funding the Study?

Federal regulations prohibit the use of Federal funds for Human Subject Research that is not conducted under current IRB approval. As the grantee of all Federal research grants and contracts, Tulane University is responsible for ensuring that Federal funds are not used for unauthorized Human Subject Research. To meet this legal obligation, the GCA will put a hold on grant(s) supporting a Suspended or Terminated study. For Suspended studies, the grant hold will remain in place until the Suspension has been lifted and the IRB has reinstated approval for the study. For Terminated studies, the grant hold is permanent.

A representative from the GCA will notify the PI directly of a grant hold and provide additional details about the hold. The PI shall direct all questions regarding a grant hold to the GCA (not the IRB or HRPP).

GCA will notify the following of a hold placed on a Suspended or Terminated grant or contract.

• PI
• PI’s Dean and Department Head
• Dean’s Chief Financial Administrator
• Department Administrator
• SPA
• VP Research/IO
• Human Resources
• IACUC and/or IBC (as applicable)

Note that GCA will notify Human Resources of all grant holds of Suspended or Terminated studies. Because the temporary or permanent loss of Federal funds used to support the salaries of faculty, students or staff can affect the employment status of faculty, students or staff, the PI and the PI’s Dean and/or Department Head should work with Human Resources to adjust or maintain appointments (if alternative sources of salary support are made available).

Once notified by GCA, SPA will notify Federal sponsors and any subrecipients of a hold placed on a grant or contract supporting a Suspended or Terminated study.
9.1.5 Subject Safety Issues
If a study includes procedures or interventions that are potentially beneficial to current subjects or are potentially harmful to subjects if suddenly stopped, the PI will be instructed to contact the IRB immediately. The IRB will work with the PI to develop interim procedures to use during the Suspension to ensure the safety of currently enrolled subjects. The GCA will be copied on letters from the IRB notifying the PI of the Suspension or Termination and will be responsible for determining appropriate use of the PI's grant funds to support approved interim procedures.

9.1.6 Submission of Corrective Action Plan
Within ten (10) business days of the IRB’s issuance of a Suspension, the PI must submit to the IRB a Corrective Action Plan (CAP) via the IRB electronic submission system to address the compliance concerns that necessitated the Suspension. The PI is encouraged to work with representatives of the IRB and the RCO to prepare the PI’s CAP with the goal of restoring IRB approval for the study as soon as possible.

9.1.7 Acknowledgement of Receipt of Suspension or Termination Letter
Within three (3) business days of the IRB’s issuance of a Suspension or Termination, the PI must submit to the IRB a confirmation that the PI has received the IRB letter issuing the Suspension or Termination. For a Suspended study, as part of the confirmation that the PI is to submit to the IRB, the PI is to indicate if the PI intends to submit a CAP by the deadline indicated in Section 9.1.7.

9.1.8 Summary of the PI’s Required Actions
In the case of a Suspended or Terminated study, the letter from the IRB to the PI will instruct the PI to do the following:

a) Immediately, the PI must inform all members of the PI’s study team to cease all Human Subject Research activity until further written notice. It is also the PI’s responsibility to make sure all members of the PI’s study team understand the scope of activities that constitutes Human Subject Research.

b) Immediately contact the IRB if cessation of all Human Subject Research activity could pose potential safety issues to currently enrolled subjects.

c) Within three (3) business days, the PI must submit to the IRB a confirmation that the PI has received the Suspension or Termination letter from the IRB.

d) Within ten (10) business days the PI must submit to the IRB a Corrective Action Plan (CAP) via the IRB’s Electronic System to address the compliance concerns identified by the IRB.

AAHRPP Standards for Accreditation (Standard II-2, Element II.2.H)
Regulations & Guidance: DHHS 45 CFR §46.113; FDA 21 CFR §56.113
9.2 Investigator Hold

A PI or Sponsor may request an Investigator Hold on a Protocol when the PI/Sponsor wishes to temporarily or permanently stop some or all approved Research activities. Investigator Holds are not Suspensions or Terminations. An Investigator Hold is initiated by a PI.

9.2.1 Procedures

PIs must notify the IRB in writing that:

- They are voluntarily placing a study on Investigator Hold;
- A description of the research activities that will be stopped;
- Proposed actions to be taken to protect current Participants;
- Actions that will be taken prior to IRB approval of proposed changes in order to eliminate apparent immediate harm

Upon receipt of written notification from the PI, the IRB Regulatory Compliance Specialist(s) places the Research study on the agenda for review. The IRB Chair, HRPO/HRPP Director or HRPO Assistant Director, in consultation with the PI, determines whether any additional procedures need to be followed to protect the rights and welfare of current Participants as described in “Protection of Currently Enrolled Participants” below in Section 9.1.2.

The IRB Chair and/or HRPO/HRPP Director or designee, in consultation with the PI, determines how and when currently enrolled Participants will be notified of the investigator hold.

PIs may request a modification of the investigator hold by submitting a request for a modification to previously approved Research.

9.2.2 Impact of Investigator Holds on the Study and Grants

Sections 9.1.1 – 9.1.6 apply to Investigator Holds that involve cessation of all research activity. In cases where an Investigator Hold involves cessation of some but not all research activity, the PI is responsible for clearly informing the study team about the scope of research activities that remain under IRB approval and those that are not and ensuring that the research activities performed by the study team are limited to those within the scope of IRB approval.

9.2.3 Protection of Currently Enrolled Participants

Before an Administrative Hold, Termination, or Suspension is put into effect, the convened IRB, IRB Chair (or designee) considers whether any additional procedures need to be followed to protect the rights and welfare of current Participants. Such procedures might include:

1. Transferring Participants to another PI;
2. Making arrangements for clinical care outside the Research;
3. Allowing continuation of some Research activities under the supervision of an independent monitor;
4. Requiring or permitting follow-up of Participants for safety reasons;
5. Requiring Unanticipated Problems, Adverse Events, or outcomes to be reported to the IRB and the Sponsor;
6. Notification of current and/or former Participants.
10 Documentation and Records

10.1 Policy

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

10.2 Definitions

Research Records (or “Investigator Records”): consists of records (as well as Case Histories or any data) prepared, created, gathered, or maintained by a PI, Investigator or research staff for Research Under the Auspices of the Institution.

Substantive: an action taken by an IRB that materially alters the substance and meaning of a Protocol, informed consent form or process, or Investigator status, including, but not limited to, Restriction, Suspension or Termination of a study or Investigator participation, and actions taken to prevent future occurrence(s) of the Unanticipated Problem in Research.

10.3 IRB Records

Tulane IRB Records include, but are not limited to:

- Written operating procedures (See Section 1.11);
- IRB membership rosters (See Section 4.4);
- Training records. The IRB records coordinator maintains accurate records listing research Investigators, IRB members, and IRB staff that have fulfilled the facility’s human subject training requirements. Electronic copies of documentation are maintained in the official IRB records located in the IRB Office.
- IRB correspondence (other than Protocol related);
- IRB Study Files (See Section 10 for information included in study files);
- Documentation of Emergency Exemption from Prospective IRB Approval. [FDA 21 CFR §56.104(c)]. (See Section 13.8.3.2);
- Documentation of Exceptions from Informed Consent Requirements for Emergency Use of a Test Article [FDA 21 CFR §50.23]. (See Section 10.11);
- Documentation of exemptions and when limited IRB review is a condition of exemption (See Section 10.7);
- Documentation of Convened IRB meetings minutes (see Section 10.6 for information included in the minutes);
- Documentation of IRB reliance and cooperative review agreements;
a. For nonexempt research involving human subjects covered by the Common Rule (or exempt research for which limited IRB review takes place as described in Section 10.7) that takes place at an institution in which IRB oversight is conducted by an IRB that is not operated by the institution, the institution and the organization operating the IRB shall document the institution’s reliance on the IRB for oversight of the research and the responsibilities that each entity will undertake to ensure compliance with the requirements of this policy (e.g., in a written agreement between the institution and the IRB, by implementation of an institution-wide policy directive providing the allocation of responsibilities between the institution and an IRB that is not affiliated with the institution, or as set forth in a research protocol);

- Federal-Wide Assurances;
- Federal IRB Registrations;
- Protocol Deviations submitted to the IRB;
- Quality assurance reviews.
- Documentation of complaints and any related findings and/or resolution.

Documentation for off-site IRBs includes:

- On-line access to all applicable Protocol documents
- MOU/Agreements of IRB Services
- Notes/documents pertaining to Tulane administrative reviews

AAHRPP Standards for Accreditation (Standard II-5, Element II.5.A)

Regulations & Guidance: DHHS 45 CFR §46.115(a)-(b); FDA 21 CFR §56.115(a)-(b)

10.4 IRB Study Files

HRPO will maintain an electronic study file for each IRB study submission that is submitted via the IRB electronic submission system for review. Once a study submission is confirmed to include appropriate submission materials, and signature of PI and Department Chair, it is assigned a unique IRB number by our IRB electronic submission system.

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

1. Protocol and all other documents submitted as part of an Initial Application for Human Subjects Research.

2. Protocol and all other documents submitted as part of a request for Secondary Application for Human Subjects Research (Continuing Review and Amendments) This also includes rationale for conducting continuing review of research that otherwise would not require continuing review as described in Section 10.5, annual progress reports, statements of significant new findings provided to Participants, and reports of injuries to patients;

3. Documents submitted and reviewed after the study has been approved, including reports of modifications to Research/amendments and Unanticipated Problem reports.
4. Copy of the IRB-approved **Consents** (TU Forms 402, 403)/**Assents** TU Form 401).

5. Sponsor-approved sample consent form document and Protocol, when they exist

6. IRB reviewer forms (when Expedited Review procedures are used) and scientific reviewer forms (where applicable).

7. Documentation of type of IRB review.

8. For Expedited Review, documentation of any determinations required by the regulations and Protocol-specific findings supporting those determinations, including but not limited to: waiver or alteration of the consent process, research involving Pregnant Women, Fetuses, and Neonates, Research involving Prisoners, and Research involving Children. For research reviewed by the convened board, these findings and determinations are recorded in the minutes;

9. For expedited review, documentation of the risk determination and period of approval (when continuing review is required). For research reviewed by the convened board these determinations are recorded in the minutes;

10. For expedited review, the rationale for an expedited reviewer’s determination under 45 CFR 46.110(b)(1)(i) that research appearing on the expedited review list described in 45 CFR 46.110(a) is more than minimal risk.

11. Documentation of all IRB review actions.

12. Notification of expiration of IRB approval to the PI and instructions for submitting relevant continuing review materials.


14. Correspondence pertaining to appeals.

15. Copies of approval letters and forms that describe what PIs must have before beginning the study.

16. IRB correspondence to and from Investigators.

17. All other IRB correspondence related to the Research.

18. Reports of Unanticipated Problems and Adverse Events and injuries to subjects.

19. Documentation of audits, investigations, reports of external site visits.

20. For devices, documentation of determination by IRB of significant risk/non-significant risk and a report of prior investigations.

21. DHHS-approved sample consent document and Protocol, when they exist.

22. **Study Closure Form** and final communications/correspondences

In order to allow a reconstruction of a complete history of IRB actions related to the review and approval of the protocol, the IRB records include copies of:

- Investigator brochure, if any.
- Recruitment materials.
- Data and safety monitoring reports, if any.
• Documentation of non-compliance.

Regulations & Guidance: DHHS 45 CFR §46.115(a); FDA 21 CFR §56.115(a)

10.5 IRB Membership Roster

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

1. Name;
2. Earned degrees;
3. Affiliated or non-affiliated status (neither the member nor an immediate family member of the member may be affiliated with the University);
4. Employment or other relationship between each IRB member and Tulane;
5. Status as scientist (physician-scientist, other scientist, non-scientist or social behavioral scientist). For purposes of this roster, IRB members with Research experience are designated as scientists (including the student member). Research experience includes training in Research (e.g., doctoral degrees with a Research-based thesis) and previous or current conduct of Research. Students being trained in Research fields will be designated as scientists;
6. Indications of experience, such as board certifications or licenses sufficient to describe each member's principal anticipated contributions to IRB deliberations;
7. Representative capacities of each IRB member; which IRB member is a Prisoner representative (as required by Subpart C of 45 CFR Part 46), and which IRB members are knowledgeable about or experienced in working with Children, Pregnant Women, cognitively-impaired individuals, and other subjects vulnerable to coercion or undue influence locally involved in Research;
8. Role on the IRB (e.g., IRB Chair, IRB Vice-Chair, etc.);
9. Voting status. Note that all IRB members are, by definition, entitled to vote. Guests and ex-officio guests do not have a right to vote or be counted toward a Quorum; and
10. Alternate Member status, including the primary IRB member or class of members for whom they could substitute.

The HRPO must keep the IRB membership list current. IRB Records include a curriculum vitae ("CV"), and education of each IRB member. The HRPO/HRPP Director or designee must promptly report changes in IRB membership to OHRP.

Regulations & Guidance: DHHS 45 CFR §46.115(a); FDA 21 CFR §56.115(a)

10.6 The IRB Minutes

Actions by duly convened IRB proceedings must be reduced to writing and available for review and approval within 3 weeks of the recorded meeting date. Once approved by the IRB at a subsequent IRB meeting, the minutes must not be altered by anyone including a higher Institutional
authority. It should be noted that errors or corrections to approved IRB minutes, as approved by a majority of the Convened IRB, will be included in the next meeting minutes.

A copy of IRB-approved minutes for each IRB meeting will be distributed to the IO.

Minutes of IRB meetings must contain sufficient detail to show:

1. Attendance
   a. Each member’s (or alternate’s) full name;
   b. Each member’s (or alternate’s) representative capacity (e.g., scientist, non-scientist, unaffiliated, member who represents the general perspective of research subjects);
   c. The names of members or alternate members who are participating through videoconference or teleconference and documentation that those attending remotely received all pertinent material prior to the meeting and were able to actively and equally participate in all discussions;
   d. Names of alternates attending in lieu of specified (named) absent members. (Alternates may substitute for specific absent members or categories of members only as designated on the official IRB membership roster);
   e. Names of any consultants present, a brief explanation of their expertise, and documentation to support that the consultant(s) did not vote;
   f. The names of non-members and guests in attendance, such as IRB staff, investigators, and study coordinators.

   Note: The minutes will indicate, by name, those members who enter or leave the meeting. The vote on each action will reflect the numbers of members present for the vote on that item.

2. The presence of a Quorum initially and throughout the IRB meeting, including the presence of one member whose primary concern is in a non-scientific area;

3. When both a member and an alternate are present, the minutes will reflect if and when the alternate substituted for the member. Generally, the member votes, but an alternate may substitute when appropriate (e.g., the member has a conflict of interest, the alternate has needed expertise, etc.);

4. Business items discussed;

5. Continuing education conducted;

6. Actions taken, including separate deliberations, actions, and votes for each Protocol undergoing review by the convened IRB;

7. Votes on these actions (total number voting; number voting for; number voting against; number abstaining; number of those excused, number of those recused). When a member is recused due to conflict of interest, the name of the member and reason for the recusal will be noted;

8. Basis or justification for all IRB actions and/or decisions including required changes in Research or disapproval;

9. Summary of controverted issues and their resolution;
10. Approval period for initial and continuing reviews, when applicable, including identification of Research that warrants review more often than annually and the basis for that determination;

11. The rationale for requiring continuing review of research that otherwise would not require continuing review as described in Section 8.12;

12. Risk level of initial and continuing reviews, and modifications when the modification alters the prior risk determination;

13. Review of interim reports (e.g. Unanticipated Problems or safety reports; amendments; report of deviations, serious or continuing non-compliance; Suspensions/Terminations, etc.);

14. Review of Data and Safety Monitoring Board (“DSMB”) summary;

15. Review of plans for Data and Safety Monitoring;

16. Justification of deletion or Substantive modification of information concerning risks or alternative procedures contained in the DHHS-approved sample consent document;

17. Protocol-specific documentation that the Research meets the required criteria [45 CFR §46.116(d)] when approving a consent procedure that does not include or that alters some or all of the required elements of Informed Consent, or when waiving the requirement to obtain an Informed Consent;

18. Protocol-specific documentation that the Research meets the required criteria [45 CFR §46.117(c)] when the requirements for documentation of consent are waived;

19. When approving Research that involves populations covered by Subparts B, C, or D of 45 CFR §46, including research involving subjects with diminished capacity, the minutes will document the IRB(s) justifications and findings regarding IRB determinations stated in the Subparts or the IRB(s) agreement with the findings and justifications as presented by the PI on IRB forms;

20. The rationale for Significant Risk Device/Non-Significant Risk Device determinations;

21. Determinations of Conflict of Interest;

22. Identification of any Research for which there is need for verification from sources other than the PI that no material changes are made in the Research (e.g., cooperative studies, or other collaborative Research);

23. Special protections warranted in specific Research projects for groups of subjects who 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, regardless of source of support for the Research;

24. A list of Research approved since the last meeting utilizing Expedited Review procedures including limited IRB reviews conducted using expedited procedures;

25. An indication that, when an IRB member has a COI (see Section 21) with the Research under review, the IRB member was not present during the deliberations or voting on the Proposal, and that the Quorum was maintained. The name of the IRB member will be captured in the minutes as well as the reason for their departure; and
26. Key information provided by consultants will be documented in the minutes or in a report provided by the consultant.

AAHRPP Standards for Accreditation (Standard II-5, Element II.5.B)
Regulations & Guidance: DHHS 45 CFR §46.115(a)(2); FDA 21 CFR §56.115(a)(2)

10.7 Documentation of Exempt Review Findings
Documentation of Exempt Review consists of the reviewer’s citation of a specific Exemption category and written concurrence by the IRB of the activity. When an exemption includes limited IRB review, the documentation will include this fact and the IRB action taken on those aspects of the research subject to limited IRB review in accordance with the procedures described for the review procedures used (expedited or convened board) elsewhere in this manual.

10.8 Documentation of Expedited Review
IRB Records for initial and Continuing Review by the Expedited procedure must include:
1. The specific permissible category or status as exempt but requiring limited IRB review;
2. Documentation that the activity satisfies the criteria for approval,
3. A description of action taken by the reviewer;
4. The approval period (when applicable); and
5. Any determinations required by the regulations including Protocol-specific findings justifying the following determinations:
   a. Approving a procedure which waives or alters the informed consent process;
   b. Approving a procedure which waives the requirement for documentation of consent;
   c. Approving research involving pregnant women, human fetuses, or neonates;
   d. Approving research involving prisoners;
   e. Approving research involving children.

10.9 Access to IRB Records
The IRB has policies and procedures to protect the confidentiality of research information:
1. All paper IRB records are kept secure in locked filing cabinets or locked storage rooms. The HRPO is closed and locked when unattended.
2. Tulane’s electronic IRB web-based program is hosted at an out-of-state, enterprise class, data facility. Facilities are secure, data is mirrored, and the data is backed up nightly to off-site fire-rated facilities. Authorized users have restricted access to the facility. Security precautions are state of the art. Security standards associated with user ids and passwords are in accordance with generally accepted commercial and federal security. Certified SSL (128-bit Secured Socket Layer technology) encryption is standard for all web-based
transmissions. Strict permission rules ensure that only approved individuals have access to Tulane data.

3. Access to IRB records, whether paper or electronic, is limited to the IO, IRB Chair, IRB members, HRPO staff, authorized institutional officials, and officials of Federal and state regulatory agencies (OHRP, FDA). Research Investigators are provided reasonable access to files related to their Research. Appropriate accreditation bodies are provided access and may recommend additional procedures for maintaining security of IRB records. All other access to IRB records is limited to those who have legitimate need for them, as determined by the IO.

4. Records are accessible for inspection and copying by authorized representatives of Federal regulatory agencies during regular business hours.

5. Paper records may not be removed from the HRPO Office; however, the HRPO staff will provide copies of records for authorized personnel if requested.

6. All other access to IRB study files, paper or electronic is prohibited.

10.10 Record Retention
IRB Records (as described in Section 10) pertaining to Research, which is conducted, must be stored securely. Paper records are stored in HRPO and electronically kept in the IRB electronic submission system. IRB Records must be retained for at least three (3) years after completion of the Research. IRB Records not associated with Research or for Protocols cancelled without Participant enrollment will be retained at the facility for at least 3 years after closure of the IRB file. IRB Records retained beyond their retention date will be shredded or otherwise destroyed.

See the appropriate Section 10 for record retention requirements for studies involving Investigational Drugs (Section 10.11.2) and Investigational Devices (Section 1.11.3).

AAHRPP Standards for Accreditation (Standard II-5, Element II.3.A)
Regulations & Guidance: DHHS 45 CFR §46.115(b); FDA 21 CFR §56.115(b)

10.11 Investigator Records
PIs are required to maintain accurate, current and complete records of their Human Subject Research activities. In general, PIs should establish and maintain a file for each study that has been reviewed by the IRB. These files should closely resemble the IRB’s file structure on the study. Within each study, PIs also should maintain a file for each subject who signs a consent document agreeing to participate in the study. These subject-specific files should include the original signed consent document and copies of case report forms, and any other correspondence between the PI and the subject.
Research Records should be maintained as appropriate to the type of study. For example, when a study is Sponsored externally, these records should be kept for at least 3 years after the study has been completed and the Sponsor has indicated that the records are no longer required.

There are additional requirements for record-keeping for Investigators who conduct Research that is FDA-regulated. Please see Sections below for specific requirements for use of Drugs and use of Devices in Research.

10.12 Records for FDA-Regulated Studies

10.12.1 FDA Access to Results of Quality Assurance Program Audits and Inspections

As per FDA guidance, “During routine inspections and investigations conducted at any regulated entity that has a written quality assurance program, FDA will not review or copy reports and records that result from audits and inspections of the written quality assurance program, including audits conducted under 21 CFR 820.22 and written status reports required by 21 CFR 58.35(b)(4). See

CPG Sec. 130.300 FDA Access to Results of Quality Assurance Program Audits and Inspections

10.12.2 Investigational Drugs

Investigators are expected to maintain accurate, complete and current records with respect to studies involving Investigational Drugs consistent with FDA requirements found at 21 CFR §312.62(a)(b)(c). This includes the following:

1. **Disposition of Drug:** A PI is required to maintain adequate records of the disposition of the Drug, including dates, quantity, and use by subjects.

2. **Case Histories:** A PI is required to prepare and maintain adequate and accurate Case Histories that record all observations and other data pertinent to the investigation on each individual Administered the Investigational Drug or employed as a control in the investigation. Case Histories include the case report forms and supporting data including (e.g., signed and dated consent forms), and medical records (e.g., physician progress notes, the individual’s hospital chart(s), and the nurses’ notes). The Case History for each individual shall document that Informed Consent was obtained prior to participation in the study.

3. **Record retention:** A PI shall retain records involving Investigational Drugs involved in an FDA-regulated study for a period of 2 years following the date a marketing application is approved for the Drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and FDA is notified.

Regulations & Guidance: FDA 21 CFR §312.62

10.13 Responsibilities for FDA-Regulated Research

10.13.1 General

1. Under FDA regulations and guidance, clinical investigators must be qualified by training and experience. They are responsible for the conduct of the study and for leading the
team of individuals conducting the study. Before beginning participation in a clinical investigation, the clinical investigator must commit to the sponsor that he/she will follow federal regulations governing investigation drugs (including biologics) and devices.

2. Ensuring the informed consent is obtained from subjects in accordance with IRB approval.

3. Retaining records for two years following the date the marketing application is approved by FDA or withdrawn and making those records available for inspection.

4. Furnishing the required reports to the sponsor, including reports of adverse events and study completion.

5. Providing timely reports to the IRB, including reports of changes in the research activity needed to avoid immediate hazards to participants, protocol deviations, unanticipated problems involving risks to participants or others (see Section 14 of these SOPs).

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

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

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

9. Complying with all FDA test article requirements.

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

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

12. Disclosing relevant financial information and conflicts of interest.

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

14. The Clinical Investigator is additionally responsible for all other general clinical investigator requirements as detailed in these SOPs.

10.13.2 Drug/Biologic Research

1. The Clinical Investigator must comply with the requirements specified in FDA Form 1572:
   - Personally conduct or supervise the described investigation(s).
   - Conduct the studies in accordance with the current IRB-approved protocol(s) and will only make changes in a protocol after notifying the sponsor, except when necessary to protect the safety, the rights, or welfare of participants.
   - Comply with all requirements regarding the obligations of Clinical Investigators and all other pertinent regulatory requirements.
   - Immediately report to the Sponsor any Serious Adverse Event, whether or not
considered drug related, including those listed in the Protocol or Investigator Brochure and must include an assessment of whether there is a reasonable possibility that the Drug caused the Event. Study endpoints that are Serious Adverse Events (e.g., all-cause mortality) must be reported in accordance with the Protocol unless there is evidence suggesting a causal relationship between the Drug and the Event (e.g., death from anaphylaxis). In that case, the Investigator must immediately report the Event to the Sponsor. The Investigator must record non-serious Adverse Events and report them to the Sponsor according to the timetable for reporting specified in the Protocol.

§312.64; (b)

- Read and understand the information in the Investigator’s Brochure, including the potential risks and side effects of the Drug.

- Ensure that all associates, colleagues, and employees assisting in the conduct of the study(ies) are informed about their obligations in meeting the above commitments.

- Ensure that an investigation is conducted according to the signed statement (Form FDA 1572), the Investigational Plan, and applicable regulations.

- Protecting the rights, safety, and welfare of participants under the clinical investigator’s care.

2. The Clinical Investigator proposing Drug/Biologic Research will be required to comply with the University’s Research Pharmacy Plan for storage, security, and dispensing of the Drug/Biologics, and will be responsible for accounting, return, disposition, and records of accountability per the Study Protocol.

- For research conducted at Tulane University [may need to specify sites/narrow this, depending on your specific policy], the Clinical Investigator will delegate the responsibility for drugs/biologics accountability, including storage, dispensing, labeling, and distribution, to the Research Pharmacy in the Tulane Medical Center Pharmacy Department

- If applicable: For Research conducted in any other campus site, the plan will be provided to Research Pharmacy, and evaluated by the IRB, in consultation at the time of submission review.

- [If there is a Clinical Investigator responsibility to share IRB approval notification with the IDS/Research Pharmacy, explain here]

- The Clinical Investigator must inform the IRB and Research Pharmacy when a study involving investigational drugs has been terminated by the Sponsor.

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

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

5. The Clinical Investigator is required to maintain adequate records of the disposition of
the Drug, including dates, quantity, and use by participants (in accordance with any requirements set forth by the Research Pharmacy).

6. If the Investigation is Terminated, Suspended, Discounted, or Completed, the Clinical Investigator must return the unused supplies of the Drug to the Sponsor, or otherwise provide for disposition of the unused supplies of the Drug if authorized by the Sponsor.

7. A Clinical Investigator is required to prepare and maintain adequate and accurate case histories that record all observations and other data pertinent to the Investigation on each individual administered the Investigational Drug or employed as a control in the Investigation.

   • Case histories include the case report forms and supporting data (e.g., signed and dated consent forms and medical records including, for example, progress notes of the physician, the individual’s hospital chart(s), and the nurses’ notes). The case history for each individual will document that informed consent was obtained prior to participation in the study.

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

9. A Clinical Investigator must maintain the following:

   • Current curriculum vitae (CV)
   • Protocol
   • Records of receipt and disposition of drugs
   • List of any co-investigators with their curriculum vitae
   • Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation, and
   • Case histories with particular documentation on evidence of drug effects. Emphasis is on toxicity and possible untoward happenings. All unanticipated problems involving risk to subjects or others are reportable, in accordance with Section 14.
   • IRB letters of approval.
   • Other documents as outlined in the HRPP Standard Operating Procedures

Regulations & Guidance: FDA 21 CFR §312.62

10.13.3 Device Research

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

2. The Clinical Investigator must ensure that an Investigation is conducted according to the signed agreement, the Investigational Plan and applicable FDA regulations.

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

4. All devices received for a study must be stored in a locked environment under secure control with limited access. The area must be within an area of Clinical Investigator’s control. Proper instructions on the use of the Device must be provided to the Subjects. A log must be kept regarding the receipt, use, and/or dispensing of the Device (identification/serial number of the Device, name of subject, date dispensed, by whom it was dispensed, and amount remaining) as well as the disposition of used and unused devices at the conclusion of the Investigation. Details: [21 CFR §812.140]

5. The Clinical Investigator will maintain records of each participant’s case history and exposure to the Device. Case histories include the case report forms and supporting data (e.g., signed and dated consent forms and medical records, progress notes of the physician, the individual’s hospital chart(s), and the nurses’ notes). Such records will include:
   • Documents evidencing informed consent and, for any use of a Device by the Clinical Investigator without informed consent, any written concurrence of a licensed physician and a brief description of the circumstances justifying the failure to obtain informed consent. The case history for each individual will document that informed consent was obtained prior to participation in the study.
   • All relevant observations, including records concerning Adverse Device Effects (whether anticipated or unanticipated), information and data on the condition of each participant upon entering, and during the course of, the Investigation, including information about relevant previous medical history and the results of all diagnostic tests.
   • A record of the exposure of each participant to the Investigational Device, including the date and time of each use, and any other therapy.
   • The Protocol, with documents showing the dates of and reasons for each deviation from the Protocol.
   • Any other records that FDA requires to be maintained by regulation or by specific requirement for a category of investigations or a particular investigation.

• Unanticipated Adverse Device Effects
• Withdrawal of IRB approval
• Reports of deviations from the approved investigational plan
• Progress reports (at least annually) and a final report
• Other reports as required/requested by the Sponsor or IRB

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

8. The Clinical Investigator will maintain the following:
   • Current curriculum vitae (CV)
   • Protocol of the study
   • Records of animal study reports
   • Records of receipt and disposition of Devices
   • List of any co-investigators with their curriculum vitae
   • Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the Investigation,
   • Case histories with particular documentation on evidence of effects. Emphasis is on safety and possible untoward happenings. All Unanticipated Adverse Device Effects are Reportable, per Section 14, SOPs
   • IRB letters of approval
   • Device Training
   • Other documents as required in these Standard Operating Procedures

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

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

1. Sponsors-Investigators: General
   • The Investigator has both Investigator responsibilities (as above), and Sponsor responsibilities, which include:
     i. Selecting qualified Investigators;
     ii. Providing Investigators with the information they need to conduct the Investigation properly;
iii. Ensuring proper monitoring of the Investigation and document monitoring activities;

iv. Ensuring that the FDA and (for devices) any reviewing IRBs or (for drugs) all participating Investigators are promptly informed of significant new information about an investigation; and

v. Reporting requirements to the FDA

- Sponsor-Investigators who submit protocols to the Tulane IRB involving FDA test articles must include supporting FDA documentation for their IND or IDE.

- If the IND or IDE product will be manufactured at Tulane University, the Clinical Investigator must submit documentation that the product preparation and manufacture meet the standards for current Good Manufacturing Practice (GMP), or any modification to those standards approved by the FDA in issuing the IND or IDE. This documentation will be subject to review by appropriate TU entities, as determined by the HRPO.

- The IND or IDE product must be stored, secured, dispensed, and documented as indicated in the submission materials to the IRB, and in accordance with the requirements referenced in the preceding sections.

- Comply with the Research Pharmacy Services submission requirements (see Sections 1.12.10.2 and 13).

2. Sponsors-Investigators: IDE’s

- A Sponsor-Investigator for an IDE Protocol must follow the FDA Regulations in 21 CFR 812 applicable to Sponsor responsibilities, particularly Subpart C. This includes:
  
  i. The record keeping requirements of 21 CFR 812.140(b), and

  ii. The required notification under 21 CFR 812.150(b)(1) to the FDA an all participating investigators of any evaluation of an Unanticipated Device Effect within 10 days of first receiving notice of the effect.

- An Investigation of a Device other than a Significant Risk Device is considered to have an approved application for IDE, unless FDA has given notice under 812.20(a) that approval of an application is required, if the Device is not a banned device and the Sponsor:

  i. Labels the Device in accordance with 812.5;

  ii. Obtains IRB approval of the Investigation after presenting the reviewing IRB with a brief explanation of why the Device is not a Significant Risk Device, and maintains such approval;

  iii. (Ensures that each Investigator participating in an Investigation of the Device obtains from each subject under the investigator’s care, informed consent under part 50 and documents it, unless documentation is waived by an IRB under 56.109(c).
iv. Complies with the requirements of 812.46 with respect to monitoring investigations;

v. Maintains the records required under 812.140(b) (4) and (5) and makes the reports required under 812.150(b) (1) through (3) and (5) through (10);

vi. Ensures that participating investigators maintain the records required by 812.140(a)(3)(i) and make the reports required under 812(a) (1), (2), (5), and (7); and

vii. Complies with the prohibitions in 812.7 against promotion and other practices.

3. Sponsor-Investigators: IND’s

   • A Sponsor-Investigator for an IND Protocol must follow the FDA Regulations in 21 CFR 312 applicable to Sponsor responsibilities, particularly Subpart D. This includes:

     o The record keeping requirements of 21 CFR 312.57, and

     o Promptly reporting as required in 21 CFR 312.55(b) to the FDA and all participating investigators of significant new Adverse Effects or Risk with respect to the Drug or Biologic.

4. FDA Regulations for Investigators assuming the Sponsor Function by holding an IND or IDE

Drugs or Devices:

*21 CFR §11 (Electronic records and electronic signature)

*21 CFR §54 (Financial Disclosure by Clinical Investigators)

Drugs and Biologics:

*21 CFR §210 (Current Good Manufacturing Practice In Manufacturing, Processing, Packing, Or Holding of Drugs; General

*21 CFR §211 (Current Good Manufacturing Practice for Finished Pharmaceuticals)

*21 CFR §312 (Investigational New Drug Application)

*21 CFR §314 (Drugs for Human Use)

*21 CFR §320 (Bioavailability and Bioequivalence Requirements)

*21 CFR §330 (Over-The-Counter (OTC) Human Drugs Which are Generally Recognized as Safe and Effective and Not Misbranded)

*21 CFR §601 (Biologics Licensing)

Devices:

*21 CFR §812 (Establishment Registration and Device Listing for Manufacturers and Initial Importers of Devices)

*21 CFR §812 (Investigational Device Exemptions)
*21 CFR §814 (Premarket Approval of Medical Devices)
*21 CFR §820 (Quality System Regulation)
*21 CFR §860 (Medical Device Classification Procedures)
11 Obtaining Informed Consent from Research Subjects

11.1 Policy
No Investigator conducting Research Under the Auspices of the Institution may involve a Human Subject in Research without obtaining the legally effective Informed Consent of the subject or the subject’s Legally Authorized Representative unless a waiver of consent has been approved by the IRB in accordance with Section 11.16 of these procedures. Except as provided in Section 11.17, Informed Consent must be documented by the use of a written consent form approved by the IRB (See Section 11.9).

The informed consent process involves three key features: (1) disclosing to the prospective Human Subject information needed to make an informed decision; (2) facilitating the understanding of what has been disclosed; and (3) promoting the voluntariness of the decision about whether or not to participate in the Research.

Informed consent is more than just a signature on a form. It is a process of information exchange to include reading and signing the informed consent document. The informed consent process is the critical communication link between the prospective Human Subject and an Investigator, beginning with the initial approach of an Investigator and continuing through the completion of the Research study. Investigators must have received the appropriate training and be knowledgeable about the study Protocol in order that they may answer questions to help provide understanding to the study Participant or potential study Participant. The exchange of information between the Investigator and study Participant can occur via one or more of the following modes of communication, among others; face-to-face contact, telephone (case-by-case basis if approved by the IRB; or electronic mediums such as video conferencing.

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

The following procedures describe the requirements for obtaining consent from Participants in Research Under the Auspices of the Institution.

Neither “passive” nor “implied” consent is recognized by the IRB, per HHS regulations.

Regulations & Guidance: DHHS 45 CFR §46.116; FDA 21 CFR §50.20; AAHRPP Standards for Accreditation (Standard II-3, Element II.3.F)

11.2 Definitions
**Guardian (or Legal Guardian):** means an individual who is authorized under applicable State or local law to consent on behalf of a Child to (a) general medical care when general medical care includes participation in Research; or (b) to participate in Research. [DHHS 45 CFR §46.402(e); FDA 21 CFR 50.3(s); LA. Children’s Code 116(12-12.1), 718, 719]. A Guardian of a Minor retains the duty and authority to (1) act in the best interests of the Minor, subject to residual parental rights and responsibilities (if any); (2) make important decisions in matters having a permanent effect on the life and development of the Minor; and (3) to be concerned with the Minor’s general welfare. For Research conducted in jurisdictions other than Louisiana, the Research must comply
with the laws regarding guardianship in all relevant jurisdictions where the Research will take place. [LA Children’s Code 116(12-12.1), 718, 719].

**Legally Authorized Representative**—is an individual, judicial, or other body authorized under applicable law to consent or otherwise provide permission on behalf of a subject, either prospectively or during the course of Research, to the subject’s participation in the procedure(s) involved in the Research. [DHHS 45 CFR §46.102(c); FDA 21 CFR §50.3(l)]. For the purposes of this document, a Legally Authorized Representative includes a person appointed as a Health Agent, a court-appointed Legal Guardian of the person, as well as next-of-kin in the following order of priority unless otherwise specified by applicable State law: the subject’s spouse; adult Child(ren) of subject (18 years of age or older); Parent of subject; adult sibling(s) of subject (18 years of age or older); grandparent(s) of subject; or adult grandchild(ren) of subject (18 years of age or older). If there is more than one person within the above-named class, the consent shall be given by a majority of those members of the class available for consultation. [LA R.S. 40:1159.4] Legally Authorized Representative should not be confused with Legal Guardian.

**11.3 PI Delegation for Securing and Documenting Informed Consent**

A PI is required to obtain legally effective Informed Consent from a subject or the subject’s Legally Authorized Representative. [DHHS 45 CFR §46.116; FDA 21 CFR §50.20; AAHRPP II.7.D]. When Informed Consent is required, it must be sought prospectively, and properly documented. [DHHS 45 CFR §46.117; FDA 21 CFR §50.27]. The requirement to obtain the legally effective Informed Consent of individuals before involving them in Research is one of the central protections provided for by the Federal regulations and the Tulane HRPP. If someone other than the PI conducts the interview and obtains consent from the Subject, the PI needs to formally delegate this responsibility, and the person so delegated must have received appropriate training to perform this activity. The person so delegated must be knowledgeable about the Research to be conducted and the consenting process and must be able to answer questions about the study. The PI should complete, maintain and update the Log entitled **PI Delegation and Signature Log (TUF 1001)**.

If the PI proposes to delegate consenting responsibilities, then the PI must provide an explanation to the IRB of how the proposed delegate has been trained to obtain consent by answering the following questions in the Protocol application:

1. What qualifies this individual to obtain consent?
2. What specific training has this individual had or will this individual have to assure that he/she knows the Protocol and can answer all questions posed by potential subjects?
3. What ongoing supervision/training will be provided for this individual?

Sample or draft consent documents may be developed by a Sponsor or cooperative study group. However, the IRB-of-record is the final authority on the content of the consent documents that is presented to the prospective study subjects.

These informed consent requirements are not intended to preempt any applicable Federal, State, or local laws that require additional information to be disclosed for Informed Consent to be legally effective.
11.4 Basic Requirements

Except as provided elsewhere in these Standard Operating Procedures:

1. Before involving a human subject in research, an investigator shall obtain the legally effective informed consent of the subject or the subject’s LAR

2. An investigator shall seek informed consent only under circumstances that provide the prospective subject or the LAR sufficient opportunity to discuss and consider whether or not to participate and that minimize the possibility of coercion or undue influence

3. The information that is given to the subject or the LAR shall be in language understandable to the subject or the LAR

4. The prospective subject or the LAR must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information

5. Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or LAR in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension.

6. Informed consent as a whole must present information in sufficient detail relating to the research, and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject’s or LAR’s understanding of the reasons why one might or might not want to participate.

7. No informed consent may include any exculpatory language through which the subject or the LAR is made to waive or appear to waive any of the subject’s legal rights, or releases or appears to release the investigator, the sponsor, the institution, or its agents from liability for negligence.

These informed consent requirements are not intended to preempt any applicable federal, state, or local laws (including tribal laws passed by the official governing body of an American Indian or Alaska Native tribe) that have additional requirements for informed consent to be legally effective.

11.5 Additional Requirements for Informed Consent

Informed consent must be obtained under the following circumstances:

1. Informed consent may only be obtained from subjects who have the legal and mental capacity to give consent. For subjects without that capacity, consent must be obtained from a Legally Authorized Representative. See Section 11.10 for details regarding additional requirements for individuals with impaired decision making.

2. The informed consent information must be presented in language that is understandable to the subject (or Legally Authorized Representative). To the extent possible, the language should be understandable by a person who is educated to 8th grade level and layman’s terms shall be used in the description of the Research. The IRB may require or allow different readability standards based upon the characteristics of the target subject population;
3. For subjects whose native language is not English, Informed Consent must be obtained in a language that is understandable to the subject (or Legally Authorized Representative). In [DHHS 45 CFR §46.116; FDA 21 CFR §50.20].

4. The PI is ultimately responsible for ensuring that each prospective subject is adequately informed about all aspects of the Research and understands the information provided. However, the HRPO, the Research Investigators and the Research staff all share in the responsibility of ensuring that the informed consent process is adequate.

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.F)

11.6 Determining a potential adult subject’s ability to consent to Research

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

1. That the activity is Research
2. Of the risks and benefits of a study
3. Of the study procedures and requirements
4. Of the alternatives that are available if not participating
5. That, by choosing not to participate, this decision will be accepted without penalty

In reaching a decision about participation, it is essential for the potential subject to demonstrate an ability to use this information in a rational manner. Thus, in considering risks, benefits, and available alternatives, subjects must show they understand the aspects of these factors that are unique to them as individuals.

See Section 11.10 for further discussion regarding adults who cannot consent for themselves. The decision-making capacity of a potential research subject should be evaluated when there are reasons to believe that the subject may not be capable of making voluntary and informed decisions about Research participation.

The Investigator and Research staff must have adequate procedures in place for assessing and ensuring subjects’ capacity, understanding, and informed consent or assent. The IRB will evaluate whether the proposed plan to assess capacity to consent is adequate including consideration of state, local, and Institutional policy.

It is often possible for Investigators and others to enable persons with some decisional impairment to make voluntary and informed decisions to consent, assent, or refuse participation in Research. Potential measures include repetitive teaching, group sessions, audiovisual presentations, and oral or written recall tests. Other measures might include follow-up questions to assess subject understanding, videotaping or audio-taping of consent interviews, second opinions, use of independent consent observers, allowing a waiting period before enrollment, or involvement of a trusted family member or friend in the disclosure and decision-making process.
Both Investigators and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision-making capacity or those with decreasing capacity to provide consent, periodic reevaluation of capacity and re-consent or consent for continuing participation by a legally authorized representative may be necessary.

In the event that Research participants lose or become impaired in decision-making capacity after enrollment, and this is not anticipated in the Research plan, the Investigator is responsible for developing a plan for the IRB’s consideration which follows the guidelines outlined above for persons with fluctuating or diminishing capacity.

Whenever the participants have the capacity to give consent (as determined by qualified professionals), informed consent should be obtained and documented in accordance with Section 11 above. When participants lack the capacity to give consent, Investigators may obtain consent from the legally authorized representative of a subject as described in Section 11.10.

When assent is possible for some or all subjects, the Investigator should provide the IRB with an assent plan that describes when and how assent will be obtained, provisions that will be taken to promote understanding and voluntariness, and how assent will be documented. Under no circumstances may subjects be forced or coerced to participate.

If the Investigator plans to use audio or videotapes, computer video presentations, or written materials, to promote understanding, these materials must be provided to the IRB for review. If the Investigator intends to use audio or video recordings to document assent, provisions to ensure the security of the recordings should be described to the IRB. If the Investigator will use an assent form to document assent, this must be submitted to the IRB for review.

11.7 Basic Elements of Informed Consent

To be valid, the consent process must provide the following basic elements of information to potential subjects:

1. A statement that the study involves Research, an explanation of the purposes of the Research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental and done for Research purposes;
2. A description of any reasonably foreseeable risks or discomforts to the subject including privacy risks (legal, employment, etc.);
3. A description of any benefits to the subject or to others which may reasonably be expected from the Research;
4. A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;
5. A statement describing the extent, if any, to which confidentiality of records identifying the subject must be maintained;
6. For Research involving more than Minimal Risk, an explanation as to the availability of medical treatment in the case of Research-related injury, including who will pay for the treatment and whether other financial compensation is available;
7. An explanation of whom to contact on the research team for answers to pertinent questions about the Research or to voice concerns or complaints about the Research, and whom to contact in the event of a Research-related injury to the subject;

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

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

10. One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens:

   • A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or

   • A statement that the subject’s information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

11. For FDA-regulated studies, the possibility that the FDA may inspect the records needs to be included in the statement regarding subject Confidentiality.

12. For applicable FDA-regulated clinical trials, the following statement must be included verbatim:

   “A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.”


Regulations & Guidance: DHHS 45 CFR §46.116(a); FDA 21 CFR §50.25(a); OHRP Guidance on Exculpatory Language in Informed Consents; FDA Information Sheets: A Guide to Informed Consents
11.8 Additional Elements of Informed Consent to be Applied, as Appropriate:

Additional situational-specific elements that an Informed Consent should include are:

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

2. A statement that if the subject is or becomes Pregnant, the particular treatment or procedure may involve risks to the embryo or Fetus, which are currently unforeseeable (e.g., include when the Research involves Pregnant Women or women of childbearing potential and the risk to Fetuses of the Drugs, Devices, or other procedures involved in the Research is not well known);

3. Anticipated circumstances under which the subject’s participation may be Terminated by the Investigator without regard to the subject’s consent;

4. Any additional costs to the subject that may result from participation in the Research;

5. When applicable, the amount and schedule of all payments;

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

7. Procedures for orderly termination of participation by the subject (e.g., include when the Protocol describes such procedures);

8. A statement that significant new findings developed during the course of the Research which may relate to the subject’s willingness to continue participation will be provided to the subject (e.g., include when the Research is long term and interim information is likely to be developed during the conduct of the Research);

9. The approximate number of subjects involved in the study (e.g., include when the Research involves more than Minimal Risk);

10. A statement that the subject’s biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit;

11. A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions;

12. For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).

13. Use of a written translation of the entire IRB-approved English consent form is required for subjects who do not speak English and where researchers can reasonably expect that more than an incidental number of subjects speaking the same non-English language will be enrolled (e.g., if the Investigator is targeting a non-English speaking group). The IRB must approve all translated versions of the consent form and recommends that the translation is done by a certified translator. However, the IRB will consider, on a case-
by-case basis, allowing other translators to perform this function with verification that the translation is an accurate and acceptable presentation of the entire English version.


Regulations & Guidance: DHHS 45 CFR §46.116(b); FDA 21 CFR §50.25(b)

11.9 Documentation of Informed Consent

Except as provided in Section 11.9, Informed Consent must be documented by the use of a written consent form that embodies the basic and required additional elements of informed consent. The investigator shall give either the subject or the subject’s LAR adequate opportunity to read the informed consent form before it is signed; alternatively, this form may be read to the subject or the subject’s legally authorized representative. The form must be approved by the IRB and signed (including in an electronic format), dated and timed by the subject or the subject's Legally Authorized Representative at the time of consent. The subject should initial the bottom of each page of the informed consent documentation. This includes non-therapeutic clinical trials (i.e., a trial in which there is no anticipated direct clinical benefit to the subject) should be conducted in subjects who personally give consent and who sign and date the written consent document. A copy of the signed and dated consent form must be given to the person signing the form.

The informed consent process must also be conducted, and consent obtained in person in addition to reading and signing the informed consent document. The exchange of information between the Investigator and study Participant can occur via one or more of the following modes of communication, among others; face-to-face contact, telephone (case-by-case basis if approved by the IRB; or interactive electronic mediums such as video conferencing. Tulane does not allow for obtaining Informed Consent by mail to ensure subject understanding and to allow for question/answer sessions. In addition to signing the consent document, the subject or representative should enter the date and time of signature on the consent document to permit verification that consent was actually obtained before the subject began participation in the study. If the consent is obtained on the same day as the subject’s involvement in the study begins, the subject’s medical records/source documentation should document that consent was obtained prior to participation in the study. A written copy of the signed and dated consent document should be provided to the subject, a copy placed on all of the appropriate Tulane medical records, and the original signed consent document should be retained in the study records.

Documentation of the consent process includes:

- Prior to a participant’s participation in the trial, the written consent document should be signed (including in an electronic format) 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.

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.”

11.9.1 Informed Consent-- Document Stamp Date

If the Informed Consent is to be documented, then the PI will receive, along with the approval letter, one copy of the IRB-approved consent form for the study that will have been stamped with the IRB approval date and expiration date. The PI is to make copies of the informed consent document that bears the IRB-approval stamp and use those copies for consenting study Participants.

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.F)

11.9.2 Electronic Informed Consent

Subject to IRB prior approval, when written Informed Consent is required, it may be obtained electronically. Electronic signatures must be trustworthy, reliable, and generally equivalent to handwritten signatures executed on paper (see 21 CFR part 11, subpart A 183 (11.1)(a)).

Tulane does not mandate a specific method of electronic signature (e.g., an encrypted digital signature, electronic signature pad, voice print, digital fingerprint, etc.). The IRB should consider issues such as how the electronic signature is created, if the electronic signature can be shown to be legitimate, the date and time that consent was given, and if the consent or permission document can be produced in hard copy for review by the subject upon request.

Processes used for obtained electronic Informed Consent must meet the requirements of all applicable regulations and these policies.

Electronic Consent refers to using electronic systems and processes that may employ electronic media to convey information related to the study and to obtain and document informed consent. Electronic Consent is an option for some minimum risk studies on a case-by-case basis. The PI is responsible to verify the identity of the Subject completing the electronic Consent. When the IRB approves electronic Consent, the Investigator must include all applicable components of informed consent along with the following considerations:

- Electronic version of ICF
  - Viewable on all mobile and desktop devices
- Comprehension Verification
  - Audio track (voice overs of important information)
  - Pictures (illustrations to assist comprehension, especially useful for young and illiterate participants)
  - Imbedded and/or Final Quizzes (i.e., teach back method)
Questions (for example, communication with research team via video conference calls, phone, email, text)

- Phrase/word definitions (text or video definitions with mouse over or click on term/phase)
- Decision tools (time on page, scrolling through the whole page, or comprehension question for each section)

- Documentation
  - Individual or multiple digital hand-written signatures (use of stylus, mouse, or finger)
    - Including witness and or PI
  - Automatic date and time stamp

- System Controls
  - Audit tracking (ability to access and report on all data entered in the system and time spent on the system)
  - Version control
  - System user role management/controls
  - Multi ICF/AF versions on system

Use of electronic Consent requires that IRB has access to the hard copy prior to the development of the electronic version of the electronic Consent form or they are provided access to the electronic version with the ability to make suggestions/stipulations in their review process. The IRB will consult with the Tulane technology expert to advise on this process when necessary.


11.10 Special Consent Circumstances

11.10.1 Non-English Speaking Subjects

1. Expected enrollment of non-English speaking subjects: In some Protocols, the PI expects to enroll non-English speaking subjects because, for example, the Protocol is studying a disease or condition that is likely to attract such individuals, or the PI is actively recruiting them. When the study subject population includes non-English speaking people or the PI and/or the IRB anticipates that consent discussions will be conducted in a language other than English, the IRB shall require a translated consent document to be prepared. In order to assure itself that the translation is accurate; the IRB will require a certified translation, to have an independent back translation. Certification can be made by any person not involved in the study who is fluent in that language and willing to certify the accuracy of the translation. When non-English
speaking subjects enroll, they and the witness sign the translated document. The subjects are given a copy of the signed translated consent document.

2. **Unexpected enrollment of a non-English speaking subject:** If a non-English speaking subject is unexpectedly eligible for Protocol enrollment, there may not be an IRB-approved written translation of the consent document. Investigators should carefully consider the ethical and legal ramifications of enrolling subjects when a language barrier exists. If the subject does not clearly understand the information presented at the signing of the consent document or in subsequent discussions, his/her consent may not be informed, and therefore, not effective.

3. **Unexpected enrollment:** If a person who does not speak or read, or has limited proficiency in, English presents for possible enrollment, and IRB-approved translated version of the written consent may not be available for use. Investigators should carefully consider the ethical and legal ramifications of enrolling subjects when a language barrier exists. If the subject does not clearly understand the information presented during the consent process or in subsequent discussions, his/her consent may not be informed, and therefore, not effective.

4. **Use of interpreters in the consent process:** Unless the person obtaining consent is fluent in the prospective subject’s language, an interpreter will be necessary to deliver information in the IRB-approved script and to facilitate the consent conversation. Preferably someone who is independent of the subject (i.e., not a family member) should assist in presenting information and obtaining consent.

   **11.11 Braille consent**

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

   **11.12 Consenting in American Sign Language (ASL)**

For deaf subjects who are fluent in ASL, the IRB may approve a consent process using ASL and the IRB-approved written consent form. When this process is approved, the individual authorized to consent prospective subjects must use a certified interpreter fluent in ASL to conduct the consent process and the documentation of the consent process must conform to the requirements set forth in **Section 11.9**.

   **11.13 Oral Consent**

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

For Research that is no more than Minimal Risk, documentation of consent may be waived according to the criteria in **Section 11.17**.

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

11.14 Consent Monitoring

In reviewing the adequacy of informed consent procedures for proposed Research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (consent monitor) is required in order to reduce the possibility of coercion and undue influence, ensure that the approved consent process is being followed, or ensure that subjects are truly giving Informed Consent.

Such monitoring may be particularly warranted for:

- High risk studies;
- Studies that involve particularly complicated procedures or interventions;
- Studies involving highly Vulnerable Populations (e.g., ICU patients, Children);
- Studies involving study staff with Minimal Risk experience in administering consent to potential study Participants, or
- Other situations when the IRB has concerns that consent process is not being conducted appropriately.

Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular Investigator or a Research project.

If the IRB determines that consent monitoring is required, the IRB Chair and the HRPO/HRPP Director will develop a monitoring plan and submit it to the IRB for approval. The consent monitoring may be conducted by IRB staff, IRB members or another party, either affiliated or not with the Institution. The PI will be notified of the IRB(s) determination and the reasons for the determination. Arrangements will be made with the PI for the monitoring of the consent process for a specified number of subjects. When observing the consent process, the monitor will determine:

- Whether the informed consent process was appropriately completed and documented;
- Whether the Participant had sufficient time to consider study participation;
- Whether the consent process involved coercion or undue influence;
- Whether the information was accurate and conveyed in understandable language; and
- Whether the subject appeared to understand the information and gave their voluntary consent.

Following the monitoring, a report of the findings will be submitted to the IRB, which will determine the appropriate action to be taken.
Subject Withdrawal or Termination

For a variety of reasons, a subject enrolled in a research study may decide to withdraw from the Research, or an Investigator may decide to terminate a subject’s participation in Research regardless of whether the subject wishes to continue participating. In these circumstances, questions sometimes arise about: (1) whether the Investigator may use, study, or analyze already collected data about the subject who withdraws from the Research or whose participation is terminated by the Investigator; and (2) whether the Investigator can continue to obtain data about the subject and if so, under what circumstances. The following addresses these and related questions. Investigators must plan for the possibility that subjects will withdraw from Research and include a discussion of what withdrawal will mean and how it will be handled in their research Protocols and informed consent documents.

Regulatory requirements regarding the retention and use of data after subject withdrawal or termination differ between Research subjects to FDA regulations and that not subject to FDA regulations. Under applicable FDA law and regulations, data collected on Human Subjects enrolled in an FDA-regulated clinical trial up to the time of subject withdrawal must remain in the trial database in order for the study to be scientifically valid. [FDA 21 CFR 314.50(f)(2); FDA 21 CFR 814.20(b)(6)(ii); FDA 21 CFR 601.2(a); and FDA 21 CFR 50.25(a)(8)]. For Research not subject to FDA regulations, Investigators, in consultation with the funding agency, can choose to honor a research subject’s request that the Investigator destroy the subject’s data or that the Investigator exclude the subject’s data from any analysis.

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

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

- For Research not subject to FDA regulations, the Investigator should inform subjects whether the Investigator intends to either: (1) retain and analyze already collected data relating to the subject up to the time of subject withdrawal; or (2) honor a research subject’s request that the Investigator destroy the subject’s data or that the Investigator exclude the subject’s data from any analysis.

Sometimes, a subject wants to withdraw from the primary interventional component of a study, but is willing to allow the Investigator to continue other research activities described in the IRB-approved Protocol and informed consent document that involve participation of the subject, such as: (1) obtaining data about the subject through interaction with the subject (e.g., through follow-up interviews, physical exams, blood tests, or radiographic imaging); or (2) obtaining identifiable private information from the subject’s medical, educational, or social services agency records or from the subject’s healthcare providers, teachers, or social worker. When a subject’s withdrawal request is limited to discontinuation of the primary interventional component of a research study, research activities involving other types of participation for which the subject previously gave consent may continue. Investigator should ask a subject who...
is withdrawing whether the subject wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the subject would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through noninvasive chart review, and address the maintenance of privacy and confidentiality of the subject’s information.

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

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

Regulations and Guidance: FDA 21 CFR 50.25(b)(4); DHHS 45 CFR 46.116(b)(4)

11.16 Waiver or Alteration of Informed Consent

(For studies receiving initial approval on or before 1/20/19, please refer to SOP’s available at https://research.tulane.edu/hrpo/policies for content of this section).

An IRB may waive the requirement to obtain informed consent, provided that the IRB finds and documents that the below criteria are satisfied. Likewise, an IRB may approve a consent procedures that omits some, or alters some or all, of the basic and additional elements of informed consent (an ‘alteration’) provided that the IRB finds and documents that the below criteria are satisfied.

1. The research or clinical investigation involves no more than minimal risk to the subjects;
2. The research or clinical investigation could not practicably be carried out without the requested waiver or alteration;
3. 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;
4. The waiver or alteration will not adversely affect the rights and welfare of the subjects and;
5. Whenever appropriate, the subjects or LARs will be provided with additional pertinent information after participation.

This option applies to both FDA-regulated and DHHS-conducted or supported research.
Public Benefit or Service Programs Waiver or Alterations

An IRB may waive the requirement to obtain informed consent, provided the IRB finds and documents that the below criteria are satisfied.
Likewise, an IRB may approve a consent procedure that omits some, or alters some or all, of the basic and additional elements of informed consent (an “alteration”) provided that the IRB finds and documents that the below criteria are satisfied.

1. 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:
   a. Public benefit or service programs;
   b. Procedures for obtaining benefits or services under those programs;
   c. Possible changes in or alternatives to those programs or procedures; or
   d. Possible changes in methods or levels of payment for benefits or services under those programs; and

2. The research could not practicably be carried out without the waiver or alteration.

This option does not apply to FDA-regulated research.

Regulations & Guidance: DHHS 45 CFR §46.116(c)-(d); FDA 21 CFR §50.23; and IRB Waiver or Alteration of Informed Consent for Clinical Investigations Involving No More Than Minimal Risk to Human Subjects

11.16.1 Screening, Recruiting, or Determining Eligibility

An IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject’s legally authorized representative, if either of the following conditions are met:
1. The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or
2. The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

11.17 Waiver of Documentation of Informed Consent

(For studies receiving initial approval on or before 1/20/19, please refer to SOP’s available at https://research.tulane.edu/hrpo/policies for content of this section).

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

1. The only record linking the subject and the research would be the informed consent document and the principal risk would be potential harm from a breach of confidentiality (e.g., domestic violence research where the primary risk is discovery by the abuser).
Each subject (or LAR) must be asked whether they want documentation linking them with the research, and their wishes must govern.

This option does not apply to FDA-regulated research.

OR

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

This option does apply to FDA-regulated research (most commonly in the context of minimal risk screening activities that are necessary to determine eligibility for enrollment in a clinical trial).

3. If the subjects or LARs are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

This option does not apply to FDA-regulated research.

Unless the IRB has granted a full waiver of the requirement to obtain informed consent, investigators who seek and receive approval for a waiver of documentation of consent still must perform an appropriate consent process.

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

See Section 26.11.4 for details with regards to waiver of Informed Consent regarding Deception and Incomplete Disclosure.

AAHRPP Standards for Accreditation (Standard II-3, Elements II.3.C.1 and II.3.G)

Regulations & Guidance: DHHS 45 CFR §46.109(c); 45 CFR §46.117; FDA 21 CFR 56.109(c) and IRB Waiver or Alteration of Informed Consent for Clinical Investigations Involving No More Than Minimal Risk to Human Subjects

11.18 Posting of Clinical Trial Consent Forms (2018 Common Rule Studies Only)

For each clinical trial conducted or supported by a Federal department or agency, one IRB approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal Web site that will be established as a repository for such informed consent forms.

If the Federal department or agency supporting or conducting the clinical trial determines that certain information should not be made publicly available on a Federal Web site (e.g.
confidential commercial information), such Federal department or agency may permit or require redactions to the information posted.

The informed consent form must be posted on the Federal Web site after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol. For additional guidance regarding posting of Clinical Trial Consent Forms, please refer to the following link at https://www.hhs.gov/ohrp/regulations-and-policy/informed-consent-posting/index.html or contact the RCO.
12 Vulnerable Subjects in Research

12.1 Policy
When some or all of the Participants in a Research Under the Auspices of the Institution’s IRB are likely to be vulnerable to coercion or undue influence or have diminished decision-making capacity, the Research must include additional safeguards to protect the rights and welfare of these Participants. The IRB must ensure that all of the regulatory requirements for the protection of Vulnerable Subjects are met and that appropriate additional protections for Vulnerable Subjects are in place.

The following procedures describe the requirements for involving vulnerable Participants in Research Under the Auspices of the Institution’s IRB.

12.2 Involvement of Vulnerable Populations
When some or all of the Participants in a Protocol are likely to be vulnerable to coercion or undue influence, the PI is to include additional safeguards to protect the rights and welfare of these Participants. The IRB review should ensure that such additional safeguards have been included by the PI. Some of the Vulnerable Populations that might be involved in Research include, but not limited to, individuals who are educationally or financially disadvantaged, Children, Pregnant Women, Fetuses, Neonates, Prisoners, adults who lack the ability to consent (either temporarily or long-term), students, employees, or homeless persons.

If the IRB reviews Research that involves categories of Participants vulnerable to coercion or undue influence, and if the IRB Reviewer feels it is necessary, the review process will include consulting with one or more individuals who are knowledgeable about or experienced in working with these Participants. For example, he/she will consult with one or more individuals who are knowledgeable about or experienced in working with Children, Prisoners, or adults with limited decision-making capacity, when reviewing Research that involves individuals from these populations.

Additional requirements for IRB oversight of Research involving Vulnerable Populations can be found at 45 CFR §part 46, which includes the following:

- Subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research;
- Subpart C - Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects; and
- Subpart D - Additional Protections for Children Involved as Subjects in Research.

DHHS-funded Research that involves any of these populations must comply with the requirements of the relevant subparts. Research funded by other federal agencies may or may not be covered by the subparts.

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

*Vulnerable Population (or “Vulnerable Subjects”): Subjects vulnerable to coercion or undue influence*, e.g., Children, Prisoners, adults with limited decision-making capacity, or economically- or educationally disadvantaged persons, etc.

12.4 Responsibilities

1. The PI is responsible for identifying the potential for enrolling Vulnerable Subjects in the Research Proposal. The PI is responsible for identifying patients who are at risk for impaired decisional capacity as a consequence of psychiatric illness, and who are being asked to participate in a Research study with greater than Minimal Risk.

2. The IRB shall include representation, either as members or ad hoc consultants, individual(s) interested in or who have experience with the Vulnerable Populations involved in a Research Proposal.

3. The IRB reviews the PI’s justifications for including Vulnerable Populations in the Research to assess appropriateness of the Research Proposal.

4. The IRB must ensure that additional safeguards have been included in each study to protect the rights and welfare of Vulnerable Subjects as needed at the time of Initial Review of the Research Proposal.

5. The IRB shall continue to review Research at intervals appropriate to the degree of risk and determine whether the proposed Research continues to fulfill criteria for approval. Information reviewed should include the number of Participants considered as members of specific Vulnerable Populations.

6. For studies that do not have or are not required to have a DSMB or a Data Monitoring Committee and have entered Vulnerable Subjects, the IRB needs to carefully review the DSM plan.

7. Information reviewed as part of continuing review process should include the number of Participants considered as members of specific vulnerable populations.

8. The IRB should be knowledgeable about and experienced in working with populations who are vulnerable to coercion and undue influence. If the IRB requires additional qualification or expertise to review a Protocol, it should obtain consultation.

12.5 Procedures

12.5.1 Initial Review of Research Proposal:

The following steps are relevant with respect to initial review of a Research Proposal:

1. The PI should identify the potential to enroll Vulnerable Subjects in the proposed Research at Initial Review and provide the justification for their inclusion in the study.

2. The IRB evaluates the proposed plan for consent of the specific Vulnerable Populations involved. If the Research involves adults unable to consent, the IRB evaluates the proposed plan for permission of Legally Authorized Representatives.
3. The IRB evaluates and approves the proposed plan for the Assent of Participants.

4. The IRB evaluates the Research to determine the need for additional protections and consider the use of a DSMB or data safety monitoring committee, as appropriate.

5. The PI should provide appropriate safeguards to protect the subject’s rights and welfare, which may include the addition of an independent monitor. The independent monitor is a qualified individual not involved in the Research study who will determine the subject’s capacity to provide voluntary Informed Consent. Populations requiring independent monitoring might include individuals with schizophrenia, other psychotic disorders or conditions characterized by lack of reality testing (i.e., psychosis). Populations not usually requiring independent monitoring would include those with substance use disorders.

6. The IRB assess the adequacy of additional protections for Vulnerable Populations provided by the PI.

12.5.2 Continuing Review and Monitoring

At Continuing Review, the PI should identify the number of Vulnerable Subjects enrolled and any that needed an independent monitor in the progress report.

12.6 Research Involving Pregnant Women or Fetuses

12.6.1 Definitions

**Dead Fetus:** is a Fetus that exhibits neither a heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord, if still attached. [DHHS 45 CFR 46.202(a)]

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

**Fetus:** is the product of conception (i.e., fusion of human spermatozoa with human ova) from the time of implantation until Delivery. [DHHS 45 CFR §46.202(c); LA R.S.40:1061.9(9)]

**Pregnant (or Pregnancy):** is the period of time from confirmation of implantation (through any of the presumptive signs of pregnancy, such as missed menses, or by a medically acceptable pregnancy test), until expulsion or extraction of the Fetus. [DHHS 45 CFR §46.202(f)]

12.6.2 Research Not Funded by DHHS

For Research not funded by DHHS, no additional safeguards are required by the regulations and there are no restrictions on the involvement of Pregnant Women in Research where the risk to the Fetus is no more than Minimal Risk except as may be determined otherwise by the IRB.

Pregnant Women or Fetuses may be involved in Research not funded by DHHS involving more than Minimal Risk to Fetuses if all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-Pregnant Women, have been conducted and provide data for assessing potential risks to Pregnant Women and Fetuses;

2. The risk to the Fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the Fetus;
3. Any risk is the least possible for achieving the objects of the Research;

4. If the Research holds out the prospect of direct benefit to the Pregnant woman, the prospect of a direct benefit both to the Pregnant woman and the Fetus, then the consent of the Pregnant woman is obtained in accordance with the provisions for Informed Consent;

5. If the Research holds out the prospect of direct benefit solely to the Fetus then the consent of the Pregnant woman and the father is obtained in accordance with the provisions for Informed Consent, except that the father’s consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the Pregnancy resulted from rape or incest;

6. Each individual providing consent under paragraph 4 or 5 of this Section is fully informed regarding the reasonably foreseeable impact of the Research on the Fetus or Neonate;

7. For Children who are Pregnant, Assent and permission are obtained in accordance with the provisions of permission and Assent (see Section 12.9.3.3);

8. No inducements, monetary or otherwise, will be offered to terminate a Pregnancy;

9. Individuals engaged in the Research will have no part in any decisions as to the timing, method, or procedures used to terminate a Pregnancy; and

10. Individuals engaged in the Research will have no part in determining the viability of a Neonate.

Regulations & Guidance: DHHS 45 CFR §46.204

12.6.3 Research Funded by DHHS

For DHHS-funded Research, 45 CFR Subpart B applies to all Research involving Pregnant Women. According to 45 CFR Subpart B, Pregnant Women or Fetuses may be involved in Research funded by DHHS if all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-Pregnant Women, have been conducted and provide data for assessing potential risk to Pregnant Women and Fetuses.

2. The risk to the Fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the Fetus or, if there is no such prospect of benefit, the risk to the Fetus is not greater than Minimal Risk and the purpose of the Research is the development of important biomedical knowledge which cannot be obtained by any other means;

3. Any risk is the least possible for achieving the objects of the Research;

4. If the Research holds out the prospect of direct benefit to the Pregnant woman, the prospect of a direct benefit both to the Pregnant woman and the Fetus, or no prospect of benefit for the woman nor the Fetus when risk to the Fetus is not greater than Minimal Risk and the purpose of the Research is the development of important biomedical knowledge that cannot be obtained by any other means, then the consent of the Pregnant woman is obtained in accordance with the provisions for Informed Consent.
5. If the Research holds out the prospect of direct benefit solely to the Fetus then the consent of the Pregnant woman and the father is obtained in accordance with the provisions for Informed Consent, except that the father’s consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the Pregnancy resulted from rape or incest.

6. Each individual providing consent under paragraph 4 or 5 of this Section is fully informed regarding the reasonably foreseeable impact of the Research on the Fetus or Neonate;

7. For Children who are Pregnant, Assent and permission are obtained in accord with the provisions of permission and Assent in Section 12.9.3.3;

8. No inducements, monetary or otherwise, will be offered to terminate a Pregnancy;

9. Individuals engaged in the Research will have no part in any decisions as to the timing, method, or procedures used to terminate a Pregnancy; and

10. Individuals engaged in the Research will have no part in determining the viability of a Neonate.

12.7 Research Involving Neonates

12.7.1 Definitions

**Neonate**: means Newborn. [DHHS 45 CFR 46.202(d)]

**Neglect**: Neglect of Neonate means a medical finding by a Louisiana licensed physician that a Neonate either is dependent upon or suffers from withdrawal symptoms from an illegal controlled dangerous substance (“CDS”). It also includes a medical finding by a physician that a Neonate suffers from an illness, disease or condition attributable to the exposure of the newborn, *in utero*, of an illegal CDS.

**Non-Viable Neonate (or “Non-Viable Fetus”)**: is a Fetus *ex utero* that, although living, is not able to survive to the point of independently maintaining a heartbeat and respiration. [DHHS CFR 46.202(e)]

**Viable Neonate (or “Viable Fetus”)**: Means a Fetus that is able, after Delivery, to survive to the point of being able to independently maintain a heartbeat and respiration (given the benefit of available medical therapy). [DHHS 45 CFR §46.202(h)]

12.7.2 General Requirement Regarding Research Involving Neonates

Neonates of uncertain viability and Non-Viable 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 that’s providing consent is fully informed regarding the reasonably foreseeable impact of the Research on the Neonate; and

3. Individuals engaged in the Research will have no part in determining the viability of a Neonate.
4. The requirements of Neonates of Uncertain Viability or Non-Viable Neonates (see below in this Section) have been met as applicable.

Regulations & Guidance: DHHS 45 CFR §46.205(a)

12.7.3 Neonates of Uncertain Viability

Until it has been ascertained whether or not a Neonate is viable, a Neonate may not be involved in Research covered by this subpart unless the following additional conditions have been met:

The IRB determines that:

1. The Research holds out the prospect of enhancing the probability of survival of the Neonate to the point of viability, and any risk is the least possible for achieving that objective; OR

2. The purpose of the Research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the Neonate resulting from the Research; AND

3. The legally effective Informed Consent of either Parent of the Neonate or, if neither Parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective Informed Consent of either Parent’s Legally Authorized Representative is obtained in accordance with the provisions of permission and Assent, except that the consent of the father or his Legally Authorized Representative need not be obtained if the Pregnancy resulted from rape or incest.

Regulations & Guidance: DHHS 45 CFR §46.205(b)

12.7.4 Non-Viable Neonates

After Delivery, Non-Viable Neonates may not be involved in Research covered by this subpart unless all of the following additional conditions are met:

1. Vital functions of the Neonate will not be artificially maintained;

2. The Research will not terminate the heartbeat or respiration of the Neonate;

3. There will be no added risk to the Neonate resulting from the Research;

4. The purpose of the Research is the development of important biomedical knowledge that cannot be obtained by other means; and

5. The legally effective Informed Consent of both Parents of the Neonate is obtained in accordance with the provisions of permission and Assent, except that the waiver and alteration of the provisions of permission and Assent do not apply.

6. However, if either Parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the Informed Consent of one Parent of a Non-Viable 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 Non-Viable Neonate will not suffice to meet the requirements of this paragraph.

Regulations & Guidance: DHHS 45 CFR §46.205(c)
12.7.5 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 accordance with the requirements of IRB Review Process and Research Involving Children. [DHHS 45 CFR §46.205(d)]

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

Research involving, after Delivery, the placenta; the dead Fetus; macerated fetal material; or cells, tissue, or organs excised from a dead Fetus, must be conducted only in accordance with any applicable Federal, State, or local laws and regulations regarding such activities.

If information associated with material described above in this Section is recorded for Research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are Research subjects and all pertinent Sections of this document are applicable. [DHHS 45 CFR §46.206]

12.7.7 Research Not Otherwise Approvable

12.7.7.1 Research Not Funded by DHHS

If the IRB finds that the Research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of Pregnant Women, Fetuses or Neonates; and the Research is not approvable under the above provisions, then the IRB will consult with a panel of experts in pertinent disciplines (e.g., science, medicine, ethics, and law). Based on the recommendation of the panel, the IRB may approve the Research based on either:

1. That the Research in fact satisfies the conditions of Section 11.6, as applicable; or

2. The following:
   a. The Research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of Pregnant Women, Fetuses or Neonates;
   b. The Research will be conducted in accordance with sound ethical principles; and
   c. Informed consent will be obtained in accordance with the provisions for Informed Consent and other applicable Sections of this document.

12.7.7.2 Research Funded by DHHS

DHHS-funded Research that falls in this category must be approved by the Secretary of DHHS. If the IRB finds that the Research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of Pregnant Women, Fetuses or Neonates; and the Research is not approvable under the above provisions, then the Research will be sent to OHRP for DHHS review.

Regulations & Guidance: DHHS 45 CFR §46.207
12.8 Research Involving Prisoners

Research conducted under the auspices of Tulane’s IRB is subject to the following requirements. Prisoners are another class deemed so vulnerable to exploitation in Research that there are special rules protecting them. In the past, Prisoners were viewed as a convenient Research population because they are housed in a single location, constitute a large and relatively stable population, and live a routine life. Unfortunately, all the things that make a prison and Prisoners a convenient Research population also make Prisoners ripe for exploitation. The concern Subpart C and these SOPs based on Subpart C attempt to address is whether Prisoners have any real choice in participation in Research, or whether incarceration prohibits free choice.

For the review of research involving prisoners, the IRB determine whether the criteria for approval of research are met when research involves prisoners. The IRB determines and documents that:

- For DHHS-funded research, OHRP has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of its intent to approve such research.
- For DHHS-funded research which require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the research, the study may proceed only after OHRP has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of its intent to approve such research.
- For DHHS-funded research, indicate the individual (Institutional Official) who certifies to OHRP the duties of the IRB have been fulfilled. At Tulane, the certification is made by the Institutional Official or designee. If no participants have been enrolled, the research may receive continuing review using the expedited procedure under expedited category #8.

12.8.1 Definitions

**Minimal Risk for Prisoners**: is the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons. [DHHS 45 CFR §46.303(d)] The definition of Minimal Risk for Prisoners contained in the Subpart C of the Federal regulations is different than the definition of Minimal Risk (for non-Prisoners).

**Prisoner**: is any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures that provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing. [DHHS 45 CFR §46.303(c)]

12.8.2 Applicability

The requirements in this Section apply to all Research involving Prisoners under the purview of the Institution’s IRB, regardless of the funding source, (unless the research qualifies for exemption and only incidentally includes prisoners). Even though the IRB may approve a Research Protocol involving Prisoners as subjects according to this policy, Investigators also are
still subject to the Administrative Regulations of the Louisiana Department of Corrections and any other applicable State or local law. [DHHS 45 CFR §46.301]

12.8.3 Composition of the IRB

In addition to satisfying the general requirements detailed in the IRB section of this document, when reviewing Research involving Prisoners, the IRB must also meet the following requirements:

- A majority of the IRB (exclusive of Prisoner members) must have no association with the prison(s) involved, apart from their membership on the IRB; and
- At least one member of the IRB must be a Prisoner, or a Prisoner representative with appropriate background and experience to serve in that capacity, except that where a particular Research project is reviewed by more than one IRB, only one IRB need to satisfy this requirement.
- The prisoner representative must be a voting member of the IRB. The prisoner representative may be listed as an alternative member who becomes a voting member when needed.

AAHRPP Standards for Accreditation (Standard II-1, Element II.1.E)
Regulations & Guidance: DHHS 45 CFR §46.304

12.8.4 Review of Research Involving Prisoners

The prisoner representative must review Research involving Prisoners, focusing on the requirements in Subpart C.

The prisoner representative must receive all review materials pertaining to the Research (same as primary reviewer).

The prisoner representative must be present at a convened meeting when the Research involving Prisoners is reviewed. If the prisoner representative is not present, Research involving Prisoners cannot be reviewed or approved. The prisoner representative may attend the meeting by phone, videoconference, or webinar, as long as the representative is able to participate in the meeting as if they were present in person at the meeting.

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

Modifications to Research involving Prisoners requires the following review:

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

**Exemption Review:** Research involving prisoners cannot undergo review for exemption, unless the research is subject to the 2018 Common Rule and only incidentally includes prisoners.

**Expedited Review** to Research involving Prisoners requires the following review:

- Research involving interaction with Prisoners may be reviewed by the expedited procedure, if a determination is made that the Research involves no greater than Minimal Risk for the prison population being studied. The prisoner representative must concur with the determination that the Research involves no greater than Minimal Risk. The prisoner representative must review the Research as a reviewer, designated by the chair, or consultant. This may be as the sole reviewer or in addition to another reviewer, as appropriate. Review of modifications and Continuing Review must use the same procedures for initial review using this expedited procedure including the responsibility of the prisoner representative.

- Research that does not involve interaction with Prisoners (e.g. existing data, records review, etc.) may be reviewed by the expedited procedure, if a determination is made that the Research involves no greater than Minimal Risk for the prison population being studied. Review by a prisoner representative is not required. The prisoner representative may review the Research as a reviewer or consultant if designated by the IRB chair. Review of modifications and Continuing Review must use the same procedures as initial review.

**12.8.5 Incarceration of Enrolled Subjects**

If a participant becomes a prisoner while enrolled in a research study that was not reviewed according to Subpart C, the investigator must promptly notify the IRB and the IRB shall:

1. Confirm that the participant meets the definition of a prisoner.

2. Consult with the investigator to determine if it is in the best interests of the participant to continue participation in the study, in part or in full, and if so, if there are specific study activities which are in the best interests of the subject and should continue until the IRB is able to review the research study under Subpart C.

3. If the participant should continue, one of two options are available:
   
   a. Keep the participant enrolled in the study and review the research under Subpart C. If some of the requirements of Subpart C cannot be met or are not applicable (e.g., procedures for the selection of subjects within the prison), but it is in the best interests of the participant to remain in the study, keep the participant enrolled and inform OHRP of the decision along with the justification.

   b. Remove the participant from the study and keep the participant on the study intervention under an alternate mechanism such as compassionate use, off label use, etc.

4. If a participant is incarcerated temporarily while enrolled in a study:
a. If the temporary incarceration has no effect on the study (i.e., there is no need for study activities to take place during the temporary incarceration), keep the participant enrolled.

b. If the temporary incarceration has an effect on the study, follow the above guidance.

12.8.6 Additional Duties of the IRB

In addition to all other IRB responsibilities prescribed in this document, the IRB will review Research involving Prisoners and approve such Research only if it finds that:

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

- Any possible advantages accruing to the Prisoner through this or her participation in the Research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh the risks of the Research against the value of such advantages in the limited choice environment of the prison is impaired;

- The risks involved in the Research are commensurate with risks that would be accepted by non-Prisoner volunteers;

- Procedures for the selection of subjects within the prison are fair to all Prisoners and immune from arbitrary intervention by prison authorities or Prisoners. Unless the PI provides to the IRB justification in writing for following some other procedures, control subjects must be selected randomly from the group of available Prisoners who meet the characteristics needed for that particular Research project;

- The information is presented in language which is understandable to the subject population;

- Adequate assurance exists that parole board will not take into account a Prisoner’s participation in the Research in making decisions regarding parole, and each Prisoner is clearly informed in advance that participation in the Research will have no effect on his or her parole; and

- Where the IRB finds there may be a need for follow-up examination or care of subjects after the end of their participation, adequate provision has been made for such
examination or care, taking into account the varying lengths of individual Prisoners’ sentences, and for informing subjects of this fact.

Regulations & Guidance: **DHHS 45 CFR §46.305**

### 12.8.7 Certification to DHHS

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

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

The above requirement does not apply to Research that is not DHHS conducted or supported.

### 12.8.8 Waiver for Epidemiology Research involving Prisoners

The Secretary of DHHS has waived the applicability of 45 CFR §46.305(a)(l) and 46.306(a)(2) (see Section 6.8.4 for details) for certain Research conducted or supported by DHHS that involves epidemiologic studies that meet the following criteria:

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

2. Where the IRB has approved the Research, and fulfilled its duties under 45 CFR §46.305(a)(2)–(7) and determined and documented that:
   - The Research presents no more than Minimal Risk for Prisoners and no more than inconvenience to the Prisoner-subjects; and
   - Prisoners are not a particular focus of the Research; and

3. The specific type of epidemiological Research subject to the waiver involves no more than Minimal Risk for Prisoners and no more than inconvenience to the Human Subject Participants. The waiver would allow the conduct of Minimal Risk for Prisoners Research that does not now fall within the categories set out in 45 CFR §46.306(a)(2); and
4. The range of studies to which the waiver would apply includes epidemiological Research related to chronic diseases, injuries, and environmental health. This type of Research uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than Minimal Risk for Prisoners to the subjects; and

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

12.9 Research Involving Children

The following applies to all Research involving Children, regardless of funding source. The requirements in this Section are consistent with Subpart D of 45 CFR 46 (applicable to DHHS-funded Research) and Subpart D of 21 CFR 50 (applies to FDA-regulated Research involving Children).

Regulations & Guidance:  
FDA 21 CFR 50 Subpart D; DHHS 45 CFR 46 Subpart D

12.9.1 Definitions

**Assent**: means a Child’s affirmative agreement to participate in Research. Mere failure of a Child to object may not, absent affirmative agreement, be construed as Assent. [DHHS 45 CFR 46.402(b); FDA 21 CFR §50.3(n)]

**Child (or “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. [DHHS 45 CFR §46.402(a); FDA 21 CFR §50.3(o)]

Louisiana law is silent with respect to the legal age to consent with respect to Research. For purposes of these SOPs, any person who is under the age of 18 generally is unable to consent for him/herself. Several important exceptions exist under Louisiana law that effectively treat Children as adults and gives them the capacity to consent to their own medical care and to participate in Research. They include the following:

- For a Child to receive medical and/or surgical care at a hospital and/or to receive physicians’ services [LA R.S. 40:1079.1]. This may or may not overlap with the proposed Research;
- If a Child is emancipated by marriage. Regardless of age, a Child is fully emancipated upon his or her marriage [LA Civil Code Art 367];
- If a Child is judicially emancipated. This requires a court order for Child older than 16 years of age [LA Civil Code Art 366 and 1922];
- If a Child is emancipated by authentic act. This requires a Child older than 16 years of age and the Child’s Parents to execute a written document of emancipation, signed before 2 witnesses and a notary [LA Civil Code Art 368];
- If a Child seeks to be treated for venereal disease [LA R.S. 40: 1121.8]; and
- If a Child seeks to be treated for drug abuse [LA R.S. 40: 1079.2].
Because Louisiana law does not specifically address consent of Children with majority status to Research, the University’s IRB will review issues of consent related to enrollment of these Children in Research on a case-by-case basis.

AAHRPP Standards for Accreditation (Standard I-3, Element I.3.G)

Guardian (or Legal Guardian): means an individual who is authorized under applicable State or local law to consent on behalf of a Child to (a) general medical care when general medical care includes participation in Research; or (b) to participate in Research. [DHHS 45 CFR §46.402(e); FDA 21 CFR 50.3(s); LA. Children’s Code 116(12-12.1), 718, 719]. A Guardian of a Minor retains the duty and authority to (1) act in the best interests of the Minor, subject to residual parental rights and responsibilities (if any); (2) make important decisions in matters having a permanent effect on the life and development of the Minor; and (3) to be concerned with the Minor’s general welfare. For Research conducted in jurisdictions other than Louisiana, the Research must comply with the laws regarding guardianship in all relevant jurisdictions where the Research will take place. [LA. Children’s Code 116(12-12.1), 718, 719].

Health Agent: Is an authorized representative legally acting for a person pursuant to a Durable Power of Attorney for Health Care (“Medical Power of Attorney”) or other legal document permitted within a jurisdiction that allows a person to appoint another person(s) to make medical decisions for the patient if the patient should become temporarily or permanently unable to make those decisions for himself/herself. Any adult (18 or older) can be granted this power. [LA R.S.13:5108.2].

Legally Authorized Representative: is an individual, judicial, or other body authorized under applicable law to consent or otherwise provide permission on behalf of a subject, either prospectively or during the course of Research, to the subject's participation in the procedure(s) involved in the Research. [DHHS 45 CFR §46.102(c); FDA 21 CFR §50.3(l)]. For the purposes of this document, a Legally Authorized Representative includes a person appointed as a Health Agent, a court-appointed Legal Guardian of the person, as well as next-of-kin in the following order of priority unless otherwise specified by applicable State law: the subject’s spouse; adult Child(ren) of subject (18 years of age or older); Parent of subject; adult sibling(s) of subject (18 years of age or older); grandparent(s) of subject; or adult grandchild(ren) of subject (18 years of age or older). If there is more than one person within the above-named class, the consent shall be given by a majority of those members of the class available for consultation. [LA R.S. 40:1159.4] Legally Authorized Representative should not be confused with Legal Guardian.

Minor means any person under the age of 18 years. [LA Children’s Code Art 116]. Do not confuse the definitions of Minor (pertaining to a person’s age) with Child/Children (pertaining to a person’s ability to consent).

Parent means a Child’s biological or adoptive parent. [DHHS 45 CFR §46.402(d); FDA 21 CFR §50.3(p)].

12.9.2 Allowable Categories

Research on Children must be reviewed and categorized by the IRB into one of the following groups:

1. [45 CFR 46.404/21 CFR 50.51] Research/Clinical Investigations not involving Greater Than Minimal Risk: Research on Children not involving physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine
physical or psychological examinations or tests (i.e., Minimal Risk). This includes adequate provisions are made for soliciting the Assent of Children and the permission of their Parents or Legal Guardians as set forth in Section 12.9.3.

2. /45 CFR 46.405/21 CFR 50.52/ Research/Clinical Investigations involving Greater Than Minimal Risk but presenting the prospect of direct benefit to the individual subjects: Research on Children involving greater than Minimal Risk but presenting the prospect of direct benefit to the individual subject.
   • The risk is justified by the anticipated benefit to the subjects;
   • 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
   • Adequate provisions are made for soliciting the Assent of Children and the permission of their Parents or Legal Guardians as set forth in Section 12.9.3.

3. /45 CFR 46.406/21 CFR 50.53/ Research/Clinical Investigations involving Greater Than Minimal Risk and No Prospect of Direct Benefit to the individual subject, but likely to yield generalizable knowledge about the subject's disorder or condition: Research on Children involving greater than Minimal Risk and no reasonable prospect of direct benefit to the individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition.
   • The risk represents a minor increase over Minimal Risk;
   • The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
   • The intervention or procedure is likely to yield generalizable knowledge about the subjects’ disorder or condition which is of vital importance to the understanding of amelioration of the subjects’ disorder or condition; and
   • Adequate provisions are made for soliciting the Assent of Children and the permission of their Parents or Legal Guardians as set forth in Section 12.9.3.

4. /45 CFR 46.407/21 CFR 50.54/ Research Not Otherwise Approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children: Research on Children not otherwise approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of Children.
   • Federally funded Research in this category must be approved by the DHHS Secretary, and requires consent of either both Parents or the Legal Guardian.
   • FDA-regulated Research in this category must be approved by the FDA Commissioner.
   • For non-Federally funded Research, the IRB will consult with a panel of experts in pertinent disciplines (e.g., science, medicine, ethics, or law). Based on the recommendation of the panel, the IRB may approve the Research based on either:
That the Research in fact satisfies the conditions of the previous categories, as applicable; or

The following:

- The Research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of Children;
- The Research will be conducted in accordance with sound ethical principles; and
- Informed consent will be obtained in accordance with the provisions for Informed Consent and other applicable Sections of this document.
- Adequate provisions are made for soliciting the Assent of Children and the permission of their Parents or Legal Guardians as set forth in Section 12.9.3.


12.9.3 Parental Permission and Assent

12.9.3.1 Parental Permission

The IRB must determine that adequate provisions have been made for soliciting the permission of each Child’s Parent or Legal Guardian, as documented in the Consent Form Templates (TU Forms 402, 403). Parents, guardians or legally authorized representatives must be provided with the basic elements of consent and any additional elements the IRB deems necessary, as described in Section 11.7.

Consent should be obtained as follows in this order of priority:

- Mother and father [LA Civil Code Art 178 and 221] or adoptive foster parents [LA Civil Code Art 199; LA R.S.40:1159.6]. The right first rests with married Parents of the Child [LA Civil Code Art 221]. If either parent consents during the marriage, comply with his or her wishes (subject to the Assent requirements below)[LA Civil Code Art 232], unless the consenting parent’s authority has been suspended due to extraordinary circumstances [LA Civil Code Art 232] or as a result of a custody award [LA Civil Code Art 234].
- Upon execution of a mandate from the Child’s Parents granting provisional custody to another adult [LA Civil Code Art 233 and LA R.S. 9:951-54] or upon a voluntary transfer of custody to other responsible adults consistent [LA Children’s Code Art 1510 et seq.].
- The court recognized tutor/tutrix [LA Civil Code Art249 et seq.; LA Code of Civil Procedure Art 4031 et seq.]. The IRB will also consider situations where a minor may consent to his or her medical treatment. A fully emancipated minor may consent on his or her own behalf [See LA Civil Code Art 366-68]. Under limited emancipation, a minor may consent to medical treatment if specified in the order of limited judicial
emancipation or authentic act of limited emancipation [LA Civil Code Art 366 and 368]. A minor who is or believes he or she is afflicted with an illness or disease may consent to the provision of medical or surgical care or services [LA R.S. 40:1079.1]. A minor may consent to medical care or administration of medication to alleviate pain during labor and childbirth [LA R.S. 40:1079.1].

For Research conducted in jurisdictions other than Louisiana, the Research must comply with the laws regarding the legal age of consent in all relevant jurisdictions. The University Associate General Counsel for Research will provide assistance to the HRPO and PIs with regard to the laws in other jurisdictions.

Parents or Legal Guardians must be provided with the basic elements of consent and any additional elements the IRB deems necessary, as described in Section 11.7.

In addition to the requirements under Louisiana law, the IRB may find that the permission of one Parent is sufficient for Research to be conducted under Categories 6.9.2.1 & 6.9.2.2 above. Consent from both Parents is required for Research to be conducted under Categories 6.9.2.3 & 6.9.2.4 above unless:

1. One Parent is deceased, unknown, incompetent, or not reasonably available; or
2. When only one Parent has legal responsibility for the care and custody of the Child.

For Research not covered by the FDA regulation, the IRB may waive the requirement for obtaining consent from a Parent or Legal Guardian if:

- The Research meets the provisions for waiver in Section 11.16 or
- If the IRB determines that the Research Protocol is designed for conditions or a subject population for which Parental or Legal Guardian permission is not a reasonable requirement to protect the subjects (e.g., neglected or abused Children) provided an appropriate mechanism for protecting the Children who will participate as subjects in the Research is substituted, and that the waiver is not inconsistent with Federal, State, or local laws. 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.

Parental permission may not be waived for Research covered by the FDA regulations.

Permission from Parents or Legal Guardians must be documented in accordance with and to the extent required by Sections 11.9 and 11.10.

AAHRPP Standards for Accreditation (Standard I-3, Element I.3.G)

Regulations & Guidance: DHHS 45 CFR §46.408(b); FDA 21 CFR §50.55(e)

12.9.3.2 Assent from Children

Because “assent” means a Child’s affirmative agreement to participate in Research, the Child must actively show his or her willingness to participate in the Research, rather than just complying with directions to participate and not resisting in any way. When judging whether Children are capable of Assent, the IRB is charged with taking into account the ages, maturity, and psychological state of the Children involved. The IRB has the discretion to judge children’s
capacity to assent for all of the children to be involved in a proposed research activity, or on an individual basis.

The IRB should take into account the nature of the proposed Research activity and the ages, maturity, and psychological state of the Children involved when reviewing the proposed Assent procedure and the form and content of the information conveyed to the prospective subjects. For Research activities involving adolescents whose capacity to understand resembles that of adults, the Assent procedure should likewise include information similar to what would be provided for Informed Consent by adults or for Parental permission. For Children whose age and maturity level limits their ability to fully comprehend the nature of the Research activity but who are still capable of being consulted about participation in Research, it may be appropriate to focus on conveying an accurate picture of what the actual experience of participation in Research is likely to be (e.g., what the experience will be, how long it will take, whether it might involve any pain or discomfort). The Assent procedure should reflect a reasonable effort to enable the Child to understand, to the degree they are capable, what their participation in Research would involve.

The IRB presumes that Children ages 7 and older should be given an opportunity to provide Assent. Generally, oral Assent through the use of a script along with a note documenting the assent in the study record or use of a written form may be acceptable from Children 7 - 11 years of age. Written Assent using a written document for the Children to sign may be sought for older Children (generally ages 12-17). In such cases, the Child should sign and date the written Assent. The person obtaining the Assent from the Child must also sign and date the written Assent.

Parents and children will not always agree on whether the child should participate in Research (e.g., there may be inconsistency between Parent permission and Child Assent). Usually a "no" from the Child overrides a "yes" from a Parent, but a Child typically cannot decide to be in Research over the objections of a Parent. Obviously, there are individual exceptions to these guidelines (such as when the use of an experimental treatment for a life-threatening disease is being considered). The general idea, however, is that Children should not be forced to be Research subjects, even when their Parents consent to it.

If the IRB determines that the capability of some or all of the Children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the Research holds out a prospect of direct benefit that is important to the health or well-being of the Children and is available only in the context of the Research, the Assent of the Children is not a necessary condition for proceeding with the Research.

Even when the IRB determines that the subjects are capable of Assenting, the IRB may still waive the Assent requirement under circumstances detailed in the Waiver of Informed Consent Section of this document.

Regulations & Guidance: DHHS 45 CFR §46.408; FDA 21 CFR §50.55

12.9.3.3 Consent from Pregnant Minors

A Minor may consent to medical care or the administration of medication by a hospital licensed to provide hospital services or by a physician licensed to practice medicine for the purpose of alleviating or reducing pain, discomfort, or distress of and during labor and childbirth. [LA R.S.
40:1095(A)(2)]. This consent shall be valid and binding as if the Minor had achieved her majority, and it shall not be subject to a later disaffirmance by reason of her Minority.

If Research pertains to such permitted Minor consent, then the Minor may consent to the involved Research. If not and the IRB has not waived the consent requirement, then Assent from the Minor is required, as well as Parental permission.

12.9.4 Assent Form

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

Researchers should try to draft a form that is age appropriate and study specific, taking into account the typical Child's experience and level of understanding, and composing a document that treats the Child respectfully and conveys the essential information about the study.

The Assent Form Template (TU Form 401) should:

1. Tell why the Research is being conducted;
2. Describe what will happen and for how long or how often;
3. Say it's up to the Child to participate and that it is permissible to say no;
4. Explain if it will hurt and if so for how long and how often;
5. Say what the Child's other choices are;
6. Describe any good things that might happen;
7. Say whether there is any compensation for participating; and
8. Ask for questions.

For younger Children, the document should be limited to one page if possible. Illustrations might be helpful, and larger type makes a form easier for young Children to read. Studies involving older Children or adolescents should include more information and may use more complex language.

12.9.5 Children who are Wards of the State

Children who are wards of the State or any other agency, institution, or entity can be included in Research involving greater than Minimal Risk where there is no prospect of direct benefits to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition, 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.

If the Research meets the condition(s) above, an advocate must be appointed by the IRB or Institution for each Child who is a ward (one individual may serve as advocate for more than one
Child), in addition to any other individual acting on behalf of the Child as Legal Guardian or in loco parentis.

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

Regulations & Guidance: [DHHS 45 CFR §46.409; FDA 21 CFR 50.56](#)

### 12.10 Surrogate Consent/Consent for Persons with Impaired Decision-Making Capacity

The requirements in this section apply to all research involving persons who cannot provide consent or with impaired decision-making capacity regardless of funding source.

Research involving subjects without the ability to provide consent or with impaired decision-making capacity should only be conducted when the aims of the research cannot reasonably be achieved without their participation. Participation of such subjects in research cannot be justified solely on their availability or the convenience for the investigator.

When an investigator seeks to include such subjects in research, they must disclose this to the IRB and provide justification for why inclusion is necessary. If capacity to consent is questionable, or may fluctuate, investigators should include provisions for determining capacity to provide informed consent (See Section 11.10), and, if appropriate to reevaluate capacity during participation. When capacity to consent may diminish, the procedures should include, when possible and appropriate, designation of a legally-authorized authorized representative (LAR), inclusion of the future LAR in the initial consent discussion and process, and memorialization of the participant’s wishes regarding the research in writing. When the research includes subjects likely to regain capacity to consent, the investigator should include provisions to inform the subject regarding their participation and to seek consent for ongoing participation, if applicable.

When the IRB reviews research involving greater than minimal risk and the proposed subject population includes persons who cannot provide consent, may have impaired capacity to provide consent, or whose capacity can be expected to fluctuate over time, the IRB review process will include at least one member, or a consultant, who is experienced with or otherwise knowledgeable about the population.

In evaluating research, the IRB must be able to determine that the risks to subjects are reasonable not only in relation to any benefits, but also in relation to the importance of the knowledge that may reasonably be expected to result. In considering the risks of research involving subjects unable to provide consent or with diminished capacity to do so, the IRB should consider whether any components of the research involve risks that are greater for participants with diminished capacity. For example, the population might experience increased sensitivity or discomfort to certain stimuli or may not be able to verbalize or otherwise demonstrate when they are experiencing discomfort or pain.
As appropriate to the research, the IRB will consider the following in evaluating greater than minimal risk research involving persons unable to consent or with impaired decision-making capacity:

1. Whether the aims of the research cannot reasonably be achieved without inclusion of the population
2. Whether the research is likely to improve the understanding of the condition, disease, or issue affecting the subject population
3. Whether any experimental procedure or interventions have undergone pre-clinical testing or human testing on other populations and whether the data from that testing supports its use in the proposed research
4. Whether the procedures or interventions that the subject will undergo in the research place them at increased risk and if appropriate mechanisms are in place to minimize risks, when possible
5. Whether the data and safety monitoring plan, including any stopping rules, is appropriate given the risks of the research and the vulnerability of the population
6. Whether the procedures for withdrawing individual subjects from the research are appropriate
7. Whether the recruitment procedures, consent process, and any plans for financial compensation support voluntariness and minimize the likelihood of undue influence or coercion
8. Whether the subjects will be exposed to financial or other risks that they might not consider acceptable if they had the capacity to provide consent, and whether appropriate mechanisms have been put into place to minimize these risks
9. Whether the procedures for determining capacity to provide consent, and for evaluating capacity on an ongoing basis, if applicable, are appropriate
10. Whether the procedures for informing subjects who regain capacity about their involvement in the research, and for obtaining consent for on-going participation, if applicable, are appropriate
11. Whether assent should be required when possible, and, if so, if the proposed procedures to obtain and document assent are appropriate
12. Whether a research subject advocate or consent monitor should be required, for some or all subjects

AAHRPP Standards for Accreditation (Standard II-3, Element II.3.F)

12.10.1 IRB composition

The IRB membership must include at least one member who is an expert in the area of the Research. Consideration may be given to adding another member who is a member of the population, a family member of such a person or a representative of an advocacy group for that population. The IRB may utilize ad hoc members as necessary to ensure appropriate scientific expertise.
12.10.2 Determination of Decision-Making Capacity

The decision-making capacity of a potential Research subject should be evaluated when there are reasons to believe that the subject may not be capable of making voluntary and informed decisions about Research participation.

The PI and Research staff must have adequate procedures in place for assessing and ensuring subjects’ capacity, understanding, and Informed Consent or Assent. The IRB will evaluate whether the proposed plan to assess capacity to consent is adequate.

For Research Protocols that involve subjects with mental disorders that may affect decision-making capacity, the IRB may determine that capacity assessments are necessary, unless the PI can justify why such assessments would be unnecessary for a particular group.

For Research that poses greater than Minimal Risk, the IRB may require Investigators to use independent and qualified professionals to assess whether potential subjects have the capacity to give voluntary, Informed Consent. Even in Research involving only Minimal Risk, the IRB may require that the study include a capacity assessment if there are reasons to believe that potential subjects’ capacity may be impaired. It is not necessary to require a formal capacity assessment by an independent professional for all potential Research subjects with mental disorders. See the next Section for details with respect to determining capacity to consent.

For Research Protocols involving subjects who have fluctuating or limited decision-making capacity the IRB may ensure that Investigators establish and maintain ongoing communication with involved caregivers. Periodic re-consent should be considered in some cases. Third party consent monitors may be used during the recruitment and consenting process or waiting periods may be required to allow more time for the subject to consider the information that has been presented. For subjects with fluctuating decision-making capacity or those with decreasing capacity to give consent, a re-consenting process with Health Agent may be necessary.

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

Although incompetent to provide Informed Consent, some persons may resist participating in a Research Protocol approved by their representatives. Under no circumstances may subjects be forced or coerced to participate.

In the event Research Participants become incompetent or impaired in decision making capacity after enrollment, the PI is responsible for notifying HRPO. The PI is responsible for developing a monitoring plan, which follows the guidelines outlined above for incompetent and impaired decision-making Research Participants.

12.10.3 Determining Capacity to Consent

The majority of studies conducted at the University only allow enrolling subjects who have the capacity to consent. For studies that have been approved for enrolling Vulnerable Populations
who may lack capacity to consent, there must be someone who is able to assess capacity of each potential subject to consent. The PI may determine after appropriate medical evaluation that the prospective Research subject lacks decision-making capacity and is unlikely to regain it within a reasonable period of time. Additionally, if the reason for lack of capacity is because of mental illness then a psychiatrist or licensed psychologist must confirm this judgment and document in the individual’s medical record in a signed and dated progress note.

Decisional capacity in the Research context has been interpreted by the American Psychiatric Association as requiring:

- Ability to evidence a choice;
- Ability to understand relevant information;
- Ability to appreciate the situation and its likely consequences; and
- Ability to manipulate information rationally.

A range of professionals and methods may be utilized to assess capacity. In general, the consent assessor should be a Researcher or consultant familiar with dementias and qualified to assess and monitor capacity and consent in such subjects on an ongoing basis. The IRB will consider the qualifications of the proposed individual(s) and whether he or she is sufficiently independent of the research team and/or Institution.

A person who has been determined to lack capacity to consent to participate in a Research study must be notified of that determination before permission may be sought from his or her Legally Authorized Representative to enroll that person in the study. If permission is given to enroll such a person in the study, the potential subject must then be notified. If a person objects to participating, this objection should be respected.

12.10.4 Informed Consent and Assent

Whenever the Participants have the capacity to give consent (as determined by licensed health care professionals who are qualified to make such determinations consistent with the scope of their license), Informed Consent should be obtained and documented in accordance with Section 5 above. When Participants lack the capacity to give consent, PIs may obtain consent from the Legally Authorized Representative of a subject as described below.

A person who is incompetent or has been determined to lack capacity to consent to participate in a Research study should be informed about the trial to the extent compatible with the subject’s understanding and, if possible, the subject should give their Assent to participate, sign and date the written Informed Consent or a separate Assent Form Template (TU Form 401). If the subject expresses resistance or dissent to participation or to the use of surrogate consent by word or gesture, the subject shall be excluded from the Research. Under no circumstances may an Investigator or caregiver override a subject’s dissent. If no resistance or dissent is expressed by the potential subject, the Investigator shall document this fact and that the description of the Research was communicated to the subject.

Both PIs and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision-making capacity or those with decreasing capacity to give consent, a re-consenting process with Legally Authorized Representative may be necessary. Although incompetent to provide Informed Consent, some persons may resist
participating in a Research Protocol approved by their representatives. Under no circumstances may subjects be forced or coerced to participate.

12.10.5 Consent by Legally Authorized Representative

The regulations generally require that the Investigator obtain Informed Consent from subjects. Under appropriate conditions, Investigators also may obtain Informed Consent from a Legally Authorized Representative of a subject (Legally Authorized Representative).

This policy is designed to protect Human Subjects from exploitation and harm and, at the same time, make it possible to conduct essential Research on problems that are unique to persons who are incompetent, or who have an impaired decision-making capacity.

Legally Authorized Representative may be obtained from a court appointed Legal Guardian of the person or a Health Agent appointed by the person in a Medical Power of Attorney. For example, a subject might have designated an individual to provide consent with regard to health care decisions through a durable power of attorney and have specified that the individual also has the power to make decisions on entry into Research.
13  FDA-Regulated Research (e.g., Investigational Drugs & Devices in Research)

13.1  Generally

FDA regulations apply to any Research that involves a Test Article used in a Clinical Investigation involving Human Subjects as defined by the FDA regulations. For FDA regulated Research, the IRB must apply the FDA regulations found at 21 CFR 50 and 21 CFR 56, as well as, where appropriate, 45 CFR 46. (See attached Comparison between FDA and DHHS Regulations found at http://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/educationalmaterials/ucm112910.htm).

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

The following procedures describe the review of FDA-regulated Research conducted under the auspices of Institution.

AAHRPP Standards for Accreditation (Standard I-7, Element I.7.A)

Regulations & Guidelines: FDA 21 CFR parts 11, 50, 54, 56, 312, and 812

13.2  Definitions

Administer (or “Administration” or “Administering”): Means the direct application of a Drug to the body of a patient or Research subject by injecting, inhalation, ingestion, or any other means. [LA R.S. 37:1164].

Agent(s): are chemical agents that affect the function of living things.

Biological Products (or “Biologic”): are used for the treatment, prevention or cure of disease in humans and include a wide range of products such as vaccines, blood, and blood components, allergens, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Biologics are isolated from a variety of natural sources—human, animal, or microorganism—and may be produced by biotechnology methods and other cutting-edge technologies. FDA regulations and policies have established that Biological Products include blood-derived products, vaccines, in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products. Biological Products, like other Drugs, can be studied in clinical trials involving Humans Subjects under an IND in accordance with the regulations at 21 CFR §312. See Section 13.2 for details.

Clinical Investigation: means any experiment that involves a Test Article and one or more Human Subjects and that either is subject to requirements for prior submission to the FDA under section 505 of the Federal Food, Drug, and Cosmetic Act (the “FDA Act”) [21 U.S.C. §355] or to, or held
for inspection by the Food and Drug Administration (“FDA”) as part of an application for a Research or marketing permit. [21 CFR §50.3]

**Color Additive:** means any dye, pigment or substance which when added or applied to a food, Drug or cosmetic, or to the human body, is capable—alone or through reactions with other substances—of imparting color. The term “color” includes black, white and intermediate grays. [Section 201(t) of the FDA Act; 21 U.S.C. 321(t)(1)].

**Dietary Supplement:** A dietary supplement is a product taken by mouth that is intended to supplement the diet and that contains a dietary ingredient. The dietary ingredients in these products can include vitamins, minerals, herbs and other botanicals, amino acids, other dietary substances intended to supplement the diet, and concentrates, metabolites, constituents, extracts, or combinations of the preceding types of ingredients. See section 201(ff) of the FD&C Act [21 U.S.C. 321(ff)].

**Dispense (or Dispensing):** means the interpretation, evaluation, and implementation of a prescription Drug order, including the preparation and delivery of a Drug or Device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient. “Dispense” necessarily includes a transfer of possession of a Drug or Device to the patient or the patient's agent. [LA R.S. 37:1164]. Louisiana law requires that Dispensing may only be done by a licensed pharmacist or a physician who is registered with the board as a dispensing physician. [LA R.S. 37:1201].

**Distribute (or Distribution):** means the delivery of a Drug or Device other than by Administering or Dispensing.

**Drug:** is a substance whose primary intended use is achieved through chemical action or by being metabolized by the body. Drug has the following legal definitions:

- Louisiana law defines Drug as meaning: (a) any substance recognized in the official compendium, or supplement thereto, designated by the Louisiana Board of Pharmacy (or other appropriate jurisdiction) for use in the diagnosis, cure, mitigation, treatment or prevention of diseases in humans, (b) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans, or (c) any substance other than food intended to affect the structure or any function of the body of humans. [LA-R.S. 37:1164].

- The FDA defines Drug as meaning: (A) articles recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than Food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in clause (A), (B), or (C). A Food or dietary supplement is not a Drug solely because the label or the labeling contains such a claim. A Food, dietary ingredient, or dietary supplement for which a truthful and not misleading statement is made is not a Drug under clause (C) solely because the label or the labeling contains such a statement. [21 U.S.C. 321(g)(1)].
Food: include dietary supplements that bear a nutrient content claim or a health claim. [Section 201(f) of FDA Act].

Food Additive: In its broadest sense, a food additive is any substance added to food. The FDA defines the term as “any substance the intended use of which results or may reasonably be expected to result—directly or indirectly—in it becoming a component or otherwise affecting the characteristics of any food.” [Section 201(s) of the FDA Act].

Human Cells, Tissues, or Cellular or Tissue-Based Products (HCT/P’s) – HCT/P’s means articles: containing or consisting of human cells or tissues that are intended for implantation, transplantation, infusion, or transfer into a human recipient. Examples of HCT/Ps include, but are not limited to, bone, ligament, skin, dura mater, heart valve, cornea, hematopoietic stem/progenitor cells derived from peripheral and cord blood, manipulated autologous chondrocytes, epithelial cells on a synthetic matrix, and semen or other reproductive tissue.

The following articles are not considered HCT/P’s: vascularized human organs for transplantation; whole blood or blood components or blood derivative products subject to listing under parts 607 and 207, respectively; secreted or extracted human products, such as milk, collagen, and cell factors; except that semen is considered an HCT/P; minimally manipulated bone marrow for homologous use and not combined with another article (except for water, crystalloids, or a sterilizing, preserving, or storage agent, if the addition of the agent does not raise new clinical safety concerns with respect to the bone marrow); ancillary products used in the manufacture of HCT/P; cells, tissues, and organs derived from animals other than humans; in vitro diagnostic products as defined in 809.3(a); blood vessels recovered with an organ, as defined in 42 CFR 121.2, that are intended for use in organ transplantation and labeled “For use in organ transplantation only.”

HCT/P’s may be regulated as drugs, devices, and/or biologics when the use does not qualify for an establishment exception or regulation solely under section 361 of the PHS Act and 21 CFR 1271.

Infant Formula: means a Food which purports to be or is represented for special dietary use solely as a Food for infants by reason of its simulation of human milk or its suitability as a complete or partial substitute for human milk. [Section 201(z) of the FDA Act].

Investigational Drug (or “Investigational New Drug”): means a new Drug or Biological that is used in Research. It also includes a Biologic used in vitro for diagnostic purposes. The FDA considers the term “Investigational New Drug” or “Investigational Drug” to be synonymous with Investigational Drug. [FDA 21 CFR §312.2]. However, for purposes of this document, an Investigational Drug includes the following:

- An approved Drug that is being studied for an unapproved or approved use in a controlled, randomized or Blinded clinical trial.
- Those new Drugs for which the PI or a Sponsor has filed an IND application [FDA 21 CFR §312] which are exempt from pre-marketing approval requirements and may be lawfully shipped for use in Clinical Investigations in Human Subjects.

A Drug that is lawfully marketed in the U.S. that may still be considered investigational and required that an IND be filed if the proposed use of such a Drug involves a controlled study aimed towards seeking a significant change in labeling, advertising, route of Administration, dosage.
level, or other factor that affects the risks associated with the use of the product. [FDA 21 CFR §312.3(b)].

**Investigational Drug Application (or “IND”):** refers to either an Investigational New Drug application or to a new Drug that is used in Clinical Investigations. IND is synonymous with “Notice of Claimed Investigational Exemption for a New Drug.” [FDA 21 CFR §312]

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

The 21st Century Cures Act amended the FD&C Act to specifically exclude certain software functions from the definition of medical device. Summarized, these include exclusions for software functions intended for administrative support of a health care facility; for maintaining or encouraging a healthy lifestyle; to serve as electronic patient records; for transferring, storing, converting formats, or displaying clinical laboratory tests or other device data and results and related information; and for displaying, analyzing, or printing medical information, for supporting or providing recommendations to a health care professional, and enabling the health care professional to independently review the basis for such recommendations. Additional information regarding the application of these exclusions is available on FDA’s “Guidances with Digital Health Content” website.

**Mobile Medical Apps:** Mobile apps are software applications that can be executed on a mobile platform or a web-based software application that is tailored to a mobile platform but is executed on a server. Mobile medical apps are a subset of mobile apps that medical devices that meet the definition of a medical device and either are intended to be used as an accessory to a regulated medical device; or to transform a mobile platform into a regulated medical device.

**Planned Emergency Research:** is the conduct of planned Research in life threatening emergencies where the requirement to obtain prospective Informed Consent has been waived. [21CFR §50.24]. The Research plan must be approved in advance by the FDA or DHHS and the IRB, and publicly disclosed to the community in which the Research will be conducted. This term should not be confused with Emergency Use.

**Test Article:** as defined by FDA regulation, a Test Article means the following:

- Drug
- Medical Devices
- Biological Product
- Food Additive
- Color Additive
- Food
13.3 FDA Exemptions (Regulatory)

The following categories of Clinical Investigations are exempt from the requirements of FDA regulations for IRB review:

1. Emergency use of a Test Article provided that such emergency use is reported to the IRB within five (5) working days. Any subsequent use of the Test Article at the Institution is subject to IRB review. [21 CFR §56.104(c)]

2. Taste and food quality evaluations and consumer acceptance studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or below the level found to be safe, by the FDA or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. [21 CFR §56.104(d)]

13.4 Procedures

1. At initial submission, the PI must indicate whether the Research involves a Test Article and is a Clinical Investigation involving Human Subjects on the application form. The PI may use the FDA Determination Checklist (see Comparison of FDA and HHS Human Subject Protection Regulations) to assist in making this determination.

2. During the pre-review process, the IRB will confirm whether FDA regulations are applicable using the FDA Determination Checklist. If FDA regulations apply and the Research is not Exempt, the IRB will indicate on the agenda that the Protocol is an FDA-regulated study.

3. If required by the sponsor (see Section 1.7), the PI will indicate on the application form that ICH-CGP compliance is required and will affirm compliance. If the study involves Investigational Drugs and is industry sponsored and the PI does not indicate ICH-GCP compliance, the IRB will require ICH-GCP compliance.

13.5 Investigator Responsibilities

The investigator holds additional responsibilities when conducting a clinical trial evaluating FDA-regulated drugs, devices, and other articles. These responsibilities include, but are not limited to, the following:

1. The investigator is responsible for ensuring that a clinical investigation is conducted according to the signed investigator statement for clinical investigations of drugs (including biological products) or agreement for clinical investigations of medical devices, the investigational plan and other applicable regulations, and any requirements imposed by the IRB or FDA.

2. The investigator is responsible for personally conducting or supervising the investigation. When certain study-related tasks are delegated by an investigator, the investigator is responsible for providing adequate supervision of those to whom tasks are delegated. The investigator is accountable for regulatory violations resulting from failure to adequately supervise the conduct of the clinical study.
3. The investigator must maintain a list of the appropriately qualified persons to whom significant trial-related duties have been delegated. This list should also describe the delegated tasks, identify the training that individuals have received that qualifies them to perform delegated tasks (e.g., it can refer to an individual’s CV [signed and dated within the last four years] on file and/or training conducted by the investigator/sponsor), and identify the dates of involvement in the study. An investigator should maintain separate lists for each study conducted by the investigator.

4. The investigator is responsible for protecting the rights, safety, and welfare of subjects under their care during a clinical trial. This responsibility includes:
   - Informing subjects that the test articles is being used for investigational purposes and ensuring that the requirements relating to obtaining informed consent are met
   - Providing reasonable medical care for study subjects for medical problems arising during participation in the trial that are, or could be, related to the study intervention
   - Providing reasonable access to needed medical care, either by the investigator or by another identified, qualified individual (e.g., when the investigator is unavailable, or when specialized care is needed)
   - Adhering to the protocol/research plan so that study subjects are not exposed to unreasonable risks
   - As appropriate, informing the subject’s primary physician about the subject’s participation in the trial if the subject has a primary physician and the subject agrees to the primary physician being informed

5. The investigator is responsible for reading and understanding the information in the investigator brochure or device risk information, including the potential risks and side effects of the drug or device.

6. The investigator is responsible for maintaining adequate and accurate records in accordance with FDA regulations and to making those records available for inspection by the FDA. These records include: correspondence with other investigators, the IRB, the sponsor, monitors, or the FDA; drug and device accountability records; case histories; consent forms; and documentation that consent was obtained prior to any participation in the study. Records must be obtained for a minimum of 2 years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such. Other regulations, such as HIPAA, organizational policies, or contractual agreements with sponsors may necessitate retention for a longer period of time.

7. The investigator is responsible for controlling drugs, biological products, and devices according to FDA regulations and the Controlled Substances Act, if applicable.

8. The investigator proposing the clinical investigation will be required to provide a plan – to be evaluated by the IRB - that includes storage, security, and dispensing of the test article.
   - a. The investigator is responsible for investigational drug accountability that includes storage, security, dispensing, administration, return, disposition, and
records of accountability. Such details will be provided in the IRB submission and reviewed by the IRB and the Pharmacy Service for acceptability.

b. The investigator may delegate in writing, as part of the IRB submission, the responsibility detailed in ‘a’ above to the Pharmacy Service.

c. All devices received for a study must be stored in a locked environment under secure control with limited access. Proper instructions on the use of the device must be provided to the subjects. A log must be kept regarding the receipt, use, and/or dispensing of the device and the disposition of remaining devices at the conclusion of the investigation.

9. The investigator shall furnish all reports required by the sponsor of the research including adverse events, progress reports, safety reports, final reports, and financial disclosure reports.

The investigator will permit inspection of research records by the sponsor, sponsor representatives, HRPP and IRB representatives, the FDA, accrediting bodies, and any other agencies or individuals entitled to inspect such records under regulation, organizational policy, or contractual agreement.

13.6 Dietary Supplements

Research involving dietary supplements may or may not fall under FDA regulations. Under the Dietary Supplement Health and Education Act (“DSHEA”) of 1994, a dietary supplement is not considered a drug and is not subject to the premarket approval requirements for drugs if the intended use for which it is marketed is only to affect the structure or any function of the body (i.e., not intended to be used for a therapeutic purpose). Whether a study falls under FDA oversight is determined by the intent of the clinical investigation. If the Clinical Investigation is intended only to evaluate the dietary supplement’s effect on the structure or function of the body, FDA regulations do not apply. However, if the study is intended to evaluate the dietary supplement’s ability to diagnose, cure, mitigate, treat, or prevent a disease, FDA regulations to apply. Studies involving the ingestion of dietary supplements that are not subject to FDA oversight are still covered by OHRP regulations, and therefore must be reviewed by the IRB.

Similarly, whether an IND is needed for a study evaluating a dietary supplement is determined by the intent of the study. If the study is intended only to evaluate the dietary supplement’s effect on the structure or function of the body, an IND is not required. Due to a partial stay [80 FR 66907] on FDA’s guidance “Investigational New Drug Applications – Determining Whether Human Research Studies Can Be Conducted Without an IND”, at this time FDA also does not require an IND for studies intended to evaluate whether a dietary supplement may reduce the risk of a disease or studies intended to support a new or expanded health claim, unless the studies include individuals less than 12 months old, those with altered immune systems, or those with serious or life-threatening medical conditions. All other studies intended to evaluate a dietary supplement’s ability to diagnose, cure, mitigate, treat, or prevent a disease, require an IND unless FDA grants an exception to the requirement.

As with any research involving a test article, the investigator must supply the IRB with sufficient information to determine that the criteria for approval are satisfied and to determine or verify whether the research requires an IND. Applications should provide detail consistent with that expected on a drug protocol and consistent with the level of risk associated or anticipated with the research. At a minimum, the research plan should provide the following information regarding the supplement: Name, Manufacturer,
13.6.1 Researcher Responsibilities Regarding Dietary Supplements

The researcher must submit all of the following with their application to the IRB:

1. List all dietary supplements or foods to be used in this study. Include the following:
   a. Name
   b. Chemical formula
   c. Dosage strength(s)
   d. Method/route of administration
   e. Mechanism of action
   f. Known drug interactions
   g. Manufacturer/Sponsor
   h. Name of supplier
   i. IND number if applicable and letter from the FDA or industry sponsor setting forth the IND number.
   j. Documentation of approval for use in humans
   k. Documentation or certification of quality or purity

2. The rationale for choosing the supplement and dose.

3. Justification and safety information if over the counter supplements will be administered for non-approved indications or if doses or routes of administration or subject populations are changed.

4. Explain whether the use of the supplement involves a route of administration or dosage level, use in a subject population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with its use.

5. Provide a plan for the storage, dispensing, handling, inventory control, and disposal of supplements.

6. If there is no IND, confirmation that the study will be limited to evaluation of the dietary supplement’s effect on the structure or function of the body.

For IND studies, a summary of preclinical and early human studies. All of the requirements for an IND study described in Section 13.8 below apply.

13.7 Investigational Drugs and Devices in Research

All Investigational Drugs, Agents and/or Biologics used in Human Subjects Research under the purview of Tulane’s IRB shall be stored, handled, and dispensed in compliance with regulations
or requirements of the FDA, the Louisiana State Board of Pharmacy (“LSBP”), The Joint Commission, Federal, State and other laws and regulations, and the policies and procedures of the HRPP. Furthermore, if Research is conducted on hospital premises, such Research shall be conducted in accordance with applicable hospital and medical staff polices and guidelines.

The University is affiliated with and routinely conducts Human Subjects Research at Tulane University Hospital and Clinic (“TUHC”), which may require the provision of clinical care to Research subjects in a hospital setting. To this end, TUHC serves as a primary site for hospital-based clinical Research conducted by the University. For this reason, the University and TUHC entered into a Master Clinical Trial Affiliation Agreement (“Master CTA Agreement”) to facilitate the provision of necessary Research-support services, supplies and equipment, and the use of TUHC facilities including, without limitation, TUHC pharmacy services. The Master CTA Agreement only applies to Research conducted at TUHC’s Downtown, Lakeside, and Lakeview campuses, as well as any Institution ambulatory clinic (i.e., outpatient) physically located within them (“TUHC Facility”) and other hospital facilities if so agreed upon by the University and TUHC.

TUHC’s Department of Pharmacy provides administrative and clinical services to PIs, Investigators and Research staff involved in Drug-related Research conducted at TUHC’s Facility under the purview of Tulane’s IRB. See Section 13.8.2, “Responsibilities for handling Investigational Drugs or unlicensed Test Articles with respect to pharmacy, dispensing, inventory control, reporting and documentation.” Furthermore, a TUHC research pharmacist (“Research Pharmacist” or “Research Pharmacy”) will serve as a member on the Biomedical IRB to allow TUHC Research Pharmacy to have complete information about all IRB-approved Research that takes place at the TUHC’s Facility. Inclusion of the Research Pharmacist as an IRB member assures that information about all studies involving Drugs used in Research is shared with both the TUHC Research Pharmacy staff as appropriate and that TUHC’s Pharmacy and Therapeutics Committee is made aware of IRB-approved Research involving Drugs.

Regardless of whether Investigators conduct Investigational Drug studies for inpatients or outpatients, the Institution’s policy requires that the IRB review and approve all Investigational Drug Research involving Human Subjects prior to initiation of the study and prior to enrollment of subjects.

Institutional policy requires the Research Pharmacist to provide advice to the IRB with respect to all activities relating to the distribution, storage, dispensing, and accountability for Investigational Drug products for use in Human Subjects.

AAHRPP Standards for Accreditation (Standard I-7, Element I.7.A)


13.8 IND Requirements

The PI must indicate on the Initial Application for Human Subjects Research whether the Research involves Investigational Drugs. If so, the PI must indicate if there is an IND for the Research and provide documented assurance from the Sponsor that the manufacture and formulation of investigational or unlicensed Test Articles conform to Federal regulations. Documentation of the IND could be:
1. Industry sponsored Protocol with IND.
2. Letter from FDA.
3. Letter from industry Sponsor.
4. Other document and/or communication verifying the IND.

The IRB reviewer (with assistance from the HRPO) is responsible for requesting that the principal investigator obtain from the sponsor official documentation to confirm a valid IND number.

If the Research involves Drugs and there is no IND, the PI must provide a rationale why it is not required.

The IRB will review the application and determine:

1. Whether there is an IND and if so, whether there is appropriate supporting documentation.
2. If the Research involves Drugs or Devices with no IND, and whether the Research meets the criteria below.

The IRB cannot grant approval and research cannot begin, including recruiting, obtaining consent, and screening participants to the research until the IND/IDE status is determined, and, if necessary, an approved IND or IDE is in place. Please Note: An IND goes into effect 30 days after the FDA receives the IND, unless the sponsor receives earlier notice from the FDA.


### 13.8.1 IND Exemption

For drugs, an IND is not necessary if the research falls in one of the following seven (7) categories:

1. **21 CFR 312.2(b)(1)**: The drug being used in the research is lawfully marketed in the United States and all of the following requirements are met:
   
   a. The research is not intended to be reported to FDA as a well-controlled study in support of a new indication and there is no intent to use it to support any other significant change in the labeling of the drug;

   b. In the case of a prescription drug, the research is not intended to support a significant change in the advertising for the product;

   c. The research does not involve a route of administration, dose, subject population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product;

   d. The research is conducted in compliance with the requirements for IRB review and informed consent [21 CFR parts 56 and 50, respectively];

   e. The research is conducted in compliance with the requirements of **21 CFR 312.7** (i.e., the research is not intended to promote or commercialize the drug product); and

   f. The research does not intend to invoke FDA regulations for planned emergency research [21 CFR 50.24].
Please Note: FDA has provided specific guidance for evaluating whether this exemption applies to studies of marketed drugs/biologics for the treatment of cancer.

2. **21 CFR 312.2(b)(2):** For clinical investigations involving defined (blood grouping serum, reagent red blood cells, and anti-human globulin) in vitro diagnostic biological products, an IND is not necessary 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.

3. **21 CFR 312.2(b)(5):** A clinical investigation involving use of a placebo is exempt from the requirements of part 312 if the investigation does not otherwise require submission of an IND.

4. **21 CFR 320.31(b) and (d):** Bioavailability or Bioequivalence (BA/BE) studies if all of the following conditions are met:
   - a. The drug product does not contain a new chemical entity [21 CFR 314.108], is not radioactively labeled, and is not cytotoxic;
   - b. The dose (single dose or total daily dose) does not exceed the dose specified in the labeling of the approved version of the drug product;
   - c. The investigation is conducted in compliance with the requirements for IRB review and informed consent [21 CFR parts 56 and 50, respectively]; and
   - d. The sponsor meets the requirements for retention of test article samples [21 CFR 320.31(d)(1)] and safety reporting [21 CFR 320.31(d)(3)].

5. **21 CFR 361.1:** Research using a radioactive drug or biological product if all of the following conditions are met:
   - a. It involves basic research not intended for immediate therapeutic, diagnostic, or similar purposes, or otherwise to determine the safety and efficacy of the product;
   - b. The use in humans is approved by a Radioactive Drug Research Committee (RDRC) that is composed and approved by FDA;
   - c. The dose to be administered is known not to cause any clinically detectable pharmacological effect in humans, and
   - d. The total amount of radiation to be administered as part of the study is the smallest radiation dose practical to perform the study without jeopardizing the benefits of the study and is within specified limits.

6. FDA practices enforcement discretion for research using cold isotopes of unapproved drugs if all of the following conditions are met:
   - a. The research is intended to obtain basic information regarding the metabolism (including kinetics, distribution, and localization) of a drug labeled with a cold isotope or regarding human physiology, pathophysiology, or biochemistry;
   - b. The research is not intended for immediate therapeutic, diagnostic, or preventive benefit to the study subject;
   - c. The dose to be administered is known not to cause any clinically detectable pharmacologic effect in humans based on clinical data from published literature or other valid human studies;
d. The quality of the cold isotope meets relevant quality standards; and
e. The investigation is conducted in compliance with the requirements for IRB review and informed consent. [21 CFR parts 56 and 50, respectively]

13.8.2 Responsibilities for handling Investigational Drugs or unlicensed Test Articles with respect to pharmacy, dispensing, inventory control, reporting and documentation.

This Section describes the responsibilities and related responsibilities for handling Investigational Drugs or unlicensed Test Articles with respect to pharmacy, dispensing, inventory control, reporting and documentation.


Regulations & Guidelines: FDA 21 CFR §312.61; 21 CFR §312.62; 21 CFR §312.69

13.8.2.1 Principal Investigator (“PI”)

The PI is responsible for ensuring that the Research is conducted according to all regulatory guidelines and University policies and procedures. PIs should refer to the Guidance on Special Considerations & Reporting Requirements for FDA- and NIH-Regulated Items (TU Form 711) found on HRPO’s Website for additional assistance.

For TUHC inpatients, Investigational Drugs for inpatient Research studies must be dispensed by TUHC Research Pharmacy. For outpatients at a TUHC Facility and/or at a non-TUHC Facility, only a licensed pharmacist can dispense Investigational Drugs. Typically, this can take place at a retail pharmacy, or TUHC’s outpatient pharmacy. Where a PI requests to have control of the Investigational Drug, Agent or Biologic Product with respect to outpatients in a non-TUHC Facility, then the PI must submit for IRB approval a plan for the distribution, storage, dispensing, and accountability for the Investigational Drug product(s). Such plan must involve the PI contracting with a pharmacist such that the pharmacist is responsible for dispensing.

1. Dispensing to Inpatients—TUHC Research Pharmacy Coordination: For hospital inpatients, the PI must use TUHC Research Pharmacy (or equivalent at other non-TUHC hospitals) as the coordinating and control center for the Research Drug. As the coordinating and control center, TUHC Research Pharmacy assumes the responsibility for maintaining records of the Drugs delivered to the TUHC Research Pharmacy, inventory of the Drug, dispensing of Drugs to Research subjects, and then return to the Sponsor or disposition of unused product. TUHC Research Pharmacy will store and dispense the Investigational Drug as specified by the Sponsor and in accordance with applicable regulatory requirements.

TUHC Research Pharmacy may initiate or adjust Drug therapy and/or order laboratory tests associated with a Research Protocol when requested to do so by the PI. Any pharmacist participating in such a Protocol must be trained and deemed competent to participate by the PI (or his/her designee). Specific details on the adjustment of Drug therapy or ordering of laboratory tests should be reviewed during the Protocol initiation visit.

When TUHC Research Pharmacy is the coordinating and control center for the Research Drug, TUHC Research Pharmacy will store the returned dispensed Investigational Drug in a designated return area when a study Protocol requires the subject to return the empty
Investigational Drug container or any amount of the unused Investigational Drug. However, it is the responsibility of the PI to deliver the returned dispensed Investigational Drug to Research Pharmacy when subjects leave the dispensed Investigational Drug in the PI’s department.

When TUHC Research Pharmacy is coordinating the control of the Research Drug, the PI will forward a copy of the complete Research Protocol, a copy of the Investigator’s Drug brochure, ordering procedures, any special storage, handling or preparation requirements, and any pertinent dispensing information to the Research pharmacist.

A cost estimate should be obtained from TUHC Research Pharmacy during the initial stages of budget development. The mandatory Institutional pharmacy fee will be applied to all Research involving Investigational Drugs. TUHC Research Pharmacy will prepare a cost estimate of other pharmacy fees after review of the above material. The PI should provide TUHC Research Pharmacy with the account number to which any supplies should be billed. For further information please refer to Tulane Department of Pharmacy Policies.

2. **Dispensing Controlled Substances**: Controlled substances must be securely stored and must be administered by a duly licensed pharmacist.

3. **Dispensing to Outpatients**: Typically, TUHC’s Research Pharmacy (and rarely a retail outpatient pharmacy) is responsible for coordinating the control of and dispensing the investigational Drug. Dispensing of an Investigational Drug, Agent or Biologic by a PI with respect to Research Under the Auspices of Tulane’s IRB is not permitted.

When the PI (through a contracted pharmacist) retains control of Investigational Drug supplies, the PI shall ensure that the contracted pharmacist is responsible for ensuring that the Research is conducted according to all regulatory guidelines and Tulane policies and procedures, including but not limited to:

- **Drug Accountability Record** - The PI (through the contracted pharmacist) must maintain records of the product’s delivery to the study site, the inventory at the site, the use by each subject, and the return to the Sponsor or alternative disposition of unused product. These records should include shipping documents, dates, quantities, batch/serial numbers, expiration dates, and the unique code numbers assigned to the investigational product(s) trial subjects, and temperature monitoring logs. The PI (through the contracted pharmacist) should maintain records that document adequately that the subjects will provide the doses specified by the Protocol and reconcile all investigational product(s) received from the Sponsor. The Investigational Drug supply is subject to audit by the IRB.

In regard to the “use by each subject”, PIs (through the contracted pharmacist) should maintain Drug accountability records that document adequately which subject(s) received the Drug; when the subject(s) received the Drug; the specific dosage the subject(s) received; and any returned amount of the dispensed Investigational Drug;

- **Drug Storage** – Investigational product(s) should be stored as specified by the Sponsor and in accordance with applicable regulatory requirement(s). Storage guidelines, include:
  - Storage area is large enough for the supply of study Drug.
ii. Storage area can be locked.

iii. Investigational Drug is stored separately from other compounds.

iv. Non-dispensed Drug is stored separately from returned dispensed Drug.
   - If the study Protocol requires the subject to return the empty Investigational Drug container or any amount of the unused Investigational Drug, it is the Investigators responsibility to store the returned dispensed Investigational Drug separately from the non-dispensed Investigational Drug.
   - It is the responsibility of the PI to deliver the returned dispensed Investigational Drug to Research Pharmacy if it is the coordinating and control center for the Research Drug.

v. Inventory control procedures are used.

vi. Any environmental controls are maintained.

vii. Access is limited to study staff.

viii. Controlled substances are not allowed to be stored outside Tulane University Department of Pharmacy.

c. **Drug Labeling for Investigational Drugs:** The following labeling requirements are required for Investigational New Drugs:

i. The immediate package of an investigational new Drug intended for human use shall bear a label with the statement “Caution: New Drug – Limited by Federal (or U.S.) law to investigational use.”

ii. The label or labeling of an investigational new Drug shall not bear any statement that is false or misleading in any particular way and shall not represent that the investigational new Drug is sage or effective for the purposes for which it is being investigated. [FDA 21 CFR 312.6].

d. **Drug Labeling for Drugs:** Louisiana rules and Tulane require that all Drugs dispensed shall contain a medication label with the following:

i. Patient name

ii. Identifier

iii. Protocol number or name

iv. Name of prescriber/PI

v. Strength and volume of Drug

vi. Directions for use or Administration

vii. Dose

viii. Number of units dispensed

ix. Expiration date

x. Initials of preparer
xi. Initials of pharmacist performing final check
xii. Indication that it is an Investigational Drug, if applicable
xiii. Any auxiliary stickers or warning labels

e. **Drug Administration** – Investigational Drugs shall be Administered in accordance with any applicable Federal or State laws and regulations and in accordance with any policies or procedures set forth by Tulane and TUHC. An informed consent document signed and dated by the subject and the PI must be in place before Administering the Drug.

Only a person licensed within the State of Louisiana and so authorized by their professional scope of practice shall Administer an Investigational Drug to a subject. A principal Investigator may designate the responsibility of Administering the Drug only after the designee has been given and has demonstrated an understanding of basic pharmacologic information about the Drug. This education and delegation of responsibility must be documented. Investigational Drugs are to be Administered in accordance with Research Protocol and in accordance with any other hospital or clinic policy pertaining to the Administration of Investigational Drugs.

f. The PI shall report all Unanticipated Problem Involving Risks to Subjects or Others to the IRB according to the procedures outlined in **Section 15** and all Protocol Deviations (see **Section 14**).

g. For Research involving Investigational New Drugs:

i. The PI is required to inform Research Pharmacy that the IRB has approved the Protocol through submission of the IRB approval letters.

ii. The PI must inform the IRB and Research Pharmacy when a study involving Investigational Drugs has been terminated by the Sponsor.

iii. The PI will report to the Sponsor and IRB any adverse effect that may reasonably be regarded as caused by, or probably caused by, the Drug according to the procedures in the Protocol.

iv. The PI will maintain the following:

- Current *curriculum vitae* (“CV”), signed and dated within the last four years
- Protocol
- Records of receipt and disposition of Drugs
- List of any sub-Investigators with their CV, signed and dated within the last four years
- Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation, and
- Case Histories with particular documentation on evidence of Drug effects. Emphasis is on toxicity and possible untoward happenings.
- All unexpected adverse effects are reportable; even if the Investigator considers that the event is not related to the Drug. All unexpected adverse effects shall be
reported immediately to Research Pharmacy and the IRB in the manner defined by the Protocol and this document.

- IRB letters of approval.
- Other documents as outlined in the Human Subject Protection Program Standard Operating Procedures.

13.8.2.2 IRB

The IRB will review the Research using the same criteria it would use in considering approval of any Research involving an FDA-regulated product. [FDA 21 CFR §56.111].

13.8.3 Emergency Use

13.8.3.1 Definitions

**Emergency Use:** means the use of an Investigational Drug or Biological Product with a Human Subject in a Life-Threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval. [FDA 21 CFR 56.102(d)].

**Life Threatening:** for the purposes of 21 CFR 56.102(d), includes both life-threatening and severely debilitating.

- **Life-threatening** means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

- **Severely debilitating** means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

13.8.3.2 Emergency Exemption from Prospective IRB Approval

The Emergency Use provision in the FDA regulations [FDA 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. FDA regulations require that any subsequent use of the investigational product at the institution have prospective IRB review and approval. FDA acknowledges, however, that it would be inappropriate to deny emergency treatment to a second individual if the only obstacle is that the IRB has not had sufficient time to convene a meeting to review the issue.

The emergency use of a Test Article, other than a medical device, is a clinical investigation, the patient is a participant, and the FDA may require data from an emergency use to be reported in a marketing application.
DHHS regulations do not permit data obtained from patient to be classified as human subjects research, nor permit the outcome of such care to be included in a report of a research activity subject to DHHS regulations.

The IRB must be notified within 5 working days after the use of the article, via the Emergency Use Notification Form available in the IRB electronic submission system. This notification must not be construed as an approval for the Emergency Use by the IRB. The IRB Chair (or designee) will review the report to verify that circumstances of the Emergency Use conformed to FDA regulations.

### 13.8.3.3 Exception From Informed Consent Requirement

An exception under FDA regulations at 21 CFR 50.23(a-c) permits the emergency use of an investigational drug without informed consent when the investigator and an independent physician who is not otherwise participating in the clinical investigation (the emergency use) certify in writing all four of the following conditions:

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

If immediate use of the test article is, in the investigator's opinion, required to preserve the life of the subject, and time is not sufficient to obtain the independent physician determination in advance of using the test article, the determinations of the clinical investigator shall be made and, within 5 working days after the use of the article, be reviewed and evaluated in writing by a physician who is not participating in the clinical investigation.

Informed consent is required unless the conditions for the exception are met, as outlined above. Industry sponsors may have an approved consent form template that can be modified and utilized in emergency cases. If an approved consent form template is not available, the requirements at 21 CFR 50 should be used as guidelines. The IRB must be notified within 5 working days after the use of the article, via the Emergency Use Notification Form available in the IRB electronic submission system. Any subsequent use of the Test Article at the Institution is subject to IRB review. This notification must not be construed as an approval for the Emergency Use by the IRB. The IRB Chair (or designee) will review the report to verify that circumstances of the Emergency Use conformed to FDA regulations.

AAHRPP Standards for Accreditation (Standard I-7, Element I.7.C)

### 13.8.4 Expanded Access of Investigational Drugs

FDA regulations allow certain individuals not enrolled in clinical trials to obtain expanded access to Investigational Drugs, or Biologics Products through the following methods:
1. **Compassionate Use:** The term “compassionate use” is erroneously used to refer to the provision of Investigational Drugs outside of an ongoing clinical trial to a limited number of patients who are desperately ill and for whom no standard alternative therapies are available. The term “compassionate use” does not, however, appear in FDA or DHHS regulations. It is preferable, instead, to use the names of the specific access programs when discussing the use of investigational articles outside of formal clinical trials.

2. **Group C Treatment Investigational New Drug:** A means for the distribution of Investigational Drugs or Biologic Products to oncologists for the treatment of cancer under Protocols outside controlled clinical trials. Group C Drugs, Agents, or Biologic Products usually have shown evidence of relative and reproducible efficacy in a specific tumor type. Although the FDA typically grants a waiver for most Drugs used in Group C Treatment IND Protocols, Tulane IRB requires prospective IRB review and approval.

3. **Open-Label Protocol:** A study designed to obtain additional safety data, typically done when the controlled trial has ended, and treatment continues. The purpose of such a study is to allow subjects to continue to receive the benefits of the Investigational Drug, Agent, or Biologic Products until marketing approval is obtained. Prospective IRB review and approval is required.

4. **Parallel Track:** A method approved by the FDA that expands the availability of Investigational Drugs or Biologic Products as quickly as possible to persons with AIDS and other HIV-related diseases. These Drugs or Biologic Products are utilized in separate Protocols that “parallel” the controlled clinical trials and are essential to establish the safety and effectiveness of these new Drugs or Biologic Products. Although the Secretary of DHHS may, on a Protocol-by-Protocol basis, waive the provisions of 45 CFR Part 46 where adequate protections are provided through other mechanisms, prospective IRB review and approval is required by the Tulane IRB.

5. **Treatment IND or Biologic Products:** A mechanism for providing eligible subjects with Investigational Drugs (as early in the Drug development process as possible) for the treatment of serious and life-threatening illnesses for which there are no satisfactory alternative treatments. The FDA defines an immediately life-threatening disease as a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment. The FDA will permit an Investigational Drug to be used under a treatment IND after sufficient data have been collected to show that the Drug “may be effective” and does not have unreasonable risks. Prospective IRB review and approval is required.
   a. There are four requirements that must be met before a treatment IND can be issued:
      i. The Drug is intended to treat a serious or immediately life-threatening disease;
      ii. There is no satisfactory alternative treatment available;
      iii. The Drug is already under investigation or trials have been completed; and
      iv. The trial Sponsor is actively pursuing marketing approval.
   b. The FDA identifies two special considerations when a patient is to be treated under a Treatment IND:
i. **Informed Consent**: Informed consent is especially important in treatment use situations because the subjects are desperately ill and particularly vulnerable. They will be receiving medications which have not been proven either safe or effective in a clinical setting. Both the setting and their desperation may work against their ability to make an informed assessment of the risk involved. Therefore, the IRB should ensure that potential subjects are fully aware of the risks involved in participation.

ii. **Charging for Treatment IND(s)**. The FDA permits charging for the Drug or Biologic Products when used in a Treatment IND. Therefore, the IRB Committee should pay particular attention to Treatment IND(s) in which the subjects will be charged for the cost of the Drugs. If subjects will be charged for use of the Test Article, economically disadvantaged persons will likely be excluded from participation. Charging for participation may preclude economically disadvantaged persons as a class from receiving access to Test Articles. The IRB should balance this interest against the possibility that unless the Sponsor can charge for the Drug, it will not be available for treatment use until it receives full FDA approval.

6. **Single-Patient Use**: The use of an Investigational Drug outside of a controlled clinical trial for a patient, usually in a desperate situation, who is unresponsive to other therapies or in a situation where no approved or generally recognized treatment is available. There is usually little evidence that the proposed therapy is useful but may be plausible on theoretical grounds or anecdotes of success. Access to Investigational Drugs for use by a single, identified patient may be gained either through the Sponsor under a treatment Protocol, or through the FDA, by first obtaining the Drug from the Sponsor and then submitting a treatment IND to the FDA requesting authorization to use the Investigational Drug for treatment use. Prospective IRB review and approval is required (see 5 above).

7. **Emergency IND**: The Emergency Use of an unapproved Investigational Drug, Agent, or Biologic Products requires an emergency IND. The FDA has established mechanisms and guidance for obtaining an Emergency IND for the use of Investigational Drugs or Biologic Products.

Regulations & Guidelines: [FDA 21 CFR 312, Subpart I](#)

13.8.5 **Emergency Waiver of IND**

FDA regulations at [21 CFR §312.10](#) and [§312.310](#) address the need for an Investigational Drug to be used in an emergency situation that does not allow time for submission of an IND. The FDA may authorize shipment of the Drug for a specific use in such a circumstance in advance of submission of an IND. Prospective IRB review is required unless the conditions for Exemption are met ([FDA 21 CFR §56.104(c)](#) and [§56.102(d)](#)). Informed consent is required unless the conditions for Exemption are met ([21 CFR §50.23](#)). All applicable regulations must be met including those at 21 CFR Parts 50 and 56.

13.8.6 **Waiver of Informed Consent for Planned Emergency Research**

The conduct of planned Research in life-threatening emergencies where the requirement to obtain prospective Informed Consent has been waived is covered by [21 CFR §50.24](#). The Research plan must be approved in advance by the FDA or DHHS and the IRB, and publicly
disclosed to the community in which the Research will be conducted. Such studies are not allowed under the regulations covering the Emergency Use of a Test Article in a life-threatening situation.[21 CFR §56.104(c)].

To date, the Institution’s IRB has not processed any Protocols involving planned emergency Research or any Protocols requesting such an exception. Investigators should be aware that such planned emergency Research involves an extensive approval process that involves, among other requirements, consultation with representatives of the communities in which the Research will be conducted and from which Participants will be drawn, public disclosure to such communities of plans for the Research and its risks and expected benefits, and establishment of an independent data monitoring committee to exercise oversight of the Research. In view of the extensive and stringent requirements for such Research, the IRB expects Investigators who wish to use the planned emergency exception to the informed consent requirement to consult with the IRB staff prior to submission of the Protocol to the IRB for review.

13.8.6.1 For Research Subject to FDA Regulations:
The IRB (with the concurrence of a licensed physician who is a member of or consultant to the IRB and who is not otherwise participating in the clinical investigation) finds and documents each of the following:

1. The Research activity is subject to regulations codified by the FDA at Title 21 CFR part 50 and will be carried out under an FDA IND or an FDA IDE.

2. The application clearly identifies the Protocols that will include subjects who are unable to consent.

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

4. Obtaining consent is not feasible because:
   a. The subjects will not be able to give their consent as a result of their medical condition.
   b. The intervention under investigation must be administered before consent from the subjects’ Legally Authorized Representatives is feasible.
   c. There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the clinical investigation.

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

6. The clinical investigation cannot practicably be carried out without the waiver.

7. The proposed investigational plan defines the length of the potential therapeutic window based on scientific evidence, and the Investigator has committed to attempting to contact a Legally Authorized Representative for each subject within that window of time and, if feasible, to asking the Legally Authorized Representative contacted for consent within that window rather than proceeding without consent.

8. The Investigator will summarize efforts made to contact Legally Authorized Representatives and make this information available to the IRB at the time of Continuing Review.

9. The IRB has reviewed and approved consent procedures and a consent document consistent with 21 CFR 50.25. These procedures and the consent document are to be used with subjects or their Legally Authorized Representatives in situations where use of such procedures and documented is feasible.

10. The IRB has reviewed and approved procedures and information to be used when providing an opportunity for a family member to object to a subject’s participation in the clinical investigation.

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

12. Procedures are in place to inform, at the earliest feasible opportunity, each subject, or if the subject remains incapacitated, a Legally Authorized Representative of the subject, or if such a representative is not reasonably available, a family member, of the subject’s
inclusion in the clinical investigation, the details of the investigation and other information contained in the consent document.

13. There is a procedure to inform the subject, or if the subject remains incapacitated, a Legally Authorized Representative of the subject, or if such a representative is not reasonably available, a family member, that he or she might discontinue the subject’s participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

14. If a Legally Authorized Representative or family member is told about the clinical investigation and the subject’s condition improves, the subject is also to be informed as soon as feasible.

15. If a subject is entered into a clinical investigation with waived consent and the subject dies before a Legally Authorized Representative or family member can be contacted, information about the clinical investigation is to be provided to the subject’s Legally Authorized Representative or family member, if feasible.

16. The Protocol is performed under a separate IND or IDE that clearly identified such Protocols as protocols that may include subjects who are unable to consent.

17. The submission of those Protocols in a separate IND or IDE is required even if an IND for the same drug product or an IDE for the same device already exists.

18. If an IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in the exception or because of other relevant ethical concerns, the IRB must document its findings and provide these findings promptly in writing to the clinical Investigator and to the sponsor of the clinical investigation.

13.8.6.2 Research Not Subject to FDA Regulations:
The IRB finds, documents, and reports to DHHS that the following conditions have been met relative to the Research:

1. The IRB found and documented that the Research is not subject to regulations codified by the FDA at Title 21 CFR part 50.

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

3. Obtaining consent is not feasible because:
   a. The subjects are not able to give their consent as a result of their medical condition.
   b. The intervention involves in the Research is administered before consent from the subjects’ Legally Authorized Representative is feasible.
   c. There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the Research.

4. Participation in the Research held out the prospect of direct benefit to the subjects because:
   a. Subjects are facing a life-threatening situation that necessitated intervention.
b. Appropriate animal and other preclinical studies have been conducted, and the information derived from those studies and related evidence supported the potential for the intervention to provide a direct benefit to the individual subjects.

c. The risks associated with the Research are reasonable in relation to what is known about the medical condition of the potential class of subjects, the risks and benefits of standard therapy, if any, and what is known about the risks and benefits of the proposed intervention or activity.

5. The Research could not practicably be carried out without the waiver.

6. The proposed research Protocol defines the length of the potential therapeutic window based on scientific evidence, and the Investigator has committed to attempting to contact a Legally Authorized Representative for each subject within that window of time and, if feasible, asking the Legally Authorized Representative contacted for consent within that window rather than proceeding without consent. The Investigator will summarize efforts made to contact representatives and make this information available to the IRB at the time of Continuing Review.

7. The IRB has reviewed and approved consent procedures and a consent document in accordance with 45 CFR 46.116 and 46.117.

   a. These procedures and the consent document are to be used with subjects or their Legally Authorized Representative in situations where use of such procedures and documented is feasible.

   b. The IRB has reviewed and approved procedures and information to be used when providing an opportunity for a family member to object to a subject’s participation in the Research consistent with the paragraph of this waiver.

8. Additional protections of the rights and welfare of the subjects are provided, including, at least:

   a. Consultation (including, where appropriate, consultation carried out by the IRB) with representatives of the communities in which the Research is conducted and from which the subjects are drawn.

   b. Public disclosure to the communities in which the Research is conducted and from which the subjects are drawn, prior to initiation of the Research, of plans for the Research and its risks and expected benefits.

   c. Public disclosure of sufficient information following completion of the Research to apprise the community and researchers of the study, including the demographic characteristics of the research population, and its results.

   d. Establishment of an independent data monitoring committee to exercise oversight of the research.

   e. If obtaining consent is not feasible and a Legally Authorized Representative is not reasonably available, the Investigator has committed, if feasible, to attempting to contact within the therapeutic window the subject’s family member who is not a legally authorized representative, and asking whether he or she objects to the subject’s participation in the Research.
i. The Investigator will summarize efforts made to contact family members and make this information available to the IRB at the time of Continuing Review.

ii. Procedures are in place to inform, at the earliest feasible opportunity, each subject, or if the subject remained incapacitated, a Legally Authorized Representative of the subject, or if such a representative is not reasonably available, a family member, of the subject’s inclusion in the Research, the details of the Research and other information contained in the consent document.

iii. There is a procedure to inform the subject, or if the subject remained incapacitated, a Legally Authorized Representative of the subject, or if such a representative is not reasonably available, a family member, that he or she may discontinue the subject’s participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

iv. If a Legally Authorized Representative or family member is told about the Research and the subject’s condition improves, the subject is also informed as soon as feasible.

v. If a subject is entered into Research with waived consent and the subject dies before a Legally Authorized Representative or family member can be contacted, information about the Research is provided to the subject’s Legally Authorized Representative or family member, if feasible.

vi. For the purposes of this waiver “family member” means any one of the following legally competent persons: spouses; parents; children (including adopted children); brothers, sisters, and spouses of brothers and sisters; and any individual related by blood or affinity whose close association with the subject is the equivalent of a family relationship.

13.9 Investigational Devices in Research

13.9.1 Policy

Use of an Investigational Device in a clinical trial to obtain safety and effectiveness data must be conducted according to FDA’s IDE regulations found at 21 CFR Part 812 and other applicable FDA regulations.

The following procedures describe the use of Investigational Devices in Research Under the Auspices of the Institution’s IRB.

Regulations & Guidelines: FDA 21 CFR 812.00; 21 CFR 812.110; 21 CFR 812.140(a)

13.9.2 Definitions

Adverse Device Effect: Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a Device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other serious Unanticipated Problem associated with a device that relates to the rights, safety, or welfare of subjects [21 CFR 812.150(a)].
**Device (or Medical Device):** is an instrument, apparatus, implement, machine, contrivance, implant, *in vitro* reagent, or other similar or related Test Article, including a component part, or accessory which is (a) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in humans, or (b) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body, and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

**Humanitarian Use Device ("HUD"):** the FDA defines HUD as a Device intended to benefit patients by treating or diagnosing a disease that affects fewer than 4,000 individuals in the U.S. per year. [FDA 21 CFR 814.3(n)].

**Investigational Device:** as defined by the FDA, an Investigational Device is a Device that is the object of a clinical study designed to evaluate the safety or effectiveness of the Device. [21 CFR §812.3(g)]. Investigational Devices include transitional Devices [21 CFR §812.3(r)] that are objects of investigations. However, for the purposes of this document, an Investigational Device may be an approved Device that is being studied for an unapproved use or efficacy.

**In Vitro Diagnostic Product (IVD):** In vitro diagnostic products are those reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body. [21 CFR 809.3(a)].

**Investigational Device Exemption ("IDE"):** is an FDA-approval of the application for an exemption that permits an unmarked Device to be shipped for the purpose of doing Research on the Device. [See 21 CFR §812.1 and §812.2 for the scope and applicability].

**Non-Significant Risk Device:** is an Investigational Device other than a Significant Risk Device.

**Significant Risk Device:** is an Investigational Device that:

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a Human Subject;
- 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 Human Subject;
- Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presented a potential for serious risk to the health, safety, or welfare or a Human Subject;
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a Human Subject.

**13.9.3 IDE Requirements:**

The PI must indicate in the Initial Application for Human Subjects Research whether the Research involves Investigational Drugs or Devices. If so, the PI must indicate if there is an IND/IDE for the Research and provide documented assurance from the Sponsor that the manufacture and formulation of investigational or unlicensed Test Articles conform to Federal regulations. Documentation of the IDE could be a:

- Industry Sponsored Protocol with IDE;
• Letter from the FDA;
• Letter from industry Sponsor; or
• Other document and/or communication verifying the IDE.

For Investigational Devices, Non-Significant Risk Device studies follow abbreviated IDE requirements and do not have to have an IDE application approved by the FDA. If a Sponsor has identified a study as non-significant risk, then the PI must provide an explanation of the determination. If the FDA has determined that the study is non-significant risk, documentation of that determination must be provided.

If the Research involves Drugs or Devices and there is no IDE, the PI must provide a rationale why it is not required.

The IRB will review the application and determine:

• Whether there is an IDE and is so, whether there is appropriate supporting documentation; and
• If the Research involves Drugs or Devices with no IDE, and whether the Research meets the criteria below.

When research is conducted to determine the safety or effectiveness of a device:

• The device fulfills the requirements for an abbreviated IDE.
  o The device is not a banned device.
  o The sponsor labels the device in accordance with 21 CFR 812.5.
  o 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.
  o 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.
  o The sponsor complies with the requirements of 21 CFR 812.46 with respect to monitoring investigations;
  o 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);
  o 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
  o The sponsor complies with the prohibitions in 21 CFR 812.7 against promotion and other practices.

Who confirms that the IDE number is valid?
• The IRB reviewer (with assistance from the HRPO) is responsible for requesting that the principal investigator obtain from the sponsor official documentation to confirm a valid IDE number.

• When the research requires an IDE, the research must not begin until a valid IDE is in effect. This includes recruiting, obtaining consent, and screening participants for a specific study that is subject to the IDE.

• The IDE goes into effect 30 days after the FDA receives the IDE, unless the sponsor receives earlier notice from the FDA.

13.9.4 Exempted IDE Investigations

For Devices, an IDE is not necessary if:

1. The Research involves a Device, other than a transitional Device, in commercial distribution immediately before May 28, 1976, when used or investigated in accordance with the indications in labeling in effect at that time;

2. The Research involves a Device other than a transitional Device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent to a Device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of 21 CFR §807 in determining substantial equivalence;

3. The Research involves a diagnostic Device, if the Sponsor complies with applicable requirements in 21 CFR §809.10(c) and if the testing:
   a. Is noninvasive;
   b. Does not require an invasive sampling procedure that presents significant risk;
   c. Does not by design or intention introduce energy into a subject; and
   d. Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure;

4. The Research involves a Device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more Devices in commercial distribution, if the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk;

5. The Research involves a Device intended solely for veterinary use;

6. The Research involves a Device shipped solely for Research on/or with laboratory animals and labeled in accordance with 21 CFR §812.5(c); and/or

7. The Research involves a custom Device as defined in 21 CFR §812.3(b), unless the Device is being used to determine safety or effectiveness for commercial distribution.
13.9.5 Responsibilities

13.9.5.1 Principal Investigator (“PI’)

The PI is responsible for ensuring that the Research is conducted according to all regulatory guidelines, this document, and Institutional policies and procedures. The PI must obtain approval from the IRB before initiating any Research activities or enrolling any subjects in the Research.

The PI proposing the Device Research will be required to provide a plan – to be evaluated by the IRB - that includes storage, security, and dispensing of the Device. Elements of a sound control plan include the following:

1. **Investigational Device Accountability Policy/Procedures** (TU Form 409): A document that describes policies/procedures for the receipt, storage, dispensing, reconciliation, accountability, and return or authorized destruction of investigational devices used in human research.

2. **Storage**: All Devices received for a study must be stored in a locked environment under secure control with limited access. The area must be within an area of PI’s control. Proper instructions on the use of the Device must be provided to the subjects. A log must be kept regarding the receipt, use, and/or dispensing of the Device and the disposition of remaining Devices at the conclusion of the investigation.

3. **Reporting**: The PI shall report all Unanticipated Problems Involving Risk to Subjects or Others to the IRB according to the procedures outlined in Section 15.

4. **New Device Requirements**: For Research involving investigational new Drugs:
   a. If a Device is considered a Non-Significant Risk Device by the PI or Sponsor, but after review the IRB determines the Device to have significant risk, upon receipt of written notice the PI is responsible for notifying the Sponsor of the IRB(s) determination. The PI must provide the IRB with confirmation of this action.
   b. If the PI is storing the Devices, he/she must maintain a log indicating the identification/serial number of the Device, name of subject, date dispensed, by whom it was dispensed, and amount remaining.
   c. The PI will maintain the following:
      i. Current curriculum vitae (“CV”); signed and dated within the last four years;
      ii. Protocol of the study;
      iii. Records of receipt and disposition of Devices;
      iv. List of any co-Investigators with their CV; signed and dated within the last four years;
      v. Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation;
      vi. Case Histories with particular documentation on evidence of effects. Emphasis is on safety and possible untoward happenings. All Unanticipated Adverse Device Effects are reportable;
vii. IRB letters of approval.

viii. Device training; and

ix. Other documents as outlined in the Human Subject Protection Program Standard Operating Procedures.

d. Logs:

i. The **Device Accountability Log** (TU Form 1011) must be completed regarding the receipt, use and/or dispensing of the Device and the disposition of remaining Devices at the conclusion of the investigation; and

ii. After use, the PI must maintain a log regarding the receipt, use and/or re-dispensing of the Device and the disposition of remaining Devices at the conclusion of the investigation

e. **Reporting**: The PI will submit to the Sponsor and to the IRB a report of any Unanticipated Adverse Device Effect occurring during an investigation as soon as possible, but in no event later than 10 working days after the Investigator first learns of the effect;

5. **Investigator-Sponsored or Investigator-Initiated Studies**: When a PI files an IND or IDE; the PI is considered the Sponsor and as such is accountable for all of the FDA regulatory responsibilities and reporting obligations of both the PI and the Sponsor, as described in the FDA regulations.

An individual or group of individuals or medical center is considered a Sponsor for an investigation if they hold the IND or IDE. At Tulane these studies are typically called “investigator-initiated studies” when they involve the use an Investigational Drug or Device or use an approved Drug or Device for investigational purposes. The Research Plan asks the PI if he/she also acts as the Sponsor of the Research and, if so, asks him/her to affirm that he/she has reviewed the **Guidance Document on Requirements of Un-sponsored/Investigator-Initiated Research** (TU Form 713) and will comply with the regulatory responsibilities of a Sponsor.

The Sponsors’ or the Investigator as a Sponsor’s responsibilities includes the following:

- Selecting qualified Investigators;
- Providing Investigators with the information they need to conduct the investigation properly;
- Ensuring proper monitoring of the investigation; and
- Ensuring that the FDA and (for Devices) any reviewing IRB(s) or (for Drugs) all participating Investigators are promptly informed of significant new information about an investigation.

Additionally, if the IND or IDE product will be manufactured or produced at Tulane, the PI must submit documentation that: The product preparation and manufacture meets the standards for current Good Manufacturing Practice (GMP), or any modification to those standards approved by the FDA in issuing the IND or IDE.

- The GMP plan has been approved by the applicable University IO.
• The GMP plan has been reviewed and accepted by Tulane’s Risk Management and Compliance Office.

The HRPO and others as applicable will assist Investigators holding an IND or IDE on the Sponsor regulations and periodically conduct random audits of PIs holding an IND or IDE as part of ongoing Research compliance efforts.

13.9.5.2 IRB

The IRB will review the Research involving Investigational Devices in accordance with the following requirements and the same criteria it would use in considering approval of any Research involving an FDA-regulated product [21 CFR §56.111].

1. Control plan;

2. Unless the FDA has already made a risk determination for the study, the IRB will review Non-Significant Risk Device studies and determine if the Device represents significant or non-significant risk and report the findings to the PI in writing. The IRB will consider the risks and benefits of the Medical Device compared to the risks and benefits of alternative Devices or procedures. Non-Significant Risk Device studies do not require submission of an IDE application but must be conducted in accordance with the abbreviated requirements of IDE regulations. If the study was submitted as non-significant risk and is considered SR, the IRB may approve the study, but the study cannot begin until an IDE is obtained;

3. The IRB will not review Protocols involving Significant Risk Devices under Expedited Review;

4. The IRB will document in the minutes and provide written documentation to the PI of the rationale for determining whether a Device is classified as Non-Significant Risk Device/Significant Risk Device; and

6. If the FDA has already made the Significant Risk Device or Non-Significant Risk Device determination for the study, the agency’s determination is final, and the IRB does not need to make a risk determination.

13.9.6 Expanded Access to Investigational Devices

As with investigational drugs, unapproved medical devices may normally only be used in humans in an approved clinical trial under the supervision of a participating clinical investigator. However, there may be circumstances under which a health care provider may wish to use an unapproved device when a patient is facing life-threatening circumstances or suffering from a serious disease or condition for which no other alternative therapy or diagnostic exists or is a satisfactory option for the patient.

FDA has made the following mechanisms available for these circumstances:

• Emergency Use

• Planned Emergency Research

• Compassionate Use (or Single Patient/Small Group Access)

• Treatment Use
Continued Access

Investigators, when seeking access to investigational or unapproved devices under one of the above provisions, should work closely with the sponsor or manufacturer, the FDA, and the HRPO Office, to ensure that proper regulatory procedures are followed.

Unless the conditions that permit an emergency, use exemption are satisfied, prospective IRB review and approval is required. This requires, among other things, that the IRB review the proposed use at a convened meeting at which a majority of IRB members are present.

13.9.7 Emergency Use of Unapproved Medical Devices

FDA regulations permit the emergency use of an investigational or unapproved device without prior approval by the FDA or IRB when an appropriately trained and licensed health care provider determines that:

- The patient has a life-threatening or serious disease or condition that needs immediate treatment;
- No generally acceptable alternative treatment for the condition exists; and
- Because of the immediate need to use the device, there is no time to use existing procedures to obtain FDA approval for the use.

FDA expects the provider to make the determination that the above criteria are satisfied, to assess the potential for benefit from the use of the unapproved device, and to have substantial reason to believe that benefits will exist. Because prior FDA approval is not required, FDA expects providers planning the emergency use of an investigational device to obtain as many of the following as possible:

- An independent assessment from an uninvolved physician;
- Authorization from the device manufacturer;
- Concurrence of the IRB Chair or designee;
- Institutional clearance; and
- Informed consent from the patient or legally authorized representative.

At Tulane, providers planning the emergency use of an investigational or unapproved device must contact the HRPP/IRB office as early in the process as possible and submit documentation to support the use for review by the IRB Chair or designee. The IRB Chair or designee will review the information provided and determine whether the use conforms with FDA’s requirements and expectations and whether the provisions for the protection of the patient appear adequate using the applicable criteria at 21 CFR 50 and 56 as guidelines (e.g., minimization of risks, risk/benefit, safety monitoring, informed consent, etc.).

The emergency use must be reported to the FDA by the IDE Sponsor, when one exists, or by the provider if no IDE exists. Information regarding what to include in the report and where to submit it is available on FDA’s website. When the provider is responsible for the FDA report, a copy of the report and any related correspondence must be submitted to the IRB office. Reports of emergency uses will be brought to the convened IRB for their information.
Providers are reminded that they must comply with all other organizational policies and requirements applicable to the use of the investigational or unapproved devices.

13.9.8 Significant and Non-Significant Risk Device Studies

A device study is a Non-Significant Risk (NSR) Device study if it is not IDE exempt and does not meet the definition of a Significant Risk (SR) Device study.

Under 21 CFR 812.3(m), an SR device means an investigational device that:

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject;
- Is purported or represented to be for use supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject;
- 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
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

If the FDA has already determined a study to be SR or NSR, documentation evidencing such should be provided to the IRB as described in Section 13.9.8. The FDA’s determination is final, and the IRB does not have to make the device risk determination.

Unless the FDA has already made a device risk determination for the study, the IRB will review studies that the sponsor or investigator have put forth as NSR at a convened meeting to determine if the device represents SR or NSR.

The sponsor or sponsor-investigator is responsible for providing the IRB with an explanation describing the basis for their initial determination of NSR and any other information that may help the IRB in evaluating the risk of the study (e.g., reports of prior investigations of the device).

The IRB will review the information provided by the sponsor and investigator including, but not limited to: the sponsor or investigator’s NSR assessment, the description of the device, reports of prior investigations of the device (if applicable), the proposed investigational plan, and subject selection criteria.

The NSR/SR determination made by the IRB will be based on the proposed use of the device in the investigation, not on the device alone. The IRB will consider the nature of any harm that may result from use of the device, including potential harms from additional procedures subjects would need to undergo as part of the investigation (e.g., procedures for inserting, implanting, or deploying the device). The IRB may consult with the FDA or require the sponsor or investigator to obtain a determination from the FDA. The IRB will document the SR or NSR determination and the basis for it in the meeting minutes and provide the investigator, and sponsor when applicable, with the determination in writing.

Non-significant risk device studies do not require submission of an IDE application to the FDA but must be conducted in accordance with the abbreviated requirements of IDE regulations (21 CFR 812.2(b)). Under the abbreviated requirements, the following categories of investigations
are considered to have approved applications for IDE's, unless FDA has notified a sponsor under 812.20(a) that approval of an application is required:

An investigation of a device other than a significant risk device, if the device is not a banned device and the sponsor (or sponsor-investigator):

1. Labels the device in accordance with 812.5;
2. Obtains IRB approval of the investigation after presenting the reviewing IRB with an explanation of why the device is not a significant risk device, and maintains such approval;
3. Ensures that each investigator participating in an investigation of the device obtains from each subject under the investigator's care, informed consent under part 50 and documents it, unless documentation is waived by an IRB under 56.109(c).
4. Complies with the requirements of 812.46 with respect to monitoring investigations;
5. Maintains the records required under 812.140(b) (4) and (5) and makes the reports required under 812.150(b) (1) through (3) and (5) through (10);
6. Ensures that participating investigators maintain the records required by 812.140(a)(3)(i) and make the reports required under 812.150(a) (1), (2), (5), and (7); and
7. Complies with the prohibitions in 812.7 against promotion and other practices.

When the FDA or IRB determines that a study is SR, the IRB may approve the study, but the study cannot begin until an IDE is obtained.

13.9.9 Humanitarian Use Devices (HUD)

A Humanitarian Use Device (“HUD”) is an approved (marketed) medical device intended to benefit patients in the treatment or diagnosis of a disease or condition that affects or is manifested in fewer than 4,000 individuals in the United States per year [21 CFR 814.3(n)]. Federal law requires that IRBs (or alternate institutional committee) approve the use of a HUD at a facility under the auspices of the IRB. Once approved, the clinical use of the HUD may be considered as any other approved device, with the caution that effectiveness has not been shown in clinical trials.

13.9.9.1 Definitions

**Humanitarian Use Device (“HUD”):** the FDA defines HUD as a Device intended to benefit patients by treating or diagnosing a disease that affects fewer than 4,000 individuals in the U.S. per year. [FDA 21 CFR 814.3(n)].

**Humanitarian Device Exemption:** A Humanitarian Device Exemption (HDE) is a “premarket approval application” submitted to FDA pursuant to Subpart A, 21 CFR Part 814 “seeking a humanitarian device exemption from the effectiveness requirements of sections 514 and 515 of the [FD&C Act] as authorized by section 520(m)(2) of the [FD&C Act].” HDE approval is based upon, among other criteria, a determination by FDA that the HUD will not expose patients to an unreasonable or significant risk of illness or injury and the probable benefit to health from use of the device outweighs the risk of injury or illness from its use while taking into account the probable risks and benefits of currently available devices or alternative forms of treatment.

**HDE Holder.** An HDE Holder is a person who or entity that obtains to approval of an HDE from the FDA.
13.9.9.2 IRB Review Requirements

A Humanitarian Use Device ("HUD") may only be used in a facility after an IRB (or alternative institutional committee) has approved its use, except in certain emergencies. The HDE holder is responsible for ensuring that a HUD is provided only to facilities having an IRB constituted and acting in accordance with the FDA’s regulations governing IRBs (21 CFR Part 56), including continuing review of use of the device. The IRB must have members or consultants with the appropriate experience and expertise to perform a complete and adequate review of the use of a HUD at the institution (21 CFR 56.107(a)). When necessary, the IRB may defer in writing to another similarly constituted IRB that has agreed to oversee the use of the HUD but must provide the deferral letter to the HDE holder.

When a HUD is used in a clinical investigation (i.e., research involving one or more subjects to determine the safety or effectiveness of the HUD), the full requirements for IRB review and informed consent apply (21 CFR 50 and 56) as well as other applicable regulations. It is essential for the health care provider to differentiate whether the HUD is being studied for the indication(s) in its approved labeling or for different indication(s). When the HUD is being studied for the indication(s) in its approved labeling, the IDE regulations at 21 CFR 812 do not apply. However, when the HUD is being studied for a different indication(s), 21 CFR 812 does apply, including the requirement for an FDA-approved IDE before starting the clinical investigation of a Significant Risk Device.

13.9.9.3 Procedures

The relevant requirements and procedures for investigators and for IRB review described elsewhere in these SOPs apply to clinical investigations of HUDs. The material within this section applies to diagnostic or treatment uses of HUDs.

The health care provider seeking approval for diagnostic or treatment use of a HUD at the Institution is responsible for obtaining IRB approval prior to use of the HUD at the facility and for complying with the applicable regulations, including those for medical device reporting, Institutional policies, and the requirements of the IRB.

The procedures the IRB follows for initial and continuing review of diagnostic or treatment uses of HUDs are not specified in the regulations, other than the requirement for initial review by the convened IRB and the requirement for submission of medical device reports to the IRB. The following procedures are based upon the recommendations in FDA’s guidance document, which specifically states that the amount/type/level of review is up to the IRB and Institution.

Health care providers seeking initial IRB approval for diagnostic or treatment use of a HUD for the indication(s) in the HUDs approved labeling should submit the following materials to the IRB:

1. Application Form – Humanitarian Use Devices (non-research uses)
2. A copy of the HDE approval letter from the FDA
3. A description of the device, such as a device brochure
4. The product labeling;
5. The patient information packet for the HUD
6. The proposed clinical consent process
7. Other relevant materials (e.g., training certificates) as identified in the Application Form
The IRB will review the proposal at a convened meeting ensuring that appropriate expertise is available either within the membership in attendance or via the use of consultants. The IRB will review the risks to patients that are described in the product labeling and other materials, the proposed procedures to ensure that risks are minimized, and will evaluate whether the risks are reasonable in relation to the potential benefits to patients at the facility. The IRB will evaluate the patient information packet and proposed consent process and will determine if the materials are adequate and appropriate for the patient population.

The IRB may specify limitations on the use of the device, require additional screening and follow up procedures, require interim reports to the IRB, require continuing review more often than annually, or set other conditions or requirements as appropriate to minimize risks to patients and ensure the safe use of the device in the facility.

Once use of the HUD is approved, the health care provider is responsible for submitting any proposed changes to the IRB-approved plan or patient materials and obtaining approval for those changes prior to implementation, unless the change is necessary to avoid or mediate an apparent immediate risk to a patient. Proposed changes may be submitted using the Modification Form and should be accompanied by any revised materials or supporting documentation. The IRB may review these changes using expedited review procedures or refer the changes for review by the convened IRB.

The health care provider is responsible for submitting reports to the FDA, the IRB, and the manufacturer/HDE Holder whenever a HUD may have caused or contributed to a death, and must submit reports to the manufacturer (or to FDA and the IRB if the manufacturer is unknown) whenever a HUD may have caused or contributed to a serious injury (21 CFR 803.30 and 814.126(a)). Serious injury means an injury or illness that (1) is life-threatening, (2) results in permanent impairment of a bodily function or permanent damage to a body structure, or (3) necessitates medical or surgical intervention to preclude permanent impairment of a bodily function or permanent damage to a body structure (21 CFR 803.3). The specific requirements for this reporting are in the Medical Device Reporting (MDR) Regulation, at 21 CFR Part 803. The IRB will review these reports via either expedited or convened review, as appropriate, and will consider whether any changes are needed to the IRB-approved plan or patient materials.

The health care provider is responsible for submitting continuing review materials to the IRB sufficiently in advance of the expiration date to ensure IRB review and re-approval prior to expiration. Materials to be submitted include:

1. The Continuing Review Report – Humanitarian Use Devices (non-research uses)
2. Any safety reports or summaries provided by the HDE holder that had not previously been submitted
3. The current patient information packet, if applicable
4. The current consent, if applicable
5. Other materials as identified on the Continuing Review Report
6. Any other new relevant information or materials

The IRB may conduct continuing review using expedited review procedures or review by the convened IRB.
13.9.9.4 Emergency Uses of HUDs
Unapproved HUDs - If an appropriately trained and licensed health care provider in an emergency situation determines that IRB approval for the use of the HUD at the facility cannot be obtained in time to prevent serious harm or death to a patient, a HUD may be used without prior IRB approval. The health care provider must comply with the HDE holder’s requirements for certification of the emergent need for the HUD. Within 5 days after the emergency use of the device, See Section 25.9, Procedures for Requesting a Facilitated Review where Tulane defers to/reliies upon an External IRB, for submission requirements to the Tulane IRB.

The provider must provide written notification of the use to the Chair of the IRB including the identification of the patient involved, the date of the use, and the reason for the use [21 CFR 812.124].

Off-label Use of HUDs - If a HUD is approved for use in a facility, but an appropriately trained and licensed health care provider wants to use the HUD outside its approved indication(s) in an emergency or determines that there is no alternative device for a patient’s condition, the physician should consult with the HDE holder and IRB in advance whenever possible, obtain informed consent if possible, and ensure that reasonable measures are taken to protect the well-being of the patient such as a schedule and plan for follow up examinations and procedures to monitor the patient, taking into consideration the patient’s specific needs and what is known about the risks and benefits of the device. The provider should submit a follow up report to the HDE holder and the IRB and must comply with medical device reporting requirements.

The IRB may require additional reports, patient protection measures, or other requirement, as appropriate given the specifics of the situation.

Regulations & Guidelines: FDA 21 CFR §814

13.10 Digital Health
Certain medical and decision support software have been excluded from the definition of medical device under the 21st Century Cures Act and thus are not subject to FDA’s regulations. These include exclusions for software functions:

- Intended for administrative support of a health care facility, including the processing and maintenance of financial records, claims or billing information, appointment schedules, business analytics, information about patient populations, admissions, practice and inventory management, analysis of historical claims data to predict future utilization or cost-effectiveness, determination of health benefit eligibility, population health management, and laboratory workflow;

- Intended for maintaining or encouraging a healthy lifestyle and unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition;

- Intended to serve as electronic patient records, including patient-provided information, to the extent that such records are intended to transfer, store, convert formats, or display the equivalent of a paper medical chart, so long as—

  o such records were created, stored, transferred, or reviewed by health care professionals, or by individuals working under supervision of such professionals;

  o such records are part of health information technology that is certified under section 300jj–11(e)(5) of title 42; and

  o such function is not intended to interpret or analyze patient records, including medical image data, for the purpose of the diagnosis, cure, mitigation,
prevention, or treatment of a disease or condition

- Intended for transferring, storing, converting formats, or displaying clinical laboratory test or other device data and results, findings by a health care professional with respect to such data and results, general information about such findings, and general background information about such laboratory test or other device, unless such function is intended to interpret or analyze clinical laboratory test or other device data, results, and findings; and

- Not intended to acquire, process, or analyze a medical image or a signal from an in vitro diagnostic device or a pattern or signal from a signal acquisition system; and
  - Is intended for the purpose of displaying, analyzing, or printing medical information about a patient or other medical information (such as peer-reviewed clinical studies and clinical practice guidelines);
  - Is intended for the purpose of supporting or providing recommendations to a health care professional about prevention, diagnosis, or treatment of a disease or condition; and
  - Is intended for the purpose of enabling such health care professional to independently review the basis for such recommendations that such software presents so that it is not the intent that such health care professional rely primarily on any of such recommendations to make a clinical diagnosis or treatment decision regarding an individual patient.

Additional information regarding the application of these exclusions is available on the FDA website referenced below. Research involving software excluded from the definition of medical device will be evaluated by Tulane’s IRB in accordance with any other applicable regulations (e.g., the Common Rule, HIPAA) and the criteria outlined in this manual.

Other digital health products may be subject to FDA regulations and will be evaluated accordingly. FDA has provided a website listing of Guidances with Digital Health Content to help the regulated community understand FDA’s interpretation and application of the regulations and to describe when FDA will practice enforcement discretion in regards to certain requirements such as those for pre-market review and for device reports. Investigators are encouraged to consult these guidances in advance of their submission to the IRB and to consult directly with the FDA as needed.

### 13.11 Human Cells, Tissues, or Cellular- or Tissue-Based Products HCT/P’s

Generally, research involving HCT/P’s regulated as drugs, devices, and/or biologics will require an IND or IDE depending on how the HCT/P is categorized. Because the regulatory and policy framework for HCT/P’s is complex, consultation with the FDA prior to submission to the IRB is encouraged to appropriately categorize the HCT/P, understand which regulations and requirements apply, and to obtain an IND or IDE if necessary (or FDA determination that such is not required).
13.12 Investigator-Sponsored or Investigator-Initiated Studies

When a PI files an IND or IDE, the PI is considered the Sponsor and as such is accountable for all of the FDA regulatory responsibilities and reporting obligations of both the PI and the Sponsor, as described in the FDA regulations. An Investigator-Initiated or Investigator-Sponsored study may be required to undergo full-board (convened) review by the IRB, even if the study may otherwise qualify for expedited or exempt review.

An individual or group of individuals or medical center is considered a Sponsor for an investigation if they hold the IND or IDE. At Tulane University these studies are typically called “investigator-initiated studies” when they involve the use an Investigational Drug or Device or use an approved Drug or Device for investigational purposes.

The Research Plan asks the PI if he/she also acts as the Sponsor of the Research and, if so, asks him/her to affirm that he/she has reviewed and will comply with the regulatory responsibility of a Sponsor.

The Sponsors’ or the Investigator as a Sponsor’s responsibilities includes the following:

1. Selecting qualified Investigators
2. Providing Investigators with the information they need to conduct the investigation properly
3. Ensuring proper monitoring of the investigation
4. Ensuring that the FDA and (for Devices) any reviewing IRB(s) or (for Drugs) all participating Investigators are promptly informed of significant new information about an investigation.

Additionally, if the IND or IDE product will be manufactured or produced at Tulane University, the PI must submit documentation that:

5. The product preparation and manufacture meet the standards for current Good Manufacturing Practice (GMP), or any modification to those standards approved by the FDA in issuing the IND or IDE.
6. The GMP plan has been approved by the applicable Tulane University IO.
7. The GMP plan has been reviewed and accepted by Tulane University Risk Management and Compliance Office.

The HRPO and others as applicable will assist Investigators holding an IND or IDE on the Sponsor regulations and periodically conduct random audits of PIs holding an IND or IDE.
14  Reportable Events

14.1  Policy

Regulations require an Organization to have written procedures for ensuring prompt reporting of changes in Research activity; unanticipated problems involving risks to Subjects or others; and any instances of Serious or Continuing Noncompliance to the IRB, Organizational Officials, and applicable Federal Agencies. In order to comply with this requirement, Tulane HRPP has procedures to review issues that arise during the conduct of Research.

The following sections provide definitions and procedures regarding issues that arise during the conduct of Research that must be reported to the IRB.

14.2  Definitions

**Unanticipated Problem Involving Risks to Subjects or Others** (or “Unanticipated Problem”): means any incident, experience, outcome, or new information where all three elements exist:

1. Is unexpected;
2. Is Related or Possibly Related to participation in the Research, and
3. Indicates that subjects or Others are at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

“Unexpected”: means the incident, experience or outcome is not expected (in terms of nature, severity, or frequency) given the Research procedures that are described in the Protocol-related documents, such as the IRB-approved research Protocol and informed consent documents; and the characteristics of the subject population being studied;

“Related”: there is reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research.

**Adverse Event**: For the purposes of these policies and procedures, an Adverse Event (AE) is any untoward or unfavorable occurrence in a Human Subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom or disease, temporarily associated with the Subject’s participation in the Research, whether or not considered related to the Subject’s participation in the Research. Adverse Events encompass both physical and psychological harms. They occur most commonly in the context of biomedical research, although on occasion, they can occur in the context of social and behavioral Research.

**Unanticipated Adverse Device Effect**: An Unanticipated Adverse Device Effect (UADE) means any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that related to the rights, safety, or welfare of Subjects [21 CFR 812.3(s)].

**Protocol/Research Plan Deviation(s)**: means a violation that is unanticipated and happens without any prior agreement (e.g., a protocol visit scheduled outside the protocol window; blood work drawn outside the protocol window, etc.). The IRB will review these reports for frequency and may request, among other reasons, that an audit be conducted for any protocol reporting frequent deviations. [Not defined by Common Rule or FDA regulations].
**Protocol/Research Plan Exception (or “Exception”):** means a circumstance in which the specific procedures called for in a Protocol are not in the best interests of a specific patient/subject (e.g., patient/subject is allergic to one of the medications provided as supportive care). Usually it is a violation that is anticipated and happens with prior agreement from the sponsor. [Not defined by Common Rule or FDA regulations].

### 14.3 Procedures

#### 14.3.1 Reporting

Adverse events in clinical trials must be reported to the sponsor in compliance with FDA regulations and sponsor requirements. **Unless specifically required by the IRB (e.g. first in human clinical trials), the University’s IRB does not accept reports of adverse events and IND Safety Reports that do not meet the definition of an unanticipated problem involving risks to subjects or others.**

If investigators are uncertain but believe that the event might qualify as an unanticipated problem, a report should be submitted.

Investigators must report the following events or issues to the IRB as soon as possible, but in no event later than 10 working days after the investigator first learns of the event.

1. A single occurrence of a serious, unexpected event that is uncommon and strongly associated with drug exposure (such as angioedema, agranulocytosis, hepatic injury, or Stevens-Johnson syndrome).
2. A single occurrence, or more often a small number of occurrences, of a serious, unexpected event that is not commonly associated with drug exposure, but uncommon in the study population (e.g., tendon rupture, progressive multifocal leukoencephalopathy.)
3. Multiple occurrences of an AE that, based on an aggregate analysis, is determined to be an unanticipated problem. There should be a determination that the series of AEs represents a signal that the AEs were not just isolated occurrences and involve risk to human subjects (e.g., a comparison of rates across treatment groups reveals higher rate in the drug treatment arm versus a control). A summary and analyses supporting the determination should accompany the report.
4. An AE that is described or addressed in the investigator’s brochure, protocol, or informed consent documents, but occurs at a specificity or severity that is inconsistent with prior observations. For example, if transaminase elevation is listed in the investigator’s brochure and hepatic necrosis is observed in study subjects, hepatic necrosis would be considered an unanticipated problem involving risk to human subjects. A discussion of the divergence from the expected specificity or severity should accompany the report.
5. A serious AE that is described or addressed in the investigator’s brochure, protocol, or informed consent documents, but for which the rate of occurrence in the study represents a clinically significant increase in the expected rate of occurrence (ordinarily, reporting would only be triggered if there were a credible baseline rate for comparison). A discussion of the divergence from the expected rate should accompany the report.
6. Changes made to the research without prior IRB approval to eliminate apparent immediate hazards to the subject(s).
7. Adverse events involving direct harm to subjects enrolled by the investigator (i.e., local adverse events), which in the opinion of the investigator or sponsor, may represent an unanticipated problem involving risk to subjects or others.

8. An unanticipated event related to the research that exposes subjects to potential risk but that does not involve direct harm to subjects (e.g. lost laptop).

9. An unanticipated event related to the research that results in actual harm or exposes individuals other than the research participants (e.g., investigators, research assistants, students, the public, etc.) to potential risk.

10. IND Safety Reports from sponsors that meet the criteria for an unanticipated problem involving risk to subjects.

11. Data and Safety Monitoring Reports that indicate that risks are greater than previously known or that indicate that the study requires modification or should be suspended or terminated.

12. New information that indicates an increase to the risks or decrease to potential benefits of the research. Examples include:
   - an interim analysis or safety monitoring report indicates that frequency or magnitude of harms or benefits may be different than initially presented to the IRB
   - a paper is published from another study that shows that the risks or potential benefits of the research may be different than initially presented to the IRB.

13. New information that may impact the willingness of participants to continue in the research.


15. Incarceration of a participant in a study not approved to enroll prisoners.

16. Complaint of a subject when the complaint involves the health, safety, or rights of the subject or indicates unexpected risks, possible non-compliance, or cannot be resolved by the research team.

17. Protocol/research plan deviations.

18. Sponsor or lead investigator/coordinating center-imposed suspension or termination of some or all research activities.

19. Unanticipated adverse device effects (UADEs). (Note: Regulations require that UADEs be reported to the sponsor and IRB as soon as possible but in no event later than 10 working days after the investigator first learn of the event [21 CFR 812.150(a)(1)]).

20. Any other adverse event or safety finding (e.g. based on animal or epidemiologic data) that indicates subjects or others might be at risk of serious, unanticipated harms that are reasonably related to the research. These would cause the sponsor to modify the investigator’s brochure, study protocol, or informed consent documents, or would prompt other action by the IRB to ensure the protection of human subjects. An explanation of the conclusion should accompany the report.
14.3.2 Submission of Reports

Investigators or the study team must report possible problems or issues with the Research to the HRPO via the IRB electronic submission system using the Event Reporting Form. The written report should contain the following:

1. Detailed information about the event or issue, including relevant dates.
2. Any corrective and preventative actions planned or already taken, to ensure that the issue or problem is corrected and will not occur again.
3. An assessment of whether any subjects or others were placed at risk as a result of the event or suffered any harm (e.g., physical, social, financial, legal or psychological) and any plan to address these consequences.
4. If a report from a sponsor is the basis for the report of a possible unanticipated problem involving risks to subjects or others, or a sponsor has requested the submission to the IRB, the report should be accompanied by an analysis from the sponsor detailing (1) how the event or problem satisfies the definition of a UAP, (2) proposed study-wide corrective actions or modifications to the research along with a timeline for anticipated completion of the actions, and (3) whether or not the problem has been reported as a UAP to any relevant federal agencies.
5. If a sponsor or lead investigator or coordinating center suspends or terminates some or all research activities, the report should be accompanied by information from the sponsor detailing (1) why the suspension or termination was enacted, (2) if it was due to a possible UAP (in which case the information in “d” above must be included), (3) any impact on subjects or actions to be taken to protect subjects, (4) any plan to inform subjects of the suspension or termination and other pertinent information, and (5) whether the suspension or termination has been reported to any relevant federal agencies.
6. Any other relevant information.
7. Any other information requested by the HRPO Office.

Reports will be screened by the HRPO staff and shared with the RCO and immediately forwarded to the Chair, or designee if the HRPO staff believes that immediate intervention may be required to protect participants or others from serious harm.

Upon receipt of a report or complaint of from someone other than the investigator or study staff on behalf of the investigator, the HRPO staff or RCO will notify the investigator when appropriate.

14.3.3 IRB Procedures for Handling Reportable Events

1. Upon receipt of the Event Reporting Form from an investigator, the HRPO staff reviews the form for completeness. If any applicable sections of the form are incomplete or have been answered unsatisfactorily, the HRPO staff will contact the investigator or the designated contact person to obtain additional information.
2. The IRB Chair and/or other experienced member(s) designated by the IRB Chair receives and reviews the report. The IRB Chair (or designee) will make the initial determination as to whether the event is to be regarded as an unanticipated problem and/or non-compliance (See Section 15 for procedures for unanticipated problems, and Section 16 for serious or continuing non-compliance).
3. Based on the information received from the investigator, the IRB Chair or designee may suspend research to ensure protection of the rights and welfare of participants. Suspension directives made by the IRB Chair or designee must be reported to a meeting of the convened IRB and must follow notification procedures for IRB suspensions.

4. The IRB or the IRB Chair (or designee) has authority to require submission of more detailed contextual information by the investigator, the sponsor, the study coordinating center, or DSMB/DMC about any event occurring in a research study as a condition of the continuation of the IRB’s approval of the research.

5. If the IRB Chair or designee determines that the problem does not possibly meet the definition of an unanticipated problem or serious or continuing non-compliance, the reviewer will consider whether any corrective or preventative actions are sufficient and whether modifications to the research plan, consent, or corrective action plan may be necessary, and refer the matter to the convened IRB for review if appropriate. The results of the review will be recorded in the study record and communicated to the investigator. If the reviewer determines that the event may be an unanticipated problem, the report will be reviewed at a convened IRB meeting and must follow notification procedures for UPs.

Regulations & Guidelines: DHHS 45 CFR §46.103(b)(4)(iii); FDA 21 CFR §56.108(a)(4); 21 CFR §56.108(b); 21 CFR §812.150
15 Unanticipated Problems Involving Risks to Subjects or Others

15.1 Policy

Tulane complies with DHHS and FDA regulations which state that institutions must have written policies on reporting Unanticipated Problems Involving Risks to Subjects or Others (as defined below) to the IRB, organizational officials and relevant Federal agencies and departments.

The following procedures describe how Unanticipated Problems Involving Risk to Subjects or Others are handled in Research under the auspices of the IRB. Unless specifically required by the IRB, the IRB does not accept reports of adverse events that do not meet the definition of an Unanticipated Problem Involving Risk to Subjects or Others. Refer to HRPO’s Website for the Decision Tree for Reporting Unanticipated Problems to IRB (TU Form 728) to facilitate determining whether a reportable Unanticipated Problem exists.

AAHRPP Standards for Accreditation (Standard II-2, Element II.2.G)

15.1.1 IRB Review

After a determination of a possible Unanticipated Problem Involving Risk to Subjects or Others ("UAP"), the report will be placed on the agenda for a Convened IRB meeting and a Reviewer will be assigned.

The Reviewer will be given access to the study records in the IRB electronic submission system, including the currently approved protocol, the currently approved consent document, previous reports of UAPs, the investigator’s brochure (if one exists), the event report, and recommendations from the IRB Chair or designee, when appropriate. All IRB members attending the convened IRB meeting where the event report will be reviewed will receive the event report and have full access to all materials upon request.

After review of the study and event report, the Convened IRB will make findings and recommendations based on the following considerations:

1. Whether the reported event is a UAP according to the definition in this policy
2. What action in response to the report is appropriate
3. Whether suspension or termination of approval is warranted

If the IRB finds that the event is not a UAP, according to the definition in the policy, the IRB may recommend any of the following actions:

1. No action
2. Requiring modifications to the protocol/research plan
3. Revising the continuing review timetable
4. Modifying the consent process
5. Modifying the consent document
6. Providing additional information to current participants (e.g., whenever the information may relate to the subject’s willingness to continue participation)
7. Providing additional information to past subjects
8. Requiring additional training of the investigator and/or study staff
9. Other actions as appropriate given the specific circumstances

If the IRB finds that the event is a UAP, according to the definition in the policy, the IRB may recommend any of the following actions:

1. Requiring modifications to the protocol/research plan
2. Revising the continuing review timetable
3. Modifying the consent process
4. Modifying the consent document
5. Providing additional information to current participants (e.g., whenever the information may relate to the subject’s willingness to continue participation)
6. Providing additional information to past participants
7. Requiring additional training of the investigator and/or study staff
8. Reconsidering approval
9. Requiring that current subjects re-consent to participation
10. Monitoring the research
11. Monitoring consent
12. Referral to other organizational entities (e.g., RCO, legal counsel, risk management, Institutional Official)
13. Suspending the research approval
14. Terminating the research approval
15. Other actions as appropriate for local context and/or given the specific circumstances

If a report suggests that participant safety is at risk, the IRB may immediately suspend or terminate the research. Any suspension or termination of research by the IRB must be promptly reported to the IO and relevant federal regulatory agencies through the IO. This should be done in writing.

If, after reviewing a report, the IRB finds that the event is a UAP or that suspension or termination of approval is warranted, the IRB will:

1. Notify the investigator in writing of its findings, with copies to the Chair of the investigator’s department and/or supervisor of investigator’s research unit/institute, as well as other affected units, and
2. Report its findings and recommendations to the RCO, on behalf of the IO, for further reporting to the appropriate federal officials (see Section14).
16 Noncompliance with the Requirements of the HRPP

16.1 Overview

The purpose of this policy is:

1. to define the duty and responsibility of individuals to report to the Tulane University Human Research Protection Office (HRPO) observed or apparent noncompliance with federal, state, or local laws and regulations or the requirements, determinations, or procedures of the Tulane HRPP; and;

2. to define noncompliance and the procedures of the HRPP in reviewing observed or apparent noncompliance.

This policy is established to comply in part with the regulatory requirement in 45 CFR 46.103(b)(5) and 21 CFR 56.108(b)(2) requiring IRBs to have written procedures which the IRB will follow for ensuring prompt reporting to the IRB, appropriate institutional officials, Office for Human Research Protections (“OHRP”), and, when applicable, the Food and Drug Administration (“FDA”), of any Serious Noncompliance or Continuing Noncompliance with the regulations or the requirements or determinations of the IRB.

This policy applies to investigators and others employed by, on staff at, or otherwise affiliated with the applicable Tulane-affiliated entities that observe or otherwise become aware of apparent noncompliance in connection with human-subjects research and clinical investigations subject to review by the IRB and to investigators who are the subject of a report of observed or apparent noncompliance.

16.2 Definitions and examples

Allegation of Noncompliance means an unconfirmed report of Noncompliance is defined as any failure to follow:

- Applicable federal regulations, state or local laws, or institutional policies governing human subject protections, or
- The requirements or determinations of the IRB, including the requirements of the approved investigational plan (i.e., protocol deviations).

Noncompliance can result from performing an act that violates these requirements or failing to act when required. Noncompliance may be minor or sporadic or it may be serious or continuing.

Minor Noncompliance: means any Noncompliance that is not Serious Noncompliance or Continuing Noncompliance. For example, Minor Noncompliance might include the following:

1. missing an original signed and dated research consent form;
2. missing pages of executed research consent forms;
3. inappropriate documentation of informed consent, e.g., missing one or more signatures or date;
4. obtaining informed consent using an invalid/outdated research consent form that contains all of the information required by the IRB;
5. failure to submit continuing review forms/documents prior to expiration of IRB approval; and
6. unplanned deviation from the approved protocol where the deviation does not impact the rights and welfare of subjects or the integrity of the research.

**Serious Noncompliance**: is defined as noncompliance that increases risk of harm to subjects; adversely affects the rights, safety, or welfare of subjects; or adversely affects the integrity of the data or the research:

1. failure to obtain prospective IRB approval for non-exempt research;
2. failure to obtain informed consent of subject(s);
3. enrollment of subject(s) who do not meet all eligibility criteria;
4. obtaining informed consent using an invalid/outdated research consent form that is missing information that might affect the individual’s willingness to participate or continue to participate in the research;
5. making substantive changes to a previously approved protocol without IRB approval
6. failure to perform follow-up as outlined in the protocol where the lack of follow-up places the subject at increased risk of harm;
7. failure to report a serious unanticipated problem involving risks to subjects or others, including adverse events; and/or
8. inappropriate oversight of the research to ensure safety of human subjects and the integrity of the research/data.

Whether the conduct was inadvertent, careless or reckless, or intentional may be taken into consideration by the IRB in a determination of Serious Noncompliance.

**Continuing Noncompliance**: is defined as a pattern of repeated noncompliance which continues after it has been determined that noncompliance occurred, including inadequate effort to take corrective actions or comply with IRB requirements within a reasonable timeframe.

### 16.3 Policy Statement

The applicable Tulane-affiliated entities involved with Human Subject Research under the auspices of the HRPP provide and maintain a research culture characterized by integrity, responsible behavior, and a commitment to the highest legal and ethical standards of human subject protection. Consistent with these principles, all human-subjects research and clinical investigations conducted by employees or agents of the applicable Tulane-affiliated entities or under the auspices of the entities shall be conducted in accordance with all applicable federal, state, and local laws and regulations and the highest ethical standards.

As part of its commitment to protecting the rights and welfare of Human Subjects in Research, the HRPP has the responsibility to: (1) fully investigate any reports of noncompliance and any audit results or reports of protocol deviations, complaints, or other problems that it receives that
indicate observed or apparent noncompliance; (2) have a process for determining appropriate actions for any findings of noncompliance; and (3) report any findings of serious or continuing noncompliance as required by DHHS and FDA regulations. When reviewing reports of noncompliance, the IRB Chairpersons, IRB Members, HRPO staff, Research Compliance Office (RCO) staff, and the Institutional Official (IO) are subject to the section of these SOPs entitled, “IRB Member Conflict of Interest.”

In order to fulfill its responsibilities regarding noncompliance and protection of human subjects, the HRPP has established the HRPP Compliance Workgroup for compliance matters needing further investigation and evaluation.

16.4 Procedures

16.4.1 Reporting Observed or Apparent Noncompliance

Any investigator or other individual employed by, on staff at, or otherwise affiliated with the applicable Tulane-affiliated entities who observes or otherwise becomes aware of apparent noncompliance with applicable federal, state, and local laws and regulations or the requirements or determinations of the IRB in connection with human-subjects research and clinical investigations has the duty and responsibility to report the noncompliance to the IRB. This responsibility includes research in which a faculty or staff member is directly involved as well as research in which a faculty or staff member has no direct involvement. This responsibility includes reporting noncompliance that is associated with or becomes apparent from protocol deviations, complaints from researchers or subjects, or other problems in the research, or from results of audits of the research performed for other reasons.

The reporting party is responsible for reporting observed or apparent noncompliance in good faith, maintaining confidentiality, and cooperating with any internal inquiries. The applicable Tulane-affiliated entities intend to protect, to the extent possible, the privacy of an individual who in good faith reports noncompliance on the part of another individual.

Reports of noncompliance made in good faith will not reflect negatively on the individual reporting such noncompliance and, when applicable, will not affect his/her employment. Retaliation against reporters of noncompliance is prohibited.

If an individual is unsure whether there are grounds to suspect noncompliance, s/he may call upon the Director of the HRPO (the Director), Chair of the IRB (the Chair), RCO, or designee to discuss the situation.

Reports of noncompliance, whether written or oral, should include a complete description of the noncompliance and of the observed circumstances, the names of the individuals involved, if known, and the relevant date(s), time(s), and location(s). Whenever possible, the report should contain sufficient details to allow an assessment of noncompliance.

16.4.1.1 Self-Reporting of Noncompliance

When a PI or a member of the PI’s research team discovers observed or apparent noncompliance about their own study, the PI shall report the noncompliance using the Event Reporting Form

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11 See Section 1.11.2 Institutional Official (“IO”) of these SOPs. At Tulane, the IO is the Tulane University Vice President for Research.
(TU Forms 606 & 607) submitted to the IRB via the IRB electronic submission system as soon as possible after the noncompliance is observed or discovered but in all cases within ten (10) working days of discovery of the noncompliance. However, if the observed or apparent noncompliance has an impact on subject safety and/or may substantially alter risks to subjects, the PI must report the observed or apparent noncompliance within 48 hours of learning of the observed or apparent noncompliance using the Event Reporting Form (TU Forms 606 & 607) submitted to the IRB via the IRB’s electronic submission system. For example,

- Noncompliance that is associated with or becomes apparent from protocol deviations,
- Unanticipated Problems involving risk to participants or others,
- Complaints from researchers or subjects, or
- Other problems in the research

All of the above examples, including but not limited to must be reported by the PI to the IRB as per these SOPs utilizing the Event Reporting Form (TU Forms 606 & 607) submitted to the IRB via the IRB electronic submission system as soon as possible after the noncompliance is observed or discovered but in all cases within ten (10) working days of discovery of the noncompliance. However, if the observed or apparent noncompliance has an impact on subject safety and/or may substantially alter risks to subjects, the PI must report the observed or apparent noncompliance within 48 hours of learning of the observed or apparent noncompliance using the Event Reporting Form (TU Forms 606 & 607) submitted to the IRB via the IRB electronic submission system.

The HRPO shall follow the same procedures for investigating and resolving reports of noncompliance received through these means as are outlined in this policy.

16.4.1.2 Third Party Reporting of Noncompliance

When someone who is not a member of a study’s research team discovers observed or apparent noncompliance, the individual should report the noncompliance to the HRPO in writing if possible (email, fax, or letter). When a report of noncompliance is received orally, the person receiving the report is responsible for creating a written account of the report using the Concerns and Complaint Form (TU Form 604) and for immediately forwarding the report to the HRPO/HRPP Director.

16.4.1.3 Anonymous Reporting of Noncompliance

Reporters of noncompliance have the right to report anonymously. If reporters of noncompliance are uncomfortable with reporting noncompliance to the HRPO, the Tulane University Fraud and Compliance Hotline is a third-party helpline provider where a reporter can choose to remain anonymous. Call 1-855-5GOWAVE (1-855-546-9283) or visit MyComplianceReport.com (access ID is “TUL”). The Research Compliance Office will refer reports for further evaluation by the IRB in accordance with these procedures while protecting the anonymity of the reporter.

16.4.2 Review of Potential Noncompliance

16.4.2.1 Initial review by HRPO

HRPO staff or IRB reviewers who receive reports of noncompliance shall consult the HRPO IRB/Compliance Auditor, HRPO/HRPP Director or Designee, or the RCO for a determination whether the noncompliance could potentially be considered Serious
Noncompliance and/or Continuing Noncompliance. The HRPO/HRPP Director or IRB/Compliance Auditor shall refer potential Serious Noncompliance and/or Continuing Noncompliance to the Compliance Workgroup, described below, for further evaluation. Minor noncompliance will not be referred to the Compliance Workgroup but rather processed by the HPRO as per normal practices outlined in these SOPs for Reportable Events. If the potential Serious Noncompliance and/or Continuing Noncompliance comes to light for the first time as part of a convened IRB discussion, the matter shall be referred to the Compliance Workgroup.

16.4.2.2 Referral to and Review by HRPP Compliance Workgroup

The HRPP Compliance Workgroup is a workgroup of the HRPP that may include the Biomedical IRB Chair or designee if the potential compliance matter relates to a biomedical study or the Social/Behavioral IRB Chair or designee if the potential compliance matter relates to a social/behavioral study, the HRPO/HRPP Director or designee, the RCO or designee, the Associate General Counsel for Research, and other members as needed based on expertise. The IO shall serve as an ad hoc member of the Compliance Workgroup, and the HRPO/HRPP Director and RCO will keep the IO informed of the work of the Compliance Workgroup. The RCO or designee shall serve as the chair of the Compliance Workgroup.

The most important function of the Compliance Workgroup is investigating noncompliance in a manner so that the IRB has all available necessary information in order to make a determination of whether or not an issue constitutes Serious Noncompliance and/or Continuing Noncompliance:

1. The Compliance Workgroup shall have available for its consideration the report of noncompliance and the preliminary report of findings and determinations (if applicable).

2. If the Compliance Workgroup determines that the matter does not potentially constitute Serious Noncompliance and/or Continuing Noncompliance, i.e., no noncompliance or minor noncompliance, the matter shall be referred back to the HRPO for further action as per normal HRPO practices for Reportable Events. For instances where the affected study is subject to an Investigator Hold or Study Suspension, the Compliance Workgroup shall make such determinations where possible within 30 days of the issue being referred to the Compliance Workgroup. For instances where a study is subject to an Investigator Hold or Study Suspension and the Compliance Workgroup is unable to make determinations within 30 days of the issue being referred to the Compliance Workgroup, the reasons for the extension of time beyond the 30 days shall be documented by the Compliance Workgroup. The extension of time and an explanation/summary of the reason for the extension of time shall be communicated by the Compliance Workgroup to the applicable PI.

3. The Compliance Workgroup will work with the affected investigator(s) to resolve the noncompliance in furtherance of protections of human subjects of the involved research.

4. Interaction among the affected investigator(s) and the Compliance Workgroup:
   a. The affected investigator(s) should provide additional relevant information and/or potential mitigating circumstances for the Compliance Workgroup’s consideration and respond timely and substantively to any request made by the Compliance Workgroup.
b. If the Compliance Workgroup requests to meet with the affected investigator(s), the affected investigator(s) shall comply with the request. If the affected investigator(s) requests to meet with the Compliance Workgroup, the Compliance Workgroup shall comply with the request.

c. The Compliance Workgroup and/or the affected investigator(s) should consider whether an Investigator Hold of the research is appropriate. See Section 3.12.2 of these SOPs entitled, “Investigator Hold.”

d. If the Compliance Workgroup determines that a study suspension or study termination may be necessary, the matter shall be referred for determinations as per Section 3.12 of the SOPs, “Study Suspension, Termination, and Investigator Hold.”

5. If the Compliance Workgroup determines that the matter could potentially constitute Serious Noncompliance and/or Continuing Noncompliance, the matter shall be referred to the IRB for determination.

   a. Prior to the convened IRB’s consideration of whether a matter constitutes serious and/or continuing noncompliance, the HRPO/HRPP Director and/or the RCO shall inform the IO that the Compliance Workgroup has determined that the facts may support a finding of Serious Noncompliance and/or Continuing Noncompliance and any recommendations as to a Corrective Action Plan (“CAP”).

   b. In performing a review of the Compliance Workgroup’s recommendations, the IO can direct the Compliance Workgroup to undertake additional steps before referral of the matter to the convened IRB and/or make modifications of the Compliance Workgroup’s recommendations to the convened IRB.

   c. In instances where the affected study is subject to an Investigator Hold or Study Suspension, the Compliance Workgroup shall make its referral to the IRB for determination within 30 days of the issue being referred to the Compliance Workgroup. For instances where a study is subject to an Investigator Hold or Study Suspension and the Compliance Workgroup is unable to make determinations within 30 days of the issue being referred to the Compliance Workgroup, the reasons for the extension of time beyond the 30 days shall be documented by the Compliance Workgroup. The extension of time and an explanation/summary of the reason for the extension of time shall be communicated by the Compliance Workgroup to the applicable PI.

16.4.2.3 Review of Serious Noncompliance and/or Continuing Noncompliance at a Convened IRB Meeting

Attending IRB members shall receive the Compliance Workgroup’s report of potentially Serious Noncompliance and/or Continuing Noncompliance, including any audit or other review generated as part of the Compliance Workgroup’s initial fact gathering process, and any recommendations by the IO. The entire study file and/or minutes of IRB meetings at which the protocol was discussed previously shall be made available to IRB members, upon request. The RCO or designee shall be responsible for presenting the Compliance Workgroup’s report of
potentially Serious Noncompliance and/or Continuing Noncompliance to the IRB, including any findings and recommendations of the Compliance Workgroup and the IO.

By majority vote of a quorum of the membership present at the convened meeting, the IRB will make a determination as to whether or not the matter constitutes Serious Noncompliance and/or Continuing Noncompliance and any additional determinations as appropriate, such as:

1. Approve the research to continue with no further action required;
2. Defer action pending additional information;
3. Require modifications in the research and/or consent form;
4. Require that subjects who are still participating in the research be re-consented or notified in writing of the noncompliance;
5. Require observation of the consent process by a member of the IRB, Compliance Workgroup, or designee;
6. Require that subjects whose participation has ended be notified in writing of the noncompliance;
7. Modify the continuing review schedule;
8. Suspension or Termination of the research (see section of these SOPs entitled “Suspension or Termination);
9. Require periodic audits; and/or
10. Any other action the IRB deems appropriate to the noncompliance.

By majority vote of a quorum of the membership present at the convened meeting, the IRB may also consider the appropriate aspects of a CAP when a determination of Serious Noncompliance and/or Continuing Noncompliance is made, such as:

1. Require remedial education;
2. Require oversight by a senior investigator;
3. Replacement of PI;
4. Removal of PI or another member of the research team from the study;
5. Restrict the conduct of research;
6. Restrict research privileges; and/or
7. Determinations regarding the use of data collected during the period of serious or continuing noncompliance. The IRB is to consider the following if restrictions are placed on use of the data collected during the period of serious or continuing noncompliance:
   a. whether the data were gathered in a way that appropriately protected subjects; and
   b. whether the data were obtained in willful disregard for the authority of the IRB.

Minutes of the IRB meeting shall be taken in accordance with the section of these SOPs regarding IRB minutes. The findings and actions of the IRB shall be communicated in writing by the HRPO to the affected investigator(s) as per the provisions of these SOPs regarding Notice to PI of IRB Actions.
If the PI disagrees with the IRB’s determinations of Serious Noncompliance and/or Continuing Noncompliance and/or any associated corrective actions, the PI has 10 business days from the date of the written notification of the IRB’s determinations to submit an appeal in accordance with the section of these SOPs entitled, “Investigator Appeal Process.” For example, a PI may include as part of the appeal additional relevant information and/or potential mitigating circumstances that might not have previously been considered.

16.4.2.4 Reporting Serious or Continuing Noncompliance and, When Applicable, Suspension or Termination of the Research

IRB determinations of Serious Noncompliance, Continuing Noncompliance, Suspension of research, and/or Termination of research shall be reported as per the section of these SOPs entitled, “Reporting to Regulatory Agencies and Institutional Officials.”

16.4.3 Recordkeeping

The records of the fact gathering process and review by the IRB and associated findings of fact and determinations and recommendations shall be maintained in the IRB electronic submission system as part of the study’s records.

AAHRPP Standards for Accreditation (Standard I-5, Element I.5.D)

Regulations & Guidance: DHHS 45 CFR §46.103(b)(5)(i); 45 CFR §46.116(b)(5); FDA 21 CFR §50.25(b)(5); 21 CFR §56.108(b)(2); OHRP Guidance on Reporting Incidents to OHRP
17 Complaints

The HRPP & IRB will be responsive and sensitive to the complaints or concerns expressed by subjects or others and will respond to all complaints or concerns in a confidential and timely manner. The PI and all other research team members are responsible for the safety and welfare of all subjects enrolled in their studies. When investigators or team members hear complaints or concerns from subjects, he or she will try to resolve them.

Investigators conducting research under the oversight of the [INSERT ORGANIZATION] IRB report complaints unable to be resolved by the investigator using the Event Report form in the IRB electronic system. All complaints, including those resolved by the investigator, should be summarized at the time of continuing review in the Continuing Review Request Form, when continuing review is applicable.

Investigators conducting research under the oversight of an external IRB must comply with the reporting requirements of the external IRB and the internal reporting requirements outlined in Section 6.2.

When the HRPO is the direct recipient of complaints or concerns, the staff will do the following:

1. Document the complaint or allegation. When appropriate, the staff may request that the subject submit the complaint in writing.
2. Reassure the subject that the HRPO/IRB will take all necessary measures to inquire into the circumstances and to address the issue.
3. Provide written confirmation of receipt of the complaint to the subject if the subject is willing to provide contact information.
4. Convey the information to the IRB of record in a timely manner.
5. When appropriate, contact the investigator for additional information or to assist with resolution.
6. When appropriate, contact other resources (e.g., Research Compliance Office, University Privacy Office, General Counsel, etc.) to assist with information-gathering or resolution.

The HRPO/HRPP Director (or designee) will promptly handle (or delegate staff to handle), and, if necessary, investigate all complaints, concerns, and appeals received by the HRPO. This includes complaints, concerns, and appeals from investigators, research participants, and others. For the Investigator Appeal process, see Section 19.7, Investigator Appeal Process.

All complaints, written or oral (including telephone complaints), and regardless of point of origin, are recorded on the Concerns and Complaint Form (TU Form 604) and forwarded to the IRB Chair (or designee) and HRPO/HRPP Director (or designee).

Upon receipt of the complaint, the IRB Chair (or designee) and HRPO/HRPP Director (or designee) will make a preliminary assessment whether the complaint warrants immediate suspension of the research project. If a suspension is warranted, the procedures in Section 9 will be followed.

If the complaint may meet the definition of Noncompliance, it will be considered an allegation of Noncompliance according to Section 16.

If the complaint may meet the definition of an Unanticipated Problem Involving Risk to Subjects
or Others, it will be handled according to **Section 15**.

If the complaint is actually a query from a subject regarding study procedures, payments not received, etc., it will be forwarded to the investigator/study team for prompt and thorough handling. The investigator/study team will be required to inform the HRPO when the matter is closed (and the subject is satisfied with the answer). The HRPO and/or IRB may intervene in resolving the dispute if the investigator/study team is not prompt or thorough enough, which may be considered noncompliance.

Within **ten (10) business days** of receipt of the complaint, the HRPO Chair (or designee) will generate a letter to acknowledge that the complaint has been received and is being investigated, if the person making the complaint provided contact information.

_AAHRRP Standards for Accreditation_ (Standard I-4, Element I.4.A)
18 Reporting to Regulatory Agencies and Organizational Officials

18.1 Policy

Federal regulations require prompt reporting to appropriate institutional officials and, as applicable, the federal department or agency (e.g., OHRP, FDA), of (i) any Unanticipated Problem Involving Risks to Subjects or Others; (ii) any Serious or Continuing Noncompliance with the applicable federal regulations or these SOPs or the requirements or determinations of the IRB; and (iii) any Suspension or Termination of IRB approval. The Tulane HRPP complies with these requirements as follows.

When research is under the oversight of an external IRB, the terms of the agreement with that IRB will guide reporting.

IND Safety Reports, UADE Reports, and any other reports that have already been reported to the applicable federal oversight agency (e.g., by a Sponsor, Coordinating Center, or sIRB) do not also need to be reported by the University. The University’s IO and any other appropriate parties will be informed of such reports by the HRPO/IRB when the matter involves local subjects or significantly impacts the conduct of the research at Tulane University.

18.2 Procedures

1. HRPO staff will initiate these procedures as soon as the IRB takes any of the following actions:
   a. Determines that an event may be considered an Unanticipated Problem Involving Risks to Subjects or Others
   b. Determines that Noncompliance was Serious and/or Continuing
   c. Suspends or Terminates approval of Research

2. The RCO (or designee), HRPO/HRPP Director (or designee) is responsible for preparing reports or letters which includes the following information:
   a. Reason for the report (Unanticipated problem involving risks to subjects or others, serious or continuing noncompliance, suspension, or termination of IRB approval)
   b. Name of the involved institution(s)
   c. Title of the Research project and/or grant Proposal in which the problem occurred
   d. Name of the PI on the Protocol
   e. Number of the Research project assigned by the IRB and the number of any applicable Federal award(s) (grant, contract, or cooperative agreement)
   f. A detailed description of the problem including the findings of the organization and the reasons for the IRB’s decision
   g. Actions the Institution is taking or plans to take to address the problem (e.g., revise the Protocol, Suspend subject enrollment, Terminate the Research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.)
h. Freeze on grant spending or spending under the agreement funding the research
   (where the IRB Suspends or Terminates approval of Research)

i. Plans, if any, to send a follow-up or final report by a specific date, upon completion of
   an investigation, or when a corrective action plan has been implemented

3. The IO and HRPO/HRPP Director (or designee) and other organizational official as
   applicable (e.g., IRB Chair, RCO, General Counsel) will review the letter and modify the
   letter/report as needed.

4. The IO is the signatory for all correspondence from the facility.

5. The RCO (or designee), HRPO/HRPP Director (or designee) sends a copy of the report
   to:
   a. The IO
   b. The following Federal departments or agencies, as follows:
      i. OHRP, if the study is subject to DHHS regulations or subject to a DHHS Federal-
         wide Assurance
      ii. FDA, if the study is subject to FDA regulations.
   c. If the study is conducted or funded by any Federal Agency other than DHHS that is
      subject to “The Common Rule”, the report is sent to OHRP or the head of the agency
      as required by the agency.
   d. If the study is conducted or supported by a federal agency that has not adopted the
      Common Rule, and reporting is required, the report is sent to the party identified by
      the agency.
   e. Reporting to a regulatory agency is not required if
      i. the event occurred at a site that was not subject to the direct oversight of the
         organization, and the agency has been notified of the event by the Investigator,
         Sponsor, another organization, or other mechanisms.
      ii. The study is approved under the 2018 Common Rule, and the study is not
          regulated or funded by that regulatory agency
   f. Principal Investigator (PI)
   g. Sponsor, if the study is Sponsored (the IRB can direct the PI to provide the
      report/letter to the Sponsor and submit evidence of same to the IRB)
   h. Contract Research Organization (“CRO”), if the study is overseen by a contract
      Research Organization (the IRB can direct the PI to provide the report/letter to the
      Sponsor and submit evidence of same to the IRB)
   i. Department Head/Supervisor of the PI
   j. Dean of the PI
   k. SPA (where the IRB Suspends or Terminates approval of Research). If the study
      subject to a Suspension or Termination of IRB approval is federally funded, SPA
      will notify the Federal sponsor and any sub-recipients of the Suspension or
      Termination as well as any hold placed on Federal grants funding the Suspended or
      Terminated study.
l. GCA (where the IRB Suspends or Terminates approval of Research). If the study subject to a Suspension or Termination of IRB approval is Federally funded, GCA will place a hold on all grants supporting the Suspended or Terminated study and notify SPA of the grant hold.

m. The University HIPAA Privacy Officer if the event involved unauthorized use, loss, or disclosure of individually identifiable patient information from that the covered entity component of Tulane

n. The University HIPAA Information Security Officer if the event involved violations of information security requirements of Tulane

o. Tulane’s Office of Insurance and Risk Management, if appropriate

p. Others as deemed appropriate by the IO

The RCO (or designee), HRPO/HRPP Director (or designee) ensures that all steps of this policy are completed within 30 working days of the determination barring any exceptional circumstances. For more serious actions, the RCO (or designee), HRPO/HRPP Director (or designee) will expedite reporting.

**AAHRPP Standards for Accreditation** (Standard I-5, Element I.5.D)

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**18.3 Reporting to AAHRPP**

Tulane’s HRPP is accredited by the Association for the Accreditation of Human Research Protection Programs (AAHRPP). In addition to the information that Tulane routinely provides to AAHRPP in annual reports and the re-accreditation application, AAHRPP requires that any of the following are reported to AAHRPP asap but generally within 48 hours after the organization or any researcher (if the researcher is notified rather than the organization) becomes aware:

- Any negative actions by a government oversight office, including, but not limited to, OHRP Determination Letters, FDA Warning Letters, FDA 483 Inspection Reports with official action indicated (OAI), FDA Restrictions Placed on IRBs or Investigators, and corresponding compliance actions taken under non-US authorities related to human research protections;
- Any litigation, arbitration, or settlements initiated related to human research protections; and/or;
- Any press coverage (including but not limited to radio, TV, newspaper, online publications) of a negative nature regarding Tulane’s HRPP.

The HRPP Director (or designee) is responsible for ensuring that such reports are made to AAHRPP and for informing appropriate Institutional officials. Investigators, research staff, HRPP/IRB staff, IRB members, and other Organizational Officials or offices are responsible for informing the HRPP/IRB office as soon as they become aware of any of the above so that these reporting obligations may be fulfilled.

**AAHRPP Standards for Accreditation** (Standard I-5, Element I.5.D)
19 Investigator Responsibilities

19.1 Policy

PIs are ultimately responsible for the conduct of Research. Research must be conducted according to the signed Investigator statement, the investigational plan and applicable regulations for protecting the rights, safety, and welfare of subjects under the PI(s) care. PIs may delegate tasks to appropriately trained and qualified members of their research team. However, Investigators must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibilities.

The following procedures describe the Investigator responsibilities in the conduct of Research involving Human Participants.

19.2 Definitions

**Key Personnel**: has the same definition as used by NIH, which means those individuals who contribute to the scientific development or execution of a project in a substantive, measurable way, whether or not salaries are requested. Key Personnel must devote measurable effort to the project. Key Personnel are required to be listed in the grant application, progress report or any other report submitted to the Federal funding agency by the Institution.

**Other Study Personnel**: are individuals who are part of the research team who intervene or interact directly with Human Subjects (including the recruitment or consenting thereof), or who analyze data and/or tissue derived from humans for the purpose of the activity in question. Other Study Personnel cannot be the PI, an Investigator or Key Personnel.

**Principal Investigator (“PI”)**: is an individual who conducts Research or under whose immediate direction Research is conducted; or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team. While the FDA considers a PI and an Investigator to be synonymous, this document does not.

**Researcher**: is the PI and/or Investigator.

19.3 Investigators

19.3.1 Principal Investigators (“PIs”)

The Tulane SPA policy entitled “Who Can Serve as A PI and Other Eligibility Requirements” (see Eligibility Requirements to Serve as Principal Investigator [http://www2.tulane.edu/asvpr/ora/upload/PI-Eligibility-Requirements-on-Sponsored-Projects-8-14.pdf]) sets forth the eligibility requirements and the duties and responsibilities of a Principal Investigator (“PI”) at the University. This Policy also describes the processes for requesting and approving exceptions to the PI eligibility requirements.

The IRB recognizes one PI for each study (although several Co-PIs may be included in addition to the PI). The PI has ultimate responsibility for the Research activities. This includes, among other things, ensuring that applicable clinical trials are registered in [www.clinicaltrials.gov](http://www.clinicaltrials.gov) before any subjects are enrolled in the study and that results of applicable clinical trials are timely reported upon in [www.clinicaltrials.gov](http://www.clinicaltrials.gov) (see Section 26.7 for additional details). Additionally, PIs should refer to the Initial Expedited and Full Board Submission Checklist (TU Form 301)
and Secondary Submissions Checklist (TU Form 302) to ensure that all submissions to the IRB are complete.

Protocols that require skills beyond those held by the PI must be modified to meet the PI’s skills or have one or more additional qualified faculty as co-investigators. Where necessary to ensure skill relative to the protocol, the IRB can mandate a change in PI and/or changes or additions of co-Investigators or other study personnel.

19.3.2 Change in Principal Investigator

If there is a change in the PI, the outgoing Investigator must submit an Secondary Application for Human Subjects Research to notify the IRB that he or she has relinquished the responsibilities of the PI to the person named, or will do so on a specific date. The newly named PI notifies the IRB that he or she has read the Protocol and agrees to accept the responsibilities of the PI.

19.3.3 Student Investigators

Students may serve as PIs for Research Under the Auspices of Tulane’s IRB, but students must have a faculty advisor and indicate same on submissions to the IRB. The student and faculty advisor are equally responsible for the oversight of the Research as well as submitting all appropriate documents to the IRB. In the absence of a Student Investigator, the faculty advisor is responsible for submitting all appropriate documents to the IRB in addition to ensuring human subjects protections. Student PIs must meet the same requirements listed in Section 19.3.1 “Principal Investigators.”

19.3.4 Key Personnel

Key personnel (“Key Personnel”) has the same definition as used by NIH, which means those individuals who contribute to the scientific development or execution of a project in a substantive, measurable way, whether or not salaries are requested. Key Personnel must devote measurable effort to the project. Key Personnel are required to be listed in the grant application, progress report or any other report submitted to the Federal funding agency by the Institution.

19.3.5 Other Study Personnel

Other study personnel (“Other Study Personnel”) are individuals who are part of the research team who intervene or interact directly with Human Subjects (including the recruitment or consenting thereof), or who analyze data and/or tissue derived from humans for the purpose of the activity in question. Other Study Personnel cannot be the PI, an Investigator or Key Personnel.

19.4 Investigator Responsibilities

In order to satisfy the requirements of this policy, Investigators who conduct Research involving Human Subjects must:

1. Develop and conduct Research that is in accordance with the ethical principles in the Belmont Report;

2. Complete and keep current IRB-required CITI training (or IRB-approved equivalent), Sponsor-required training, University-required COI training (where applicable), and any other training required by the HRPP, Institution, or other regulatory entities.
3. Ensure that Key personnel and Other Study Personnel complete and keep current IRB-required CITI training (or IRB-approved equivalent), Sponsor-required training, University-required COI training (where applicable), and any other training required by the HRPP, Institution, or other regulatory entities.

4. Develop a Research plan that is scientifically sound and minimizes risk to the subjects;

5. Incorporate into the research Protocol a plan to ensure the just, fair, and equitable recruitment and selection of subjects;

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

7. Ensure that the research Protocol includes adequate provisions for the monitoring of subjects and data to ensure the safety of subjects;

8. Ensure that there are adequate provisions to protect the privacy interests of subjects;

9. Ensure that there are adequate provisions to protect the confidentiality interests of subjects, including an information security plan that considers the collection, storage, maintenance, analysis, and transmission of data and other Individually Identifiable Private Information;

10. Have sufficient resources necessary to protect Human Subjects, including:
   a. Access to a population that would allow recruitment of the required number of subjects.
   b. Sufficient time to conduct and complete the Research.
   c. Adequate numbers of qualified staff.
   d. Adequate facilities.
   e. Necessary equipment.
   f. A plan to ensure proper supervision of the Research including a plan for periods of absence or decreased availability.
   g. A process to ensure that all persons assisting with the Research are adequately informed about the Protocol and their Research-Related duties and functions.
   h. Availability of medical, psychological, or other support that subjects might require during or as a consequence of their participation in the Research.

11. Ensure the accuracy of sponsor/funding information and consistency between the application submitted to the IRB and the federal award proposal (for potential grants, contracts or collaborative agreement) and the sponsor’s Protocol.

12. Assure that all procedures in a study are performed with the appropriate level of supervision and only by individuals who are licensed or otherwise qualified to perform such under the state and local laws and regulations, as well as the policies of the University;
13. Ensure that all Key Personnel and Other Study Personnel are educated in the regulatory requirements regarding the conduct of Research and the ethical principles upon which they are based;

14. Ensure that all persons assisting with the Research are adequately trained and informed about the Protocol and their specific duties and functions.

15. Promptly report any changes in, additions to, or loss of investigators or research staff to the IRB for evaluation and approval.

16. Ensure that Investigators and staff may not begin Human Subject Research until the IRB has issued a full approval of the study;

17. Protect the rights, safety, and welfare of participants;

18. Ensure that when Individually Identifiable Health Information is used, that legally effective HIPAA authorization is obtained for each subject unless the IRB (or other Privacy Board as applicable) has approved a waiver of the requirement;

19. Ensure that the language in the Consent Form is consistent with that in the Protocol and, when applicable, in the HIPAA Authorization;

20. Obtain valid and effective Informed Consent from all subjects and document the Informed Consent process for all subjects, in a way that clearly evidences that no subject is involved in the Research prior to giving their Informed Consent (or prior to their Legally Authorized Representative giving Informed Consent), unless a waiver of the Informed Consent requirement has been approved by the IRB;

21. Have procedures to receive questions, complaints or requests for additional information from subjects and to respond appropriately and timely;

22. Ensure that all information provided to the IRB is accurate and complete so that the IRB may fulfill its responsibilities to review the Research and make the required determinations;

23. Ensure that pertinent laws, regulations, and Institution procedures and guidelines are observed by participating Investigators and Research staff;

24. Ensure that all Research involving Human Subjects receives IRB review and approval in writing or a determination of Exemption before commencement of the Research;

25. Ensure that all Research involving Human Subjects is reviewed by other experts and organizational components and committees as applicable to the Research;

26. Comply with all IRB decisions, conditions, and requirements;

27. Ensure applications to the IRB for continuing review are provided in a timely and complete manner so that IRB continuing review approval is issued prior to expiration of the IRB approval period;

28. Report Unanticipated Problems, Deviations, Complaints, Non-Compliance, Suspensions, Terminations, and any other Reportable Events to the IRB using the Events Reporting Form (see Sections 9, 14, 15 and 16) and (TU Forms 606 & 607);

29. Notify the IRB timely if information becomes available that suggests a change to the Protocol risks or benefits of the Research;
30. Obtain IRB review and approval in writing before changes are made to approved Protocols, procedures, or Consent Forms unless a change is necessary to eliminate apparent immediate hazards to the Subject(s);

31. Seek HPRO or IRB assistance when in doubt about whether proposed Research requires IRB review (see Section 6);

32. Retain records for the time period and in the manner required by applicable regulations, contractual agreements, and Institutional policies;

33. If the Research is subject to the ICH-GCP Guidelines as required by the Sponsor, refer to the HPRO policy entitled “International Conference on Harmonization (ICH) Good Clinical Practices (GCP) Applicable to Human Subjects Research”;

34. Submit to the HPRO via the IRB electronic submission system any appropriate communications to and from the sponsor related to the research study;

35. Investigators and Investigators that serve as Faculty Advisor’s will be responsible to submit any applicable documents related to the Research study (e.g. CITI Training Certificates and Study Closures) to the HPRO/IRB Office, in the event the student investigator does not fulfill this responsibility; and

36. If there are any pending approvals from any other institutions the Research cannot commence at those respective study sites until all such approvals have been obtained, and the PI is to provide to the Tulane IRB via the IRB electronic submission system a copy of all approval letters as received. Language to this effect is included on approval letters, and the PI is to comply with the language on said approval letters.

If there are any pending approvals from any other Research oversight committees such as: Tulane Institutional Biosafety approval (when applicable), Tulane Radiation Safety Committee approval (when applicable), and any other committee approval required by the University, the Research cannot commence until all such approvals have been obtained. However, the approval letters from the respective committees do not have to be provided to the IRB.

The University’s Biosafety Policies are available on the Biosafety website, https://research.tulane.edu/biosafety/biological-safety-policies-and-manuals.

19.5 Investigator Records

PIs must maintain and keep up to date the following records on Research under these policies.

19.5.1 Study Records

1. Individual subject records
2. Recruitment materials
3. Documentation of consent process (who, what, when and how) for each and every subject
4. Original signed informed consent forms (copies are not allowed)
5. Unanticipated Problem & Reportable Events Reports
6. Subject complaint reports
7. Results of all procedures conducted on the subject, including final visit (if no final visit, reason why: e.g. removal from study, withdrawal from study, death)

19.5.2 Regulatory Records (must be kept up to date)

1. Most recent IRB-approved Protocol
2. Previous versions of Protocol
3. All correspondence (i.e., approvals, reporting forms and responses, etc.) to and from the IRB and sponsor (if applicable).
4. Continuing Review progress reports
5. Amendments
6. Most recent IRB-Approved Consent Documents
7. Previous version of the Consent Documents
8. Approved HIPAA form
9. Current curriculum vitae (CV) for all investigators signed and dated within the last four years
10. A clinical license for the principal investigator and each sub-investigator, if licensed (for example, medical license)
11. Clinical Investigator’s Brochure or package insert. Include labeling for approved medications (for any drug/product under investigation)
12. FDA Form 1572 and 1571 (where applicable) – completed and signed
13. Delegation of Authority Log
14. Clinical Research and Study Training records
15. Screening/Enrollment Log
16. Study Product Records (where applicable)
17. Local Clinical Lab Certificates (where applicable)
18. Specimen Tracking Log (where applicable)
19. Serious Adverse Events
20. Reportable Events (for example, Protocol Deviations, Violations, and Non-Compliance reports)
21. Clinical Site Monitoring Visits
22. Other (Other important study documents, such as, certificates of confidentiality, literature or publications, technology transfer agreement, Radiation Safety Approval; IBC Approval, IACUC Approval, etc.).
19.5.3 Record Retention

Investigator records must be retained in accordance with regulatory, institutional and sponsor or grantor requirements, but no less than six (6) years following the completion of the Research. All records must be maintained securely with limited access. Disposal of Research records must be done in such a manner that no identifying information can be linked to Research data. All investigator records must be maintained at a Tulane-authorized site and not in the investigator’s personal home or office unless otherwise approved with the IRB.

Investigators are encouraged to periodically complete the Investigator Self-Assessment Checklist (TU Form 201) to evaluate whether compliance with ongoing responsibilities is being met.


Regulations & Guidelines: FDA 21 CFR §312.53(c)(1); 21 CFR §312.60; 21 CFR §312.61; 21 CFR §312.62; 21 CFR §812.43(c)(4); 21 CFR §812.100; 21 CFR §812.140

19.6 Additional Resources

The HRPO will be available for scheduled in-services at departmental meetings and other settings as requested or scheduled. Additionally, human Research protection information will be made available on the Tulane University HRPP Website, with links to:

- Tulane policies and procedures
- Federal and State regulatory sites
- Newsletters
- Training opportunities

19.7 Researcher Concerns

The HRPP welcomes all forms of feedback from the Tulane research community, the members of which are a core component of the Tulane HRPP and are critical to improving research oversight processes. Members of the Tulane research community, including investigators and their staff members, who have concerns, suggestions, or other feedback regarding the Tulane HRPP should convey such concerns, suggestions, or other feedback to the HRPO/HRPP Director. If a researcher prefers not to bring concerns, suggestions, or other feedback directly to the HRPO, other avenues are available to convey concerns, suggestions, or feedback including through the IRB Chairs, IRB Vice Chairs, the RCO, the IO, the Faculty Advisory Committee to the IRB, other responsible parties (e.g., college Dean, Department Chair, etc.), and the University’s hotline, whereby any complaints, concerns, or comments can be submitted anonymously: 1-855-546-9283 or www.MyComplianceReport.com (Access I.D. is “TUL”). In addition, the IRB Chair and/or the HRPO/HRPP Director or their designees are available to address researchers’ questions, concerns, and suggestions on an ongoing basis. These avenues for providing feedback are communicated through outreach and as part of training by the HRPP.

When a researcher’s concern is submitted, the IO, IRB Chair, and/or HRPO Director (or their designees) will consider the issue, and when deemed necessary, seek additional information
and convene the parties involved to form a response for the researcher or make necessary procedural or policy modifications, as warranted.

In addition to these SOPs, which are made available on the HRPP website, members of the Tulane research community are also made aware of the process for expressing their concerns via a link on the HRPO website for Tulane’s hotline whereby any complaints, concerns, or comments can be submitted anonymously. For appeals of IRB determinations/decisions, please see Section 8.19, Investigator Appeal Process.

AAHRPP Standards for Accreditation (Standard I-5, Element I.5.C)
Regulations & Guidance: DHHS 45 CFR§46.109;FDA 21 CFR §56.109
20 Sponsored Research

20.1 Policy
Tulane’s SPA is responsible for ensuring that negotiations between Tulane and Sponsors relative to Clinical Investigations that will take place under the purview of Tulane’s IRB follow all relevant Federal and State laws, rules and regulations and Institutional policies and procedures.

The PI cannot commence Research and/or otherwise enroll subjects until the IRB has approved the study and, to the extent that the activity is Sponsored, a fully executed sponsor agreement is in place between the Sponsor and the University.

Since TUHC serves as a primary site for Sponsored University Research, to the extent that Research under the purview of Tulane’s IRB takes place at TUHC, specific coordination takes place between Tulane, through SPA, and TUHC, consistent with a Master Clinical Trial Affiliation Agreement (“Master CTA Agreement”), which is intended to expedite collaborative Research between the two institutions. See SPA’s policy entitled Coordination of Clinical Trials between TU and TUHC for details.

AAHRPP Standards for Accreditation (Standard I-1, Element I.1.D and Standard I-8)

20.2 Definitions
Self-Sponsored (or “Investigator-Initiated,” “Investigator-Sponsored,” or “Unsponsored”): refers to a situation in which the individual Investigator is a Tulane Investigator and is the holder of the IND or IDE and therefore assumes the duties of the Sponsor of the clinical Investigator under the applicable FDA regulations.

Sponsor (or “Sponsored”): is any person or party that provides funding to support the conduct of Research, usually through a specific statement of work and often with a related transfer of value to the Sponsor. A Sponsor does not actually conduct the investigation. A Sponsor can be governmental (e.g., Federal, State or a local government) or private (e.g., a company, individual donor or private foundation), as well as Self-Sponsored (e.g., where Institution is responsible for funding the involved activity). The funding mechanism may be through a grant, contract or cooperative agreement. [FDA 21 CFR §50.3; 21 CFR §56.102(j); 21 CFR §312.3(b)].

20.3 SPA Review
SPA is designated as institutional representative and is responsible for securing authorized signatures on awards with Sponsors. To this end, SPA serves as the intermediary between a Sponsor and the PI for purposes of negotiation, budget changes, modifications to an award, award date extensions, and other administrative matters. In consultation with the PI and/or Grants and Contracts Accounting, SPA reviews the award terms and conditions and the budget before obtaining authorized signatures. SPA and the PI are responsible for ensuring University compliance with the terms and conditions of the award, as well as any applicable Federal, State, and University regulations and guidelines.

For commercially sponsored clinical trials under the purview of Tulane’s IRB, when subject Informed Consent must be obtained, SPA will undertake the following:
The SPA Director (or delegate) will review sponsor agreements to ensure that they contain language reflecting:

1. Tulane’s commitment to the protection of Human Subjects involved in Research;
2. That Tulane and sponsor will follow the Protocol, applicable laws and regulations and ethical standards.
3. The responsible party for payment with respect to research-related injuries.
4. Sponsor indemnification, as appropriate, for subject injury and use of research data and results.
5. A summary of the study’s scope and a description of services to be provided by Tulane, Tulane University Hospital and Clinic (if applicable), a study budget, and the reporting obligations of the parties.
6. The sponsor’s responsibilities to notify the Tulane IRB, as soon as reasonably possible, of any information the sponsor discovers that could affect the safety or medical care for the subjects.
7. The sponsor’s responsibility to notify the Tulane IRB, as soon as reasonably possible, of any information a study monitor uncovers that could affect the safety of Participants or their willingness to continue participation, influence the conduct of the study, or alter the IRB(s) approval to continue the study.
8. The sponsor agreement assures that Participants will be notified whenever Participant safety or medical care may be directly affected by study results. This will include language that specifies how results will be communicated to study Participants. This could involve the sponsor communicating directly to the Participants or the sponsor reporting to the Investigator who reports to the Participants. ORA will assure that this duty will survive the termination of the sponsor agreement. Describe the steps followed to communicate findings from a closed research study to the researcher or organization when those findings directly affect participant safety.
9. The sponsor follows Tulane’s policies and procedures regarding the publication of findings from sponsored research.
10. Contracts or other funding agreements specify a timeframe after closure of the study during which the sponsor will communicate such findings (e.g., two years). This should be based on the appropriate timeframe for each individual study.
11. The sponsor follows Tulane’s policies and procedures regarding the publication of findings from sponsored research.
12. The sponsor promptly (no longer than within 30 days) reports to Tulane any findings that could affect the safety of participants or influence the conduct of the study or alter the IRB’s approval to continue the study.
13. The steps followed to communicate findings from a closed research study to the researcher or Tulane when those findings directly affect participant safety. Specify a time frame after closure of the study during which the sponsor will communicate such findings (e.g., two years). This should be based on the appropriate timeframe for each individual study.
Contracts and other funding agreements with sponsors will be reviewed for the following by both SPA and the IRB:

1. All sponsor contracts will indicate that Institution will follow the Protocol, applicable regulations and its ethical standards.

2. All sponsor contracts will define who is responsible for research related injuries, as applicable.

3. If the sponsor will monitor the conduct of the Research, the contract will be required to state that if the study monitor uncovers information that could affect the safety of Participants or their willingness to continue participation, influence the conduct of the study, or alter the IRB’s approval to continue the study, the sponsor will make sure that the information is communicated to the IRB.

4. If the sponsor discovers results that could affect the safety or medical care, the sponsor will make sure the IRB is notified.

5. Payment in exchange for referrals of prospective Participants from researchers (physicians) (“finder’s fees”) is not permitted. Similarly, payments designed to accelerate recruitment that is tied to the rate or timing of enrollment (“bonus payments”) are also not permitted.

SPA (or delegate) will review sponsored agreements and study information as necessary for each sponsored Protocol to ensure that the informed consent form and sponsored agreement language are consistent. To the extent that the informed consent form is not consistent, SPA will highlight or bold the objectionable language (or make redline changes) to the informed consent form and forward it to HRPO, which in turn communicates the inconsistencies to the PI. It is the ultimate responsibility of the PI to edit the informed consent form and ensure that it is consistent with the sponsored agreement.

Upon request, SPA will furnish to the HRPO copies of sponsored research agreements involving clinical trials under the purview of Tulane’s IRB.

For additional details with respect to the Sponsored Research, refer to SPA’s policy entitled Submission and Routing of Proposals for Extramural Funding and Award Acceptance and the CTA Checklist used to coordinate review of sponsored agreements involving Human Subjects.

Contracts or other funding agreements require the sponsor to promptly (no longer than within 30 days) report to the organization any findings that could affect the safety of participants or influence the conduct of the study or alter the IRB’s approval to continue the study.

Contracts or other funding agreements require the sponsor to send data and safety monitoring plans and reports to the organization. Contracts or other funding agreements specify the time frame for providing routine and urgent data and safety monitoring reports to the organization as indicated in the data and safety monitoring plan approved by the IRB.

Contracts or other funding agreements require the sponsor to follow the organization’s policies and procedures regarding the publication of findings from sponsored research.
Contracts or other funding agreements describe the steps followed to communicate findings from a closed research study to the researcher or organization when those findings directly affect participant safety. Contracts or other funding agreements specify a time frame after closure of the study during which the sponsor will communicate such findings (e.g., two years). This should be based on the appropriate timeframe for each individual study.

AAHRPP Standards for Accreditation (Standard I-8, Elements I.8.A-E)
21 Conflicts of Interest and Institutional Conflicts of Interest in Research

21.1 Policy

Tulane’s policies and guidelines on Conflicts of Interest (“COI”) and Institutional Conflicts of Interest (“ICOI”) include specific requirements (regulatory, accrediting body, or otherwise) applicable to COIs associated with the conduct of Human Subjects’ Research. Matters involving COI are governed by the “Tulane University Policies on Conflicts of Commitment and Interest” (“Tulane COI Policy”) available at Tulane University Conflict of Interest Policies. Matters involving ICOI are governed by the “Tulane University Policy on Institutional Conflicts of Interest in Research (“Tulane ICOI Policy”) (available at Tulane University Conflict of Interest Policies).

Pursuant to Tulane COI Policy, a Conflict of Interest arises whenever faculty, staff, or an affiliated Investigator’s professional interests, such as professional obligations or judgment owed to the University and its constituencies, are compromised by, or could reasonably be perceived as being compromised by, his or her leadership roles or financial interests. In the case of PHS-funded research, a PHS financial Conflict of Interest arises when the financial interests of an Investigator could directly and significantly affect the design, conduct, or reporting of PHS-funded research. A Conflict of Interest is based on the situation and not on the character of the individual. A Conflict of Interest can also occur when the academic work or research activities of a faculty member could affect a financial interest of the University or of a faculty or staff member. [Tulane University COI Policy, Part A (III)].

Pursuant to the Tulane COI Policy and ICOI Policy, Tulane maintains a Conflicts of Interest Committee (“COI Committee”) and an Institutional Conflicts of Interest Committee (“ICOI Committee”). Tulane’s IRB collaborates with the Tulane COI Committee and ICOI Committee to ensure that financial COIs and leadership role COIs are identified and managed before Tulane’s IRB begins its review of any Protocol. This Section establishes procedures to implement this collaborative arrangement.

The IRB will determine:

- Whether the methods used for management of conflict of financial and/or leadership interests of individuals involved in the Research adequately protect the rights and welfare of Human Subjects;

- Whether other actions are necessary to minimize risks to Subjects; and

- The kind, amount, and level of detail of information that must be disclosed to Research Participants regarding:
  - The interests of individuals involved in performing the Research and
  - Any conflict management arrangements applied.

21.2 Definitions

To the extent there is conflict among the definitions below and those in the Tulane COI Policy and/or the Tulane ICOI Policy, the definitions in the Tulane COI Policy and the Tulane ICOI Policy prevail.

Financial Interest: (1) Any payment received from or equity interest held in a publicly traded entity during the 12-month period prior to the disclosure with a value that, in the aggregate, exceeds $5,000; (2) Any payment received from a non-publicly traded entity during the 12-month period prior to the disclosure with a value that, in the aggregate, exceeds $5,000; (3) Any equity interest in a non-publicly traded entity; (4) Income of more than $5,000 (from one entity) generated from intellectual property rights and interests, unless paid by the University to an individual employed or appointed by the University; (5) Reimbursed or sponsored travel with a value that exceeds $5,000, unless reimbursed or sponsored by the University or a federal, state or local government agency, an institution of higher education as defined in 20 U.S.C. § 1001(a), an academic teaching hospital, a medical center or research institute affiliated with an institution of higher education. There is no dollar threshold for reimbursed or sponsored travel for Faculty and Staff who are Investigators for PHS-Funded Research, Affiliated PHS Investigators (as defined in Part A-2 of the University’s Conflicts Policy) or Sub-recipient PHS Investigators (as defined in Part A-2 of the University’s Conflicts Policy). [Tulane COI Policy, Part A].

Immediate Family:

- For non-members of Tulane University Medical Group: Immediate Family are spouse or domestic partner, children (including adoptees) and other dependents. Because of strict conflict of interest rules required by federal and state law, the definition of Immediate Family for a member of the Tulane University Medical Group and for other health care providers is broader than the definition for other Faculty and Staff members. [Tulane COI Policy, Part A(V)(F)].

- For members of the Tulane University Medical Group or other health care providers: Immediate Family are spouse or domestic partner, children and other dependents, natural or adoptive parents, siblings, stepparent, stepchild, stepbrother or sister, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, and spouse of grandparent or grandchild. [Tulane COI Policy, Part B(F)].

Institutional Research Conflict of Interest: An Institutional Research Conflict of Interest exists whenever the financial interests of the University, or of University Research Official acting within his or her authority on behalf of the University, could directly and significantly affect or reasonably appear to affect University processes for the design, conduct, reporting, review or oversight of research. [Tulane ICOI Policy, Section II].

Leadership Role: (a) Employment in any executive or administrator capacity, (b) consulting in any executive or administrator capacity, or (c) serving as (i) a member of a board of trustees, directors or administrators, (ii) an officer or (iii) a member of an advisory committee, advisory board or subcommittee of a board of trustees, directors or administrators. (Note that any such employment, consultancy, or service by an Immediate Family member of an individual subject to this policy constitutes a Leadership Role on the part of such individual.) A Leadership Role may be compensated or non-compensated. [Tulane COI Policy, Part A(III)(I)].
**Research Financial Interest:** is (1) Any investments (whether in the form of debt, stock or other equity ownership, options or warrants to purchase stock or other securities or similar instruments) or interest in a Sponsor, research or health care-related organization; (2) Royalties on any patent or other intellectual property interests, unless paid by the University; (3) Income, salary or remuneration in cash or in kind, emoluments, benefits, gifts, honoraria, travel expenses, goods or services received from a Sponsor or research or health care-related organization. [Tulane COI Policy, Part C].

**University Research Oversight Official or University Research Official:** The Tulane University Policy on Conflicts of Commitment and Interest defines Research Oversight Officials in part to include all faculty and staff of any institutional office or body (for instance, all IRB…members) at the University who perform research oversight functions in which they exercise professional or administrative-level discretion. [Tulane COI Policy, Part D(I)].

### 21.3 Initial Review

In the initial IRB application for IRB approval of the Research Protocol, each Investigator must complete the COI questions as to any potential real or perceived COI, as well as any potential real or perceived ICOI, if applicable. Each Investigator also must attest that he/she has supplied the COI Committee (and ICOI Committee, if applicable) with a complete “Conflict of Commitment and Conflict of Interest Disclosure Form,” (and any required updates thereto). The Investigator also must indicate whether the Research he or she is conducting could be affected by any of his or her Research Financial Interests and/or Leadership Roles. The IRB may not review and will not approve IRB applications until each Investigator has provided this required information to the COI Committee (and/or ICOI Committee, if applicable) and the COI Committee (and ICOI Committee, if applicable) has determined and informed the IRB that there is no Conflict of Interest or provided assurance regarding management or elimination of the conflict.) [Tulane COI Policy C (4)].

The COI Committee (and/or ICOI Committee, if applicable) will provide to the IRB a summary of the management plan approved by the COI Committee (and/or ICOI Committee, if applicable). In instances in which the COI Committee (and/or ICOI Committee, if applicable) has not completed its review and conflict management plan, the IRB will defer approval of the initial Protocol until the COI Committee (and/or ICOI Committee, if applicable) review process is complete and the results communicated to the IRB. [Tulane COI Policy, Part C (4)].

The IRB has final authority to determine whether the management of the conflict of interest, is sufficient to protect the welfare of the participants involved in the research in order to allow the Research to be approved. With regards to the financial and/or leadership role conflict management plan issued by the COI Committee (and/or ICOI Committee, if applicable), the IRB may accept the management strategies, or may strengthen them. However, the IRB cannot weaken a conflict of interest management plan proposed by the COI Committee (and/or ICOI Committee, if applicable).

If the IRB elects to strengthen the management plan proposed by the COI Committee (and/or ICOI Committee, if applicable), the IRB must document its reason for doing so and submit a copy of its written findings to the COI Committee (and/or ICOI Committee, if applicable). The IRB must promptly notify the Investigator in writing of its determination regarding the
Investigator’s real or perceived COI, who must then comply with the management plan as strengthened by the IRB.

21.4 Continuing Review

At the time of Continuing Review of the Protocol (or for studies not requiring continuing review, at the time of submission of the annual progress report), each Investigator must attest in the “Secondary Application for Human Subjects Research,” that he or she has supplied the COI Committee (and/or ICOI Committee, if applicable) with a complete Conflict of Commitment and Conflict of Interest Disclosure Form (and any required updates thereto), and must indicate whether the Research he/ she is conducting could be affected by any of his or her Research Financial Interests and/or Leadership Roles. The IRB may not review and will not approve IRB applications until each Investigator has provided this required information to the COI Committee (and/or ICOI Committee, if applicable) and the COI Committee (and/or ICOI Committee, if applicable) has determined and informed the IRB that there is no Conflict of Interest or provided assurance regarding management or elimination of the conflict. If, at the time for Continuing Review of a study, all necessary information has not been provided, the study shall not be authorized to continue, and no new subjects shall be enrolled in the study unless the IRB determines that it is in the best interest of the previously enrolled subjects to continue the study and their participation. [Tulane COI Policy, Part C (4)].

Whenever a COI (and/or ICOI, if applicable) arises or is identified after IRB approval of Research, the Investigator will promptly disclose the conflict to the COI Committee (and/or ICOI Committee, if applicable) and notify the IRB. The COI Committee (and/or ICOI Committee, if applicable) will review the COI to determine if the COI can be managed and inform the IRB of its recommendation. The IRB or IRB Chair (or designee) will include the results of the COI Committee’s (and/or ICOI Committee, if applicable) recommendation when it reviews an amendment involving a COI.

The IRB has the final authority to determine whether the management of the conflict of interest is sufficient to protect the welfare of the participants involved in the research in order to allow the Research to be approved. With regards to the financial and/or leadership role conflict management plan issued by the COI Committee (and/or ICOI Committee, if applicable), the IRB may accept the management strategies, or may strengthen them. However, the IRB cannot weaken a conflict of interest management plan proposed by the COI Committee (and/or ICOI Committee, if applicable).

If the IRB elects to strengthen the management plan proposed by the COI Committee (and/or ICOI Committee, if applicable), the IRB must document its reason for doing so and submit a copy of its written report to the COI Committee. The IRB must promptly notify the Investigator in writing of its determination regarding the Investigator’s real or perceived COI, who must then comply with the management plan as strengthened by the IRB.

21.5 Updated COIs and Failure of PIs to Complete Annual COI Form

If at any time over the course of the year one or more Research Financial Interests or Leadership Roles of an Investigator or an Investigator’s Immediate Family in any Research or health care-related organization changes in any material way, the Investigator must promptly notify the COI
Committee (and/or ICOI Committee, if applicable) of that change by updating the COI Disclosure Form. Investigators must also forward to the COI Committee (and/or ICOI Committee, if applicable) without delay any amendments or changes that an Investigator makes to any reports of Research Financial Interests that are submitted to any Sponsor of Research. [Tulane COI Policy, Part C(IV)].

All Investigators must complete Form C of the Conflict of Commitment and Interest Disclosure of Information Form. This Form C must be electronically submitted to the Investigator’s supervisor, department Chair or Dean in accordance with the Tulane COI Policy and must be updated on an annual basis (by January 31 of each year) for as long as the Investigator continues to conduct any Research at the University. [Tulane COI Policy, Part C(IV)].

Investigators must append to the Disclosure Form a copy of every report of their Research Financial Interests that they are required to submit to any Sponsor of Research. Any report of Research Financial Interests that is sent to a Sponsor of Research any time after the January 31 filing deadline must also be sent without delay to the COI Committee (and/or ICOI Committee, if applicable).

### 21.6 IRB Review of COI

The HRPO (or designee) will notify a representative of the University Conflict of Interest Committee and Institutional Conflict of Interest Committee of any Protocol submissions involving disclosure of a potential COI. Where applicable, this representative will inform the individual of the procedures for disclosing a COI. The representative will assure that all COI disclosures are reviewed in accordance with the Tulane COI Policy and Tulane ICOI Policy. The representative shall liaise with the HRPO to communicate the findings and management plan of the COI Committee (and/or ICOI Committee, if applicable) to the IRB.

In considering whether to affirm, strengthen the management plan of the COI Committee (and/or ICOI Committee, if applicable), the IRB should consider whether the COI committee has reviewed the following issues as part of the recommended management plan:

- Whether there is sufficient public disclosure of Financial Interests;
- Whether there is sufficient disclosure to subjects through the consenting process;
- Reduction of equity holdings;
- Divestiture of Financial Interest (complete or partial);
- Severance of relationships that create actual or potential COIs
- Clear separation of Research from paid activities;
- Disqualification of the Investigator with the conflict in obtaining consent and/or from participation in all or a portion of the Research; and
- More frequent Continuing Reviews by the IRB.

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12This includes, but is not limited to, reports that must be made to Sponsors pursuant to regulations of the FDA.
In considering whether a protocol specific COI exists, the IRB should consider the following additional issues with regards to the impact of the economic interests on:

- Study design;
- Protocol;
- Informed Consent document (particularly representations of risks and benefits);
- Data collection and reporting;
- Eligibility determinations and application of inclusion and exclusion criteria;
- Continuing consent
- Clinical determinations (e.g., dose modifications, removing patients from study, related care);
- Determination and reporting of Unanticipated Problems and their relationship with study mechanism for data and safety monitoring;
- Data made available on Continuing Review (i.e., integrity and sufficiency); and
- Consequences affecting the clinician researcher’s clinical duties to patient as a Participant.

With respect to protocol specific COIs and/or ICOIs, the IRB has the final authority to determine whether the management of the COI, if any, is sufficient for IRB approval. The IRB may disapprove Research that involves a COI and/or ICOI or it may require changes at the Investigator’s or Sponsor’s expense to eliminate or manage the conflict. Possible IRB determinations to strengthen a management of the COI include, but are not limited to:

- Requiring divestiture or termination of relevant economic interest;
- Requiring Investigator recusal from study;
- Altering participation by the Investigator in all, or a portion, of the Research funded;
- In case of equity, imposing a bar on insider trading, or requiring the transfer of securities to an independent financial manager or blind trust, or limiting the timing of sale or distributions;
- Monitoring of Research (i.e., independent review of data and other retrospective reviews for bias, objectivity, comprehensiveness of reporting);
- Requiring independent clinical review of appropriateness of clinical care given to Research Participants;
- Monitoring the consent process; and/or
- Requiring disclosure to institutional committees, Research Participants, journals and data safety monitoring boards.
22 Participant Outreach

22.1 Policy
Tulane is committed to ensuring that educational opportunities are offered to Research Participants, prospective Research Participants, and community members to enhance their understanding of Research involving Human Subjects at Tulane.

The following procedures describe how Tulane fulfills that responsibility.

AAHRPP Standards for Accreditation (Standard I-4, Element I.4.A)

22.2 Responsibility
It is the responsibility of the HRPO/HRPP to implement the procedures outlined below.

22.3 Outreach Resources and Educational Materials
The HRPP dedicates a section of its Website to Research Participants, which includes the following:

• Participants Bill of Rights;
• Frequently Asked Questions ("FAQs");
• Tulane Participant brochures;
• Links to regulatory websites (e.g., OHRP, FDA, NIH, NCI); and
• Opportunity to submit community concerns, trial information, and receive feedback.

Tulane periodically provides in-services and presentations related to Research to community organizations to increase public awareness and educate potential Research Participants.


22.4 Questions, Concerns, and Complaints
All questions, concerns or complaints received by HRPO from any individual through the Concerns and Complaint Form (TU Form 604) or any form of communication (i.e., written, verbal, or electronic) will be promptly acknowledged and forwarded to the appropriate individual within the Institution for handling and follow-up. Complaints are handled as per Section 17, “Complaints” of these SOPs.

The timeframe for resolution of complaints is dependent upon the nature and complexity of the issue.

HRPO contact information for reporting concerns or complaints will be provided in the Informed Consent Document, Participant Brochure and the HRPP Website.

AAHRPP Standards for Accreditation (Standard I-4, Element I.4.C)

Regulations & Guidelines: DHHS 45 CFR §46.116(a)(6)-(7); FDA 21 CFR §50.25(a)(6)-(7); FDA Information Sheets: A Guide to Informed Consent
22.5 Evaluation

Tulane periodically evaluates its outreach activities and makes changes when appropriate. These evaluations take place in an informal, ongoing manner. All HRPO staff, IRB members, IRB Chairs and IRB Vice-Chairs will report both positive and negative feedback about all HRPO outreach activities to the HRPO/HRPP who will then track the input and any changes made to improve outreach activities. The HRPO/HRPP will summarize the material annually. In order to formally evaluate its outreach activities, the HRPO/HRPP will determine:

1. The specific community outreach activities being used; and
2. Whether or not these community outreach activities have an evaluative component, and if so what, if any, changes in the outreach activities have resulted from these Evaluations.

The HRPO/HRPP will administer surveys annually to determine the adequacy of outreach activities. The survey will assess:

1. The scope, the content and the adequacy of outreach activities and resources;
2. Whether the Research community is using the HRPP Website regarding Research participation;
3. Whether the Research community is using other educational materials to inform prospective Participants about their rights and welfare as Research Participants; and
4. Whether additional resources are needed to improve Participant outreach activities.

The results of the survey will be used to establish both the adequacy of current outreach activities and any additional resources that may be needed to meet the needs of the Research community regarding Participants outreach.
Health Insurance Portability and Accountability Act (HIPAA)

23.1 Historical Background

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended by the Health Information Technology for Economic and Clinical Health Act and Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and DHHS regulations promulgated there under to include the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164, Subpart A and Subpart E), the HIPAA Security Rule (45 C.F.R. Parts 164, Subpart A and Subpart C), the HIPAA Breach Notification Rule (45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A and Subpart D), and the HIPAA Omnibus Rule (referred to herein globally as “HIPAA”), impose obligations on Tulane to use appropriate physical and administrative safeguards to protect the privacy, integrity and availability of protected health information. While the main impact of HIPAA is on the routine provision of and billing for health care, it also establishes the conditions under which protected health information may be used or disclosed by covered entities for research purposes. Therefore, Researchers, IRB staff and IRB members, as well as Research administration, must be aware of and comply with these requirements when applicable.

23.2 Health Care Component

The standards, requirements, and implementation specifications of HIPAA apply to all Covered Entities. A Covered Entity is generally defined by HIPAA as any health care provider who transmits any health information in electronic form in connection with a covered transaction. Because Tulane conducts such covered functions Tulane is a Covered Entity.

However, HIPAA provides a means by which Covered Entities that have non-covered components, such as Tulane, may avoid global application of HIPAA through the Hybrid Entity designation provisions. Any single legal entity may elect to be a Hybrid Entity if it performs both covered and non-covered functions as part of its business operations. This Hybrid Entity designation establishes which parts of the entity must comply with HIPAA and which do not. Within a Hybrid Entity, most of the requirements of HIPAA apply only to the health care component(s) (the “Health Care Component”), although the Covered Entity retains certain administrative, oversight, compliance, and enforcement obligations. To become a Hybrid Entity, the Covered Entity must elect this designation and designate the Health Care Components within its organization.

A Covered Entity’s Health Care Components must include any component that would meet the definition of Covered Entity if that component were a separate legal entity. A Health Care Component may also include any component that conducts covered functions (i.e., non-covered health care provider) or performs activities that would make the component a business associate of the entity if it were legally separate. Thus, Research components of a Hybrid Entity that function as health care providers and engage in standard electronic transactions must be included in the Hybrid Entity's health care component(s) and be subject to HIPAA. If such a Research component is included in the Hybrid Entity’s Health Care Component, then the workforce members of the Research component must comply with HIPAA. A Hybrid Entity is not permitted, however, to include in its Health Care Component, a Research component that does not function as a health care provider or does not conduct business associate-like functions. For
example, a Research component that conducts purely records Research is not performing covered or business associate-like functions and, thus, cannot be included in the Hybrid Entity’s health care component.

Tulane intends to fully comply with its obligations under HIPAA. For this reason, Tulane has designated itself as a Hybrid Entity [see 45 C.F.R. 164.504(a), 164.504(b), and 164.504(c)] for HIPAA compliance purposes. [See Tulane privacy policy entitled “Designation of Health Care Components and Hybrid Entities (GC-001)]. Furthermore, for HIPAA compliance purposes, the University has designated the following components (“Health Care Components”) as being subject to HIPAA:

Tulane University Medical Group (“TUMG”), its participating physicians and clinicians, and all University employees and departments that provide management, administrative, financial, legal and operational support services to or on behalf of TUMG to the extent that such employees and departments Use and Disclose IIHI in order to provide administrative and support services to TUMG and would constitute a “business associate” of TUMG if it were a separate legal entity from the University.

All other departments, personnel, and employees of the University are excluded from the health care component (i.e., they are not subject to the HIPAA requirements).

23.3 Policy

This policy pertains to the application of HIPAA to Research conducted under the auspices of Tulane’s IRB. Do not confuse this with Tulane’s ongoing HIPAA Privacy program that applies to its Health Care Component (see Tulane’s Website at https://counsel.tulane.edu/upo/hipaa-privacy-policies-procedures-forms for related policies, procedures and forms). Tulane Researchers within the Health Care Component (i.e., TUMG) as designated by Tulane must abide by these SOPs and all institutional policies with respect to HIPAA. PHI obtained by Tulane may not be Used internally or Disclosed to any outside person or organization for Research purposes without prior approval of the IRB. The following describe the procedures for conducting Research at Tulane in accordance and compliance with HIPAA.

AAHRPP Standards for Accreditation (Standard II-3, Elements II.3.D and II.3.E)

23.4 Definitions

The following terms, when used in these SOP’s, shall have the following meanings, as defined in the HIPAA Privacy Rule, the HIPAA Security Rule, the HIPAA Breach Notification Rule, and the HIPAA Omnibus Rule, provided that the terms set forth below will be deemed to be modified to reflect any changes made to such terms from time to time by amendment of law.

Authorization (or “HIPAA Authorization”): for HIPAA purposes, is a written document completed and signed by the individual that allows use and Disclosure of PHI for specified purposes, which are generally other than treatment, payment, or health care operations of a Covered Entity. [45 CFR §164.501 and §164.508].

Coded: means (1) Individually Identifiable Private Information (e.g., name or social security number) that would enable the Investigator to readily ascertain the identity of the individual to
whom the Private Information (or specimens) pertains has been replaced with a number, letter, symbol, or combination thereof (i.e., the Code); and (2) a key to decipher the Code exists, enabling linkage of the Individually Identifiable Private Information (or specimens).

**Covered Entity**: for HIPAA Privacy purposes, this the term applied to institutions that must comply with the HIPAA Privacy and Security Rule. They include: health plans, health care clearinghouses; and health care providers. [45 CFR §160.103; 45 CFR §164.504]. See Section 23 for details.

**De-Identified Information**: for HIPAA Privacy purposes, Health Information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. If information is de-identified, it no longer is subject to the Privacy Rule and exempt from HIPAA. [45 CFR §164.514(a) and (b); 45 CFR §164.502(d) (permitted Uses and Disclosures of De-Identified Information)].

**Disclosure (or “Disclosure of PHI”)**: for HIPAA Privacy purposes, a Disclosure is the release, transfer, provision of access to, or divulging in any other manner IIHI outside of the Covered Entity. [45 CFR §164.501].

**Health Information**: for HIPAA Privacy purposes, it means any information, whether oral or recorded in any form or medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. [45 CFR §160.103].

**Hybrid Entity**: for HIPAA Privacy purposes, it is a single legal entity that (a) is a Covered Entity; (b) whose business activities include activities covered and not covered under the HIPAA Privacy Regulations; and (c) that designates health care components that will be subject to HIPAA. [45 CFR §164.103.]

**Individually Identifiable Health Information (“IIHI”)**: for HIPAA Privacy purposes, this is information, including demographic information collected from an individual, that: (i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (iii) identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. [45 CFR §160.103]. This term should not be confused with “Individually Identifiable Private Information,” which is not covered by HIPAA.

**Limited Data Set**: for HIPAA Privacy purposes, is PHI that excludes specific direct identifiers of the individual or of relatives, employees or household members of an individual. A limited data set can only be used for the purposes of Research, public health, or healthcare operations, and disclosed for the purposes of Research.

**Minimum Necessary**: for HIPAA Privacy purposes, this refers to the principle that any access (i.e., obtaining or using PHI by any means or in any medium) to PHI by Tulane workforce members should be limited to the minimum amount of PHI needed to accomplish the intended purpose of the use or Disclosure. [45 CFR §164.502(b) and §.514(d)].
**Preparatory Research:** for HIPAA Privacy purposes, Preparatory Research is the method applied to developing or designing a research study. [45 CFR §164.512(i)(1)(ii)].

**Protected Health Information (“PHI”):** for HIPAA Privacy purposes, PHI means IIHI that is transmitted or maintained in any form or medium (i.e., electronic, paper or verbal). [45 CFR §164.501]. PHI does not include IIHI in:

- Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g;
- Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
- Employment records held by a covered entity in its role as an employer.

**Privacy:** for Research purposes, having control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others. Do not confuse this Research term with HIPAA Privacy requirements.

**Privacy Board:** for HIPAA Privacy purposes, Privacy Board is the term used to describe a board comprised of members of varying backgrounds and appropriate professional competencies, as necessary, to review individual’s private rights. It is an alternative to an IRB for privacy issues only. It cannot replace the IRB for Common Rule or FDA purposes. Tulane’s IRB shall serve as the Privacy Board for the Institution, for the purposes of making determinations related to the creation, maintenance, or storage of PHI resulting from Human Subject Research.

**Use:** means, with respect to IIHI, the sharing, employment, application, utilization, examination, or analysis of such information within the organization that maintains such information. [45 CFR §164.501].

**Waiver of Authorization (or “Waiver of HIPAA Authorization”):** For HIPAA Privacy purposes, this is a means of requesting approval from an IRB or Privacy Board rather than asking each Research subject for an Authorization to access PHI. [45 CFR §164.512(i)(1)(i)].

### 23.5 Effects of HIPAA on Research

Before HIPAA, protection of Human Subjects in Research focused primarily on assuring that the Research project was performed ethically and that the Human Subjects participated on the basis of Informed Consent. Federally Sponsored research is generally subject to the requirements of the Common Rule. This is the set of standards common to Federal agencies funding Research involving Human Subjects. It attempts to minimize the risk to which the subjects are exposed and assures continuing oversight by IRBs. While the Common Rule acknowledges the importance of Confidentiality, it does not have extensive requirements regarding the matter. Likewise, the FDA regulations governing clinical trials of new drugs and medical devices have some restrictions protecting the Confidentiality of Human Subjects. The Privacy Rule does not make any changes to these Research requirements. HIPAA supplements Research regulations within Tulane’s Health Care Component (i.e., TUMG); it does not replace them.

HIPAA also contains several provisions that resemble Federal Research provisions and does make reference to those provisions. For example, the Common Rule contains specific requirements for a composition of an IRB. Similarly, the Privacy Rule contains specific requirements for a Privacy Board. The composition of a Privacy Board is similar to that of an IRB and, effectively, the IRB can easily serve as the Privacy Board for a Covered Entity.
23.6 Privacy Board

Tulane designates its IRB as its Privacy Board for purposes of Institutional determinations of whether PHI created, maintained or stored as a result of Human Subject Research can be Used or Disclosed without subject authorization or pursuant to an alteration of subject authorization. Tulane’s Privacy Board shall be established and operated consistent with 45 CFR §164.512(i) of the Privacy Rule, which states that:

- Members must have varying backgrounds and appropriate professional competencies as necessary to review the effect of the Research Protocol on individuals’ privacy rights and related interests;
- Each Board must have at least one member who is not affiliated with the Covered Entity or with any entity conducting or Sponsoring the Research and who is not related to any person who is affiliated with such entities; and
- Members may not have COI regarding the projects they review.

Do not confuse Tulane’s Privacy Board with its Privacy Official. The role of the Privacy Board is solely to determine whether PHI related to Human Subject Research can be Used or Disclosed without subject authorization or pursuant to an alteration of subject authorization. As to the Privacy Official, HIPAA (45 C.F.R. § 164.530) requires all Covered Entity to designate a Privacy Official who is responsible for the development and implementation of the policies and procedures of the entity. The University Privacy Officer is Tulane’s designated Privacy Official. [see Tulane policy entitled “Privacy Official,” (GC-019)]. The University Privacy Officer is responsible for overseeing and implementing all other HIPAA Privacy compliance requirements for the Institution with respect to its Health Care Component. Tulane University Hospital and Clinic (“TUHC”) is a separate legal entity from the University, with separate control and operation. It is a Covered Entity for HIPAA Privacy compliance purposes and has its own policies and procedures to ensure compliance with the Privacy Regulations. Tulane’s IRB does not serve as a privacy board or privacy officer for TUHC.

23.7 Research under HIPAA

HIPAA defines Research as "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge." [45 CFR §164.501]. This definition is identical with the one used in the Common Rule, separate Federal legislation designed to protect Human Subjects involved in Research. HIPAA is only concerned
with the identifiable information of (human) individuals. Therefore, HIPAA’s privacy standards only apply to Research that involves Humans Subjects (i.e., not animals).

23.8 Uses and Disclosures of Research PHI with an Authorization

HIPAA permits Covered Entities to Use or Disclose PHI for Research purposes under certain prescribed circumstances, the first of which is when the individual who is the subject of the information authorizes the Use or Disclosure. The general rule is that a Covered Entity may not use or disclose protected health information without a valid authorization. When a covered entity obtains or receives such a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with such authorization. Therefore, a valid HIPAA Authorization is required to be obtained for all Research Uses or Disclosures of PHI that do not qualify for an IRB Waiver of Authorization (discussed below). For clinical trials, this HIPAA Authorization must be sought in addition to any Informed Consent.

The Privacy Rule has several special provisions that apply to Research Authorizations for Uses and Disclosures of PHI for Research purposes. These requirements for Tulane with respect to Tulane’s Health Care Component are as follows:

**HIPAA Authorization Core Elements** [see 45 C.F.R. §164.508(c)(1)]:

1. Description of PHI to be used or disclosed (identifying the information in a specific and meaningful manner).
2. The name(s) or other specific identification of person(s) or class of persons authorized to make the requested use or disclosure.
3. The name(s) or other specific identification of the person(s) or class of persons who may use the PHI or to whom the covered entity may make the requested disclosure.
4. Description of each purpose of the requested use or disclosure. Researchers should note that this element must be research study specific, not for future unspecified research.
5. Authorization expiration date or event that relates to the individual or to the purpose of the use or disclosure (the terms "end of the research study" or "none" may be used for research, including for the creation and maintenance of a research database or repository).
6. Signature of the individual and date. If the Authorization is signed by an individual's personal representative, a description of the representative's authority to act for the individual.

**HIPAA Authorization Required Statements** [see 45 C.F.R. § 164.508(c)(2)] In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

1. The individual's right to revoke his/her Authorization in writing and either (1) the exceptions to the right to revoke and a description of how the individual may revoke Authorization or (2) reference to the corresponding section(s) of the covered entity's Notice of Privacy Practices.
2. Notice of the covered entity's ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the Authorization, by stating either:
a. That the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations applies; or

b. The consequences to the individual of a refusal to sign the authorization when the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization. A covered entity may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research.

3. The potential for the PHI to be re-disclosed by the recipient and no longer protected by the Privacy Rule. This statement does not require an analysis of risk for re-disclosure but may be a general statement that the Privacy Rule may no longer protect health information.

Plain language requirement. The authorization must be written in plain language.

Copy to the individual. If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

Combined Authorizations. An authorization for the use or disclosure of protected health information for a research study may be combined with any other type of written permission for the same or another research study.

1. This exception includes combining an authorization for the use or disclosure of protected health information for a research study with another authorization for the same research study, with an authorization for the creation or maintenance of a research database or repository, or with a consent to participate in research.

2. At Tulane, it is recommended that the HIPAA Authorization Form for the Use or Disclosure of PHI be a separate document from the Informed Consent Form. Additionally, it is recommended that separate HIPAA Authorization be obtained for each sub-study of a protocol.

4. Where a covered health care provider has conditioned the provision of research-related treatment on the provision of one of the authorizations, any compound authorization created under this paragraph must clearly differentiate between the conditioned and unconditioned components and provide the individual with an opportunity to opt in to the research activities described in the unconditioned authorization.

Effect of Prior Authorizations. HIPAA Authorizations obtained prior to April 14, 2003 will continue to be valid unless a specific expiration date is noted in the HIPAA Authorization. Without an expiration date, the Institution may continue to use and disclose that PHI for Research purposes in perpetuity.

Authorizations for Databases and Repositories. HIPAA recognizes the creation of a Research database or a specimen repository to be a Research activity if the data/specimens to be stored contain PHI. There are two separate activities that the covered entity must consider: (1) the use of disclosure of PHI for creating a Research database or repository and (2) the subsequent use or disclosure of PHI in the database for a particular Research plan. Individual authorization for the
storage of PHI for future Research must be sought unless the IRB has determined that the criteria for a waiver of the authorization requirement are satisfied. See Section 23.8 of this policy for a discussion of waivers of authorization.

**Authorizations for Use or Disclosure of Psychotherapy Notes.** Psychotherapy notes are defined by HIPAA as notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

1. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes. An authorization for the use or disclosure of psychotherapy notes may not be combined with the research informed consent form or with a research HIPAA authorization.

2. An authorization for the use or disclosure of psychotherapy notes should be specific enough to allow both the study subject and any person disclosing psychotherapy notes to clearly understand what is authorized for disclosure. An authorization for the use or disclosure of psychotherapy notes should also list every person, class of persons, and entity who might disclose, receive, and/or use the psychotherapy notes to which the authorization applies.

Unless an exception exists, Tulane must obtain individual HIPAA Authorization to Use and/or Disclose PHI for Research purposes in compliance with the above. HIPAA Authorization Forms must be filled out completely and accurately by the Investigator, to ensure that all parties who require access to PHI for the Research (including Sponsors, CROs, DSMBs, IRBs, etc.) are identified in the form and may receive the information. The Authorization Form should be completed by the Investigator and submitted to the Tulane IRB for review and approval.

Any Research subject enrolled in a study that Uses PHI from a Covered Entity must sign a HIPAA-compliant HIPAA Authorization Form. This form is in addition to the existing Informed Consent document. The Tulane HIPAA Authorization Form may be located on the Tulane HRPP Website: http://research.tulane.edu/hrpo.

**23.8.1 Waiver of Authorization for Use or Disclosure of PHI in Research**

Under the Privacy Rule, covered entities are permitted to Use and Disclose PHI for Research without individual Authorization under limited circumstances. A Covered Entity (or with respect to Tulane, its Health Care Component) may Use or Disclose PHI for Research when it obtains documentation that an alteration to or waiver, in whole or in part, of the individual authorization required for use or disclosure of protected health information has been approved by either an IRB or a Privacy Board. [See 45 CFR §164.512(i)(1)(i)]. This provision of the Privacy Rule might be used, for example, to conduct records Research, epidemiological studies, or other Research where de-identified data is unavailable or not suited to the Research purpose.
23.8.1.1 Procedure for Uses & Disclosures without an Authorization:

The Health Care Component of Tulane may Use and/or Disclose PHI for Research without obtaining a HIPAA Authorization under the following circumstances:

**Review Preparatory to Research.** The Privacy Rule permits a Covered Entity to Use or Disclose PHI to a Researcher without Authorization or Waiver of Authorization for the limited purpose of a “review preparatory to research.” [45 CFR §164.512(i)(1)(ii)]. Such reviews may be used to prepare a Research Protocol, or to determine whether a Research site has a sufficient population of potential Research subjects. Prior to permitting the Researcher to access the PHI, the Covered Entity must obtain from the researcher representations that:

1. The Use or Disclosure of the PHI is solely to prepare a Research Protocol or for similar purposes preparatory to Research,
2. The Researcher will not remove any PHI from Tulane, and
3. That PHI for which access is sought is necessary for the Research purposes.

Researchers conducting a review preparatory to Research may not record information in identifiable form, nor may they Use the information that they receive to contact potential subjects. Researchers should consult the Covered Entity regarding any forms or applications necessary to conduct a review preparatory to Research. Because the Privacy Rule permits a Covered Entity to disclose PHI to the individual who is the subject of the information, covered health care providers and patients may continue to discuss the option of enrolling in a clinical trial without patient Authorization. Even when permitted by the Privacy Rule, however, any Use of patient information for recruitment must comply with IRB recruitment policies.

Reviews preparatory to Research that are permitted under HIPAA may or may not be Human Subjects Research depending on the investigation being conducted. Only those reviews of a database by an individual entitled to access that database intended to enumerate an available data set without reviewing PHI and for which no PHI is recorded do not require review. For example: medical records may be queried for information such as: In the year 2015, how many patients had a discharge diagnosis of hypertension. IRB Privacy Board Review is required for all other Uses of PHI as indicated.

**Uses and Disclosures of Research PHI under Waiver/Alteration of HIPAA Authorization.** To Use and/or Disclose PHI under a waiver/alteration by Tulane’s IRB (acting as the Privacy Board), certain statements must be documented. The following items must be included in the documentation:

1. A statement identifying Tulane’s IRB (acting as the Privacy Board) and the date on which the waiver/alteration was approved;
2. A brief description of the PHI necessary for Research to be conducted;
3. A statement that the waiver/alteration has been reviewed and approved by the Tulane’s IRB (acting as the Privacy Board);
4. Evidence that the documentation of the waiver/alteration has been signed by the IRB Chair (or designee); and
5. Specific waiver criteria are met. Documentation must exist that contain IRB/Privacy Board assurances that the waiver/alteration of the HIPAA Authorization meets certain criteria, including:

a. The Use or Disclosure of PHI involves no more than a Minimal Risk to an subject’s privacy, based on an adequate plan to protect identifiers from improper Use and Disclosure, an adequate plan to destroy identifiers at the earliest opportunity consistent with the research and absent a health or Research justification for retaining that information, and adequate written assurances by the PI that the PHI will not be re-Used or Disclosed to anyone else, except as is required by law, for oversight of the research itself, or for other permitted research;

b. The Research could not practicably be conducted without the waiver/alteration; and

c. The Research could not practicably be conducted without access to the PHI.

When a request for a waiver or an alteration of the Authorization requirement is considered by the convened IRB, a majority of the IRB members must be present at the meeting, including at least one member whose primary concerns are in nonscientific areas. In order for an approval of a waiver or an alteration of the Privacy Rule's Authorization requirement to be effective, it must be approved by a majority of the IRB members present at the convened meeting. If a member of the IRB has a conflicting interest with respect to the PHI use and disclosure for which a waiver or an alteration approval is being sought, that member may not participate in the review.

Expedited review of a request for a waiver or an alteration of the Authorization requirement is permitted if the research qualifies for expedited review under Common Rule requirements at 45 CFR 46.110 and 21 CFR 56.110 permit an IRB to use an expedited review procedure to review minor changes in previously approved research. A modification to a previously approved research protocol, which only involves the addition of an Authorization for the use or disclosure of PHI to the IRB-approved informed consent, may be reviewed by the IRB through an expedited review procedure, because this type of modification may be considered to be no more than a minor change to research. If expedited review procedures are appropriate for acting on the request, the review may be carried out by the IRB Chair or by one or more experienced reviewers designated by the Chair from among the IRB members. A member with a conflicting interest may not participate in an expedited review. If an IRB uses expedited review procedures, it must adopt methods for keeping all its members advised of all requests for waivers or alterations of the Authorization requirement as well as those requests that have been granted under an expedited review procedure. The Institution must maintain documentation of the IRB’s (acting as a Privacy Board) approval of the waiver/alteration of the HIPAA Authorization for at least six (6) years from the date the waiver/alteration was obtained.

**Research on Decedent Information.** The protections of the Common Rule apply to living human beings. By contrast, the HIPAA Privacy Rule also protects the IIHI of deceased persons ("Decedents") [see 45 CFR 164.512]. The Privacy Rule contains an exception to the Authorization requirement for Research that involves the PHI of Decedents. To the extent that research pertains to a deceased patient, the Covered Entity must obtain representations from the researcher that the PHI in fact belongs to a decedent, that the use or disclosure is solely for research, documentation of the patient’s death, and that the PHI is necessary for research purposes. The required attestations must be provided to the Covered Entity holding the PHI. If a
researcher is requesting decedent PHI from more than one covered entity; the researcher needs to file attestations with each in accordance with the entities’ procedures. To document these attestations for the Tulane University IRB (acting as the Privacy Board), researchers should submit the “Human Subjects Research Determination Form” in the IRB electronic submission system.

23.8.2 De-identified Data and Limited Data Sets

De-Identified Data. Tulane’s IRB may allow completely de-identified information to be Used and Disclosed for Research purposes without restriction. Information may be considered completely de-identified only when either: (1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; or (2) the information meets the safe harbor requirements by the removal of the following identifiers:

1. Names
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
4. Telephone numbers
5. Fax numbers
6. E-mail address
7. Social Security numbers
8. Medical Record numbers
9. Health Plan Beneficiary numbers
10. Account numbers
11. Certificate /License numbers
12. VIN and Serial #s, license plate numbers
13. Device identifiers, serial numbers
14. Web URLs
15. IP address numbers
16. Biometric identifiers (fingerprints)
17. Full face and any comparable photo images
18. Any other unique identifying number, characteristic, or code
A covered entity may assign a code or other means of record identification to allow information de-identified under this section to be re-identified by the covered entity, provided that: (A) The code or other means of record identification is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual; and (B) The covered entity does not use or disclose the code or other means of record identification for any other purpose, and does not disclose the mechanism for re-identification.

If Tulane’s IRB has any doubts as to whether protected health information has been completely de-identified within the meaning of this policy, the information should be treated as though it were not completely de-identified and neither used nor disclosed for research purposes unless it meets the criteria for another exception, such as the exception for a limited data set with a data use agreement discussed below.

A de-identified data set certification form must be completed submitted for administrative review and certified prior to accessing the data set. This activity also requires an IRB determined Exemption from review.

**Limited Data Sets with a Data Use Agreement.** When a Researcher does not need direct identifiers for a study but does require certain data elements that are not permitted in de-identified data, the Privacy Rule permits a Covered Entity to Disclose a Limited Data Set to the Researcher without Authorization or Waiver of Authorization, provided that the Researcher has signed a data use agreement through which the Researcher agrees to protect the privacy of the information received. [See 45 CFR §164.514(e)(1)]. The Limited Data Set is still considered to be PHI, but it must exclude only specified direct identifiers. The identifiers that must be removed from an individual’s protected health information in order to create a limited data set are as follows:

1. Names
2. Postal address info. (if other than city, state and zip)
3. Telephone and fax numbers
4. E-mail addresses
5. Social Security numbers
6. Medical record, prescription numbers
7. Health plan beneficiary numbers
8. Account numbers
9. Certificate/license numbers
10. Vin and serial numbers
11. license plate numbers
12. Device identifiers
13. Serial numbers
14. Web URLs
15. IP address numbers
16. Biometric identifiers (finger and voice prints)
17. Full face and comparable photo images

A covered entity may use protected health information to create a limited data set that meets these requirements, or disclose protected health information only to a business associate for such purpose, whether or not the limited data set is to be used by the covered entity.

HIPAA requires that a Data Use Agreement be used in conjunction with the disclosure of a Limited Data Set. The Data Use Agreement must contain provisions that:

1. Establish the permitted Uses and Disclosures of the Limited Data Set by the recipient, consistent with the purposes of the Research, and which may not include any Use or Disclosure that would violate the Rule if done by the Covered Entity;
2. Limit who can Use or receive the data; and
3. Require the recipient to agree to the following:
   4. Not to Use or Disclose the information other than as permitted by the data use agreement or as otherwise required by law;
   5. Use appropriate safeguards to prevent the Use or Disclosure of the information other than as provided for in the data use agreement;
   6. Report to the Covered Entity any Use or Disclosure of the information not provided for by the data use agreement of which the recipient becomes aware; Ensure that any agents, including a subcontractor, to whom the recipient provides the Limited Data Set agrees to the same restrictions and conditions that apply to the recipient with respect to the Limited Data Set; and
   7. Not to identify the information or contact the individual.

All requests for Data Use Agreements should be directed to the University Privacy Officer. Tulane’s standard Data Use Agreement form should be used for all outgoing transmission of limited data sets and de-identified data when appropriate.

23.8.3 Transition Provisions

The Privacy Rule contains certain grandfathering provisions that permit a Covered Entity to Use and Disclose PHI for Research after the Rule’s compliance date of April 14, 2003. [45 CFR §164.532]. If the Researcher obtained any one of the following prior to the compliance date:

7. An Authorization or other express legal permission from an individual to Use or Disclose PHI for the Research;
8. The Informed Consent of the individual to participate in the Research; or

Even if Informed Consent or other express legal permission was obtained prior to the compliance date, if new subjects are enrolled or existing subjects are re-consented after the compliance date, the Covered Entity must obtain the individual’s Authorization. For example, if there was a temporary waiver of Informed Consent for emergency Research under the FDA’s Human Subject protection regulations, and Informed Consent was later sought after the compliance date, individual Authorization must be sought at the same time.
The transition provisions apply to both Uses and Disclosures of PHI for specific Research Protocols and Uses or Disclosures to databases or repositories maintained for future Research.

23.8.4 HIPAA and Documentation Requirements

HIPAA documents include a HIPAA Authorization Form, a Waiver of HIPAA Authorization Form, and a De-Identification Form. One of these documents must be used whenever PHI is utilized in the Research. All of these documents must be retained for a minimum period of six (6) years under HIPAA. However, other document retention policies or research specific requirements may lengthen this retention period.

23.8.5 Patients’ Rights and Research

Under HIPAA, patients have certain rights. Those that may affect Research include the right to receive a Notice of Privacy Practices, the right to access, inspect, and receive a copy of one’s own PHI, the right to request an amendment to one’s own PHI, and the right to an accounting of certain disclosures of PHI that occur outside the scope of treatment, payment and health care operations that have not been authorized. Tulane’s Notice of Privacy Practices informs patients about these rights and provides guidance on how to exercise them. [see Tulane policy entitled “Notice of Privacy Practices” (GC-003)].
IRB Reliance

When engaged in multi-site research, research involving external collaborators, or research that is otherwise under the jurisdiction of more than one IRB, Tulane university acknowledges that each organization is responsible for safeguarding the rights and welfare of human subjects and for complying with applicable federal regulations. Tulane University may choose to review the research in its entirety, only those components of the research Tulane University is engaged in, rely on the review of another qualified IRB, or make other arrangements for avoiding duplication of effort. When Tulane University is the prime awardee on an HHS grant, it will ensure that at least one IRB reviews the research in its entirety.

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

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

Requests for the Tulane University to either rely upon an external IRB or to serve as the IRB of record for an external organization or investigator should be submitted as early as possible in the grant/contract process as per Section 25 of SOPs: Off-Site and Collaborative Research.

Tulane University has signed the SMART IRB joinder agreement. When the organizations participating in the research are signatories to the joinder agreement, IRB reliance may be requested and documented utilizing the SMART IRB or IRB Exchange (IREx) online reliance platform. In collaboration with the other participating organizations, Tulane University will determine on a study-by-study basis whether the SMART IRB SOPs or alternative procedures will be utilized to implement the reliance.

24.1 Tulane University Serving as Reviewing IRB

Generally, Tulane University IRB does not serve as the IRB of record for an external organization unless Tulane University is also engaged in the research or has a master agreement in place with the external organization. University Research Compliance Office evaluates the following factors, and others as appropriate, when considering a request for the Tulane University IRB to serve as the IRB of record for a particular study or studies:

1. The terms of the external organization’s FWA;
2. Prior experience with the organization and investigators;
3. The compliance history of the organization and investigators (e.g., outcomes of prior audits or inspections, corrective actions);
4. The research activities conducted by or at the external organization;
5. The willingness of the external organization to accept Tulane University’s reliance terms and procedures;
6. The ability of the organizations to collaboratively provide meaningful oversight of the proposed research, considering factors such as:
   a. The risks and procedures of the research;
   b. The resources available at each organization and ability to accommodate or collaborate with each other in observing the consent process, performing compliance reviews, investigations of potential noncompliance, and similar matters;
   c. The expertise and experience of the Tulane University IRB with the proposed research, subject population, and applicable regulations;
   d. The familiarity of the Tulane University IRB with the relevant local context considerations of the external organization; and/or
   e. The willingness or ability of the external organization to provide information and respond to questions regarding investigator qualifications, conflicts of interest, organizational requirements, local context, and other matters that may inform the IRB review.

When the Tulane University IRB serves as the reviewing IRB for another organization, all of Tulane’s documented policies and procedures apply unless an alternative procedure has been agreed to in the reliance agreement or outlined in a companion document. For example, alternative procedures may be used for any of the following:

1. Management and documentation of regulatory review, other ancillary reviews, and institutional permissions for research;
2. Training requirements and verification of qualifications and credentials for external investigators and staff;
3. For-cause and not-for-cause compliance reviews;
4. The disclosure and management of conflicts of interest. In all cases, any Conflicts of Interest (CIs) and Conflict Management Plans (CMPs) identified and developed by the relying organization will be communicated to the reviewing IRB. The reviewing IRB will determine the acceptability of the plan in accordance with their policies and procedures.
5. Review and management of matters such as site-specific consent language, HIPAA (e.g., authorizations, waivers, alterations), noncompliance, unanticipated problems, and federal reports;
6. Ensuring concordance between any applicable grant and the IRB application/protocol.
7. Procedures for and type of IRB review (e.g., expedited, convened) of additional sites after the research protocol is IRB-approved;
8. Procedures for submission and review of interim reports and continuing review materials; and/or
9. The communication of IRB determinations and other information to external investigators and organizations.
24.2 External IRB Review of Tulane University Research

All non-exempt human subject research that Tulane University is engaged in must be reviewed and approved by the Tulane University IRB or an external IRB that Tulane University has agreed to rely upon prior to the initiation of the research. Tulane University has standing agreements in place to engage the services of external IRBs for the review of specific categories of research including but not limited to:

- NCI’s Adult CIRB for NCI research involving adult subjects
- NCI’s Pediatric CIRB for NCI research involving children

Research that falls within the above parameters must be registered with Tulane University after submission to the external IRB following the procedures outlined in Section 1.2.1. Post-approval requirements are summarized in Section 1.2.2.

Tulane University may also choose to enter into an agreement to rely upon other external IRBs, most commonly when required as a condition of a grant or contract. Investigators should submit reliance requests as early in the grant/contract process as possible as described in Section 25 of SOPs: Off-Site and Collaborative Research.

University Research Compliance Office evaluates the following factors, and others as appropriate, when considering a request to rely upon an external IRB:

1. The accreditation status of the proposed IRB;
2. Registration with SMART IRB;
3. The compliance history of the IRB (e.g., outcomes of prior audits or inspections, corrective actions);
4. Prior experience with the IRB;
5. The federal IRB registration and organizational FWA, as applicable;
6. The expertise and experience of the proposed IRB (e.g., with reviewing the type of research, research procedures, and subject population(s));
7. The research activities that will be conducted at or by Tulane University;
8. The risks and complexities of the proposed research;
9. The proposed reliance terms and procedures including the procedures for collaborative management of matters such as conflicts of interest, noncompliance, unanticipated problems, and federal reports;
10. The plan for review and allowance of the incorporation of site-specific consent language; and
11. The plan for incorporation of other relevant local requirements or context information in the review process.

When reliance on a non-accredited IRB is proposed, the evaluation may also take into consideration one or more of the following based upon the risks of the research, the research activities that Tulane University will be involved in, and Tulane University’s familiarity with the IRB:

1. When the research is minimal risk (or the activities that Tulane University is involved with are minimal risk), a statement of assurance from the proposed IRB that its review will be consistent with applicable ethical and regulatory standards, and that it will report any
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regulatory investigations, citations, or actions taken regarding the reviewing IRB, and, when applicable, to the organization’s FWA;

2. An attestation about, or summary of, any quality assessment of the reviewing IRB such as evaluation by an external consultant or internal evaluation of compliance using the FDA’s self-evaluation checklist or AAHRPP’s self-evaluation instrument;

3. The willingness of the external IRB to accommodate requests for relevant minutes and other records of the proposed study and/or to copy Tulane University’s HRPO office on correspondence such as determination letters and notices of suspensions or terminations of IRB approval;

4. The willingness of the external IRB to accommodate a request for someone from the relying organization to serve as a consultant to the IRB or to observe the review of the proposed study; and/or

5. An assessment of the external IRB’s policies and procedures.

The external IRBs that serve as the IRB of record for Tulane University research have the same authority as the Tulane University IRB and all determinations and requirements of the external IRBs are equally binding. Investigators must be familiar with and comply with the external IRB’s policies and procedures and any additional requirements or procedures outlined in the IRB reliance agreement or companion materials (e.g., reliance SOPs). Tulane University will support compliance with the terms of reliance agreements by providing investigators with information relevant to their responsibilities, such as a copy or summary of the agreement, an information sheet, or reliance SOPs.

Regardless of which IRB is designated to review a research project, Tulane University is responsible for the conduct of the research in which it engages. Research reviewed by external IRBs remains subject to review and oversight by Tulane University and must adhere to all applicable policies, procedures, and requirements, including those of the Tulane University HRPO.

24.2.1 Registration of Studies Reviewed by External IRBs

Investigators must register studies that will be reviewed by an external IRB by submitting basic information about the research to the HRPO as described in Section 25 of SOPs: Off-Site and Collaborative Research. The HRPO staff will review the information and verify that CITI training, COI review, and any other applicable approvals or requirements have been completed and determine the need for relaying local context information to the reviewing IRB in accordance with the reliance agreement. The HRPO staff will forward requests for waiver or alteration of HIPAA authorization and any relevant materials to the internal IRB Chair or a designated expedited reviewer for review. The HRPO staff will notify the investigators once the proposed research has been cleared for submission to the external IRB as described in Section 25 of SOPs: Off-Site and Collaborative Research. Once approved by the external IRB, investigators must submit a copy of the approval notice and any approved consent document(s) to the HRPO as described in Section 25 of SOPs: Off-Site and Collaborative Research.

24.2.2 Post-Approval Requirements

Investigators approved through external IRB review must still report local unanticipated problems, complaints, and any serious or continuing noncompliance to the Tulane University HRPO via an Event Reports form in the IRB Electronic System in addition to reporting to the external IRB. Copies of the report submitted to the external IRB are generally acceptable, but additional
Changes in PI and the addition of other research team members must be submitted to the HRPO as an amendment in the IRB Electronic System prior to the new PI or research team member assuming any study responsibilities. The HRPO must verify CITI training, COI review, and any other applicable requirements.

Notices about and reports from external monitors, auditors, or inspectors must be provided to the HRPO as described in Section 25 of SOPs: Off-Site and Collaborative Research. Investigators are reminded that other Tulane University reporting requirements, such as to Compliance, Privacy, and Risk Management, remain applicable in addition to HRPO reporting requirements.

### 24.3 NIH Single IRB (sIRB) for Multi-Site Research

Effective January 25, 2018, the National Institutes of Health (NIH) released a final policy requiring domestic awardees and domestic sites of NIH-funded multi-site research to use a single IRB (sIRB) for review of non-exempt human subject research unless there is justification for an exception. This policy is intended to streamline the IRB review process and reduce inefficiencies and redundancies while maintaining and enhancing subject protections. The policy does not apply to career development, research training, or fellowship awards, nor to sites that are not conducting the same protocol as the other sites (e.g., sites providing statistical support or laboratory analysis only) or to foreign sites.

Exceptions to the policy are automatic when local IRB review is required by federal, tribal, or state law/regulation/policy and when the proposed research is the “child” of a grant that predates the requirement for sIRB review. Such exceptions and the basis (and information regarding the “parent” study, when applicable) should be cited in the proposed sIRB plan and, when the exception is based on law/regulation/policy, apply only to the site(s) to which the law/regulation/policy applies. Other exceptions will be considered when there is compelling justification. The site(s) and justification for why the site(s) cannot rely on the single IRB of record should be included in the proposed sIRB plan. The NIH will consider the exception request and inform the applicant of the outcome.

#### 24.3.1 Selection and Designation of a sIRB

Tulane University’s investigators submitting applications for NIH-funded multi-site research must describe the sIRB plan in the funding proposal (grant application or contract proposal), and, if applicable, may request direct cost funding to cover additional costs related to the requirements of the NIH policy. The sIRB can be the IRB at one of the participating sites or an independent, fee-based IRB. When the sIRB is named in the proposal, the IRB must have agreed to take on this responsibility in advance. Requests for the Tulane University’s IRB to serve as the sIRB should
be directed to the HRPO. The IRB Education and Compliance Coordinator and IRB Compliance Advisor will consult with others within the organization as needed and make a recommendation to the IO for consideration. Requests for Tulane University to rely upon an external IRB as the sIRB should be submitted as early in the process as possible as described in Section 25 of SOPs: Off-Site and Collaborative Research.

### 24.3.2 Reliance Agreements for sIRB Studies

A Reliance Agreement (or “Authorization Agreement”) between the sIRB and the participating sites is required. The Reliance Agreement documents the respective authorities, roles, responsibilities, and communication between an organization providing the ethical review and a participating organization relying on a reviewing IRB.

Reliance Agreements should describe the responsibilities of all parties and how communication between parties will occur, for example, notifications of the outcome of regulatory review and management of federally-mandated reports such as reports of unanticipated problems, serious or continuing noncompliance, and suspensions or terminations of IRB approval. When IRB certification requirements apply (e.g., for NIH Genomic Data Sharing), the agreement or written procedures should indicate who is responsible for meeting the certification requirements.

The agreement or written procedures should also specify points of contact and contact information for the sIRB and relying institution(s).

The institution that is awarded the funding for the research is responsible for maintaining all agreements and for ensuring that adequate and appropriate communication channels between the sIRB and participating sites are in place. Participating sites are responsible for maintaining copies of the site agreement in accordance with the terms of their FWA.

### 24.3.3 Responsibilities

The sIRB will be responsible for compliance with the regulatory requirements for IRBs specified in the federal regulations (i.e., 45 CFR 46 and other applicable regulations) and for any other responsibilities outlined in the reliance agreement and/or procedures. Participating sites (Relying institutions) are responsible for providing relevant local context information to the sIRB, ensuring that the research is conducted in accordance with applicable regulations and the determinations and requirements of the sIRB, and for other responsibilities, as outlined in the reliance agreement and/or procedures.

When an external IRB serves as the sIRB for a study Tulane University is engaged in, investigators must register the study with Tulane University after submission to the external IRB following the procedures outlined in Section 24.2.1. Post-approval requirements are summarized in Section 24.2.2.

Research reviewed by external IRBs remains subject to review, approval, and oversight by Tulane University and must adhere to all applicable policies, procedures, and requirements, including those of the Tulane University HRPO.
25 Off-Site and Collaborative Research

25.1 Background

Researchers at Tulane frequently interact with entities or individuals outside the Institution in furtherance of their Human Subjects Research. The University (and its Researchers) regulatory obligations and alternatives for addressing them differ depending on the relationship with the entity or individuals outside the University. Each engaged institution is responsible for safeguarding the rights and welfare of Human Subjects and for complying with applicable laws and regulations (including the Common Rule, as appropriate) and with its own human research protection program policies and procedures.

This policy ensures that the University can fulfill its affirmative obligation to assure appropriate oversight of Research.

AAHRPP Standards for Accreditation (Standards I-2 and I-3)

25.2 Definitions

Cooperative Research: is defined as Research conducted in cooperation with and at a performance site of an institution or facility that is not owned or operated by Tulane or TUHC or that does not fall under Tulane IRB’s authority;

Off-Site Research (or “Non-Tulane Site,” “Off-Site Institution” or “Off-Site Facility” or “Off-Site Location”): Human Subjects Research conducted under the auspices of Tulane’s IRB at performance sites that are not owned or operated by Tulane University or TUHC;

NCI CIRB: The NCI CIRB provides a "facilitated review" process that can streamline local IRB reviews of adult and pediatric national multi-center cancer treatment trials;

IREx: The University is a participant in the IREx initiative. The IREx initiative is a shared IRB review model for multi-center collaborating studies that allow institutions to share IRB reviews conducted by other member institutions, consider reliance on other IRBs, and focus the local IRB review on issues of local context. This process is designed to streamline the time for initial study start-up and to encourage collaboration among IRBs and institutions.13

Single IRB (sIRB): One IRB of record(or Reviewing IRB), selected on a study-by-study basis, which the regulatory and ethical review for all sites participating in a specific multi-site study

25.3 Types of Collaborations

The University researchers participate in a broad range of collaborative relationships with other Investigators and Institutions. They include:

“On-Site Research” (or “Tulane Site”): Human Subjects Research conducted under the auspices of Tulane’s IRB at performance sites that are owned or operated by Tulane University or TUHC;

Other U.S.-based academic institutions: most if not all, academic institutions within the U.S., if they receive Federal funding, will have already obtained assurance of compliance through the

13 Collaborative Initiatives such as Smart IRB represent a new and evolving area in Human Subject Research Protections for collaborative, multi-site research. The Tulane HRPP recognizes that its policies and procedures regarding collaborative research may change as best practices and further sponsor requirements emerge.
FWA program. Investigators need to ensure that they or their collaborators meet the respective IRB-review requirements;

**U.S.-based, non-academic hospitals, clinics, and practices:** Hospitals, clinics, and practices that are not affiliated with academic medical centers may not already have in place the IRB and FWA programs necessary for Federally funded Research to take place. If Investigators are committed to working in these settings, they may be faced with finding a local IRB to review the study and with guiding the organization’s pursuit of assurance of compliance through the FWA program;

**International entities and Researchers:** Researchers who wish to conduct Human Subjects Research in countries outside the U.S. or its territories generally must obtain approval from the host country’s ethics committee and from Tulane’s IRB.

### 25.4 Off-site Research

Off-site Research is Research conducted by Tulane PIs at non-Tulane facilities.

1. **Engaged or Not Engaged.** The Tulane PI is to determine whether the off-site facility is Engaged in Human Subjects Research. See **Section 1.9, “Research under the Auspices of the Institution and Engagement”** and **Section 6, “Human Subjects Research and Engagement Determination.”**
   
   a. **Where the off-site facility is Not Engaged:**
   
      i. The PI is to submit a Letter of Support for each off-site facility included in the research.
   
      ii. Before the IRB will provide final approval of a Study, it will require a Letter of Support from all off-site facilities where any Study activity may occur. Such letters should simply acknowledge that the institution knows about the planned Research and deems it acceptable for the Study (under the direction of the named PI) to take place on their premises with their subject population, etc. This letter should be on official letterhead, should contain relevant contact information, and must state: the names of the Study PI and each Investigator to conduct research at the particular site; the research activity to take place; the study title; and the signature of a qualified representative/authority of that site.

2. **In addition, all Research performed at a school must have a letter of support issued by the school and signed by an authorized school administrator.** The letter should be on official letterhead and contain relevant contact information.
   
   a. The Study will then be reviewed by Tulane’s IRB as per the applicable review process (i.e., Exempt Studies, Expedited Review, Convened IRB Review).
   
   b. Where the off-site facility is Engaged in Research, an IRB Authorization Agreement (IAA) executed between Tulane and each off-site facility that provides for which IRB will provide oversight for the Study. See Section below, “Collaborative Research” for the process for obtaining an IRB Authorization Agreement.
25.5 Collaborative Research

In a Collaborative Research study, a Tulane PI collaborates with investigator(s) at another institution(s) in conducting Human Subjects Research. In such situations, Tulane and the collaborating institution(s) are considered Engaged in Research See Section 1.9, “Research under the Auspices of the Institution and Engagement” and Section 6, “Human Subjects Research and Engagement Determination.”

For Collaborative Research, each Engaged Institution is responsible for safeguarding the rights and welfare of Human Subjects and for complying with applicable Federal Regulations. This can be accomplished through one of the following:

1. A joint IRB review arrangement;
2. Use of a Single Institutional Review Board;
3. Use of Smart IRB and IREx;
4. Entering into an IRB Authorization Agreement (IAA) that provides for which IRB will provide oversight for the study;
5. A similar arrangement for avoiding duplication of effort while ensuring human subjects protections.¹⁴

Such arrangements or agreements must be formalized before the Collaborative Research can begin.

25.5.1 Joint IRB reviews of Collaborative Research

For Joint IRB reviews of Collaborative Research, the Investigator must identify all institutions participating in the Research, the responsible IRB(s), and the procedures for dissemination of study information (IRB initial and continuing approvals, relevant reports of unanticipated problems, study modifications, and interim reports) between all participating Institutions.

When the University’s IRB reviews Research conducted in whole or in part at another Institution, the particular characteristics of each Institution’s local Research context must be considered, either (i) through knowledge of its local Research context by the IRB or (ii) through subsequent review by appropriate designated Institutional Officials, such as the Chair and/or other IRB members.

If the University is the coordinating facility the Investigator must document how the conduct of the Research plan and the protection of Human Subjects will be communicated to and among the other participating facilities engaged in the Research Study. The Investigator is responsible for serving as the Liaison with regulatory and funding agencies, with other participating facilities, and for all aspects of internal review and oversight procedures. The Investigator is responsible for ensuring that all participating facilities obtain review and approval from their IRB of Record and adopt all Research plan modifications in a timely fashion. The Investigator is responsible for ensuring that the Research study is reviewed and approved by any other appropriate committees at the coordinating facility ad at the participating facilities prior to enrollment at participants.

¹⁴ Collaborative Initiatives such as Smart IRB represent a new and evolving area in Human Subject Research Protections for collaborative, multi-site research. The Tulane HRPP recognizes that its policies and procedures regarding Collaborative Research may change as best practices and further sponsor requirements emerge.
The Investigator must follow these procedures when the University is the coordinating facility:

- During the initial submission of a multi-site study where the University is the coordinating facility, the Principal Investigator must indicate this in the cover letter and submit the following information in the IRB application materials:
  - A determination as to whether or not the Research activities at participating Institutions meet the definition of “Engagement”
  - Name of participating Institution
  - The FWA number and expiration date for each participating Institution
  - The contact name and information for Investigator(s) at each participating Institution
  - The contact name and information for IRB of Record at each participating Institution
  - A description of the method that will be used by the PI to ensure that all participating Institutions have the most current version of the Research Plan.
  - A description of the method for continuation that all modifications to the Research Plan are communicated to participating sites
  - A description of the process for the communication of any Serious Adverse Events and Unanticipated Problems Involving Risks to Subjects or Others
  - A description of the process of regular communication about study events
  - A description of the monitoring plan for monitoring the conduct of Research at participating Institutions, where appropriate.

- The Investigator submits an approval letter for each site from the individual site’s IRB of Record upon receipt. Following approval from the University, Research activities may commence at each site unless the University’s IRB has determined otherwise.

- The Investigator maintains documentation of all correspondence between participating sites and their IRB of Record.

When the Investigator is the lead Investigator of a multi-site study, the IRB evaluates whether the management of information that is relevant to the protection of subjects is adequate.

When the University is engaged in only part of a cooperative Research project, the University IRB only needs to approve the part(s) of the Research in which the Institution Investigator is engaged. For example, if the University is operating the statistical center for a multi-center trial that receives identifiable private information from multiple other institutions, the University IRB reviews and approves the Research activities related to the receipt and processing of the identifiable private information by the statistical center.
25.6 Use of Smart IRB and IRB Exchange (IREx)

The University is a participant in the Smart IRB and IRB Reliance Exchange (IREx) initiatives. SMART IRB is not an IRB; rather, it is a platform that offers a master IRB reliance agreement (the SMART IRB Agreement) and a web-based system (SMART IRB's Online Reliance System) that provides a central process for participating institutions and their investigators to request, track, and document study-specific reliance arrangements. Investigators and their study teams, together with institutional and HRPP/IRB offices, use the SMART IRB platform to initiate single IRB review of a study. SMART IRB may be used for any study that is eligible for IRB reliance, regardless of funding source or status.

IREx is a shared IRB review model and web-based portal that allows institutions to share IRB reviews conducted by Tulane or other member institutions and focus the local IRB review on issues of local context. These processes together, are designed to streamline the time for initial study start-up and to encourage collaboration among IRBs and institutions.15

Investigator’s interested in utilizing the Smart IRB and IREx initiatives for single IRB review must first request, track, and document the reliance via Smart IRB (smartirb.org). Investigators or their study teams should complete the Initial Application for Human Subjects Research in IRBManager and select ‘Facilitated Review’ under ‘Research Review Classification.’ When prompted, the Investigator should select Smart IRB/IREx as the reliance type. Additional guidance for use of these initiatives may be found at https://smartirb.org/ and https://www.irbexchange.org/.

25.7 IRB Authorization Agreements (IAA) (also known as Reliance Agreements)

25.7.1 IAA Deferring to (Relying on) Tulane’s IRB

When a non-Tulane entity relies on (or defers to) Tulane’s IRB is responsible to review, approve, and provide continuing oversight of Collaborative Research. These circumstances may include but are not limited to the following:

1. Research conducted at a non-Tulane affiliated site where the lead PI on the study overall is a Tulane PI.

2. Collaborative research where the lead PI is a Tulane PI and involving co-Investigators or others Engaged in Research who are affiliated with a non-Tulane affiliated site.

3. Research where, due to the specific nature of the research, the Tulane IRB is in the best position to provide IRB review and oversight for the study, e.g., local context considerations, IRB member expertise, etc.

4. Research where the sponsor requires use of a single IRB for multi-site Research, for example, NIH Policy of the Use of a Single Institutional Review Board for Multi-Site

15 Collaborative Initiative such as Smart IRB represent a new and evolving area in Human Subject Research Protections for collaborative, multi-site research. The Tulane HRPP recognizes that its policies and procedures regarding collaborative research may change as best practices and further sponsor requirements emerge.
When Tulane’s IRB conducts research reviews for a non-Tulane affiliated site, as appropriate to the agreement and in accordance with its standard policies and procedures for research review and oversight, the IRB ensures sufficient knowledge of local research context for the off-site location as detailed in Section 25.11, “IRB Knowledge of the Local Research Context.” It is the responsibility of the Tulane PI to provide the Tulane IRB with the applicable local context considerations for the study at issue.

The IO, in consultation with the RCO, HRPO and, if appropriate, Tulane Office of General Counsel, makes the final determination whether Tulane’s IRB will serve as the relied-upon IRB for another institution. Such factors that may be considered include:

1. Whether the Off-Site Facility has an OHRP-approved FWA
2. Whether the Off-Site Facility is AAHRPP accredited, if applicable, in order to ensure that all Engaged Institutions meet AAHRPP accreditation standards to ensure protection of the rights and welfare of Subjects
3. The ability to comply with the requirements for Knowledge of the Local Research Context at the Off-Site facility and any Research sites
4. The ability and willingness of those Engaged in Research to provide the Tulane IRB with the applicable local context considerations for the study at issue
5. The resources, ability, and willingness of the Off-Site Facility, the PI, the collaborating Off-Site Investigator(s), and the Research sites to handle complaints, review adverse events, and monitor compliance with applicable laws, regulations, and IRB requirements
6. The ability to comply with any additional requirements the Off-Site Facility may impose on Tulane IRB’s review
7. The ability and willingness of the Off-Site Facility to comply with requirements of the Tulane IRB
8. Compliance status and/or compliance history of the Tulane PI and/or lead PI at the Off-Site Facility
9. Compliance status and/or compliance history of the Off-Site Facility (including any OHRP and/or FDA compliance determinations as to the Off-Site Facility)
10. Compliance with the Tulane COI Policy and Tulane ICOI Policy


1. Submit a request via IRB Electronic System by starting the Initial Application for Human Subjects Research and select any option other than

NIH Policy on Use of a Single IRB for Multi-Site Research and industry trends towards use of a single IRB for collaborative multi-site Research represent a new and evolving area in Human Subject Research Protections. The Tulane HRPP recognizes that its policies and procedures regarding collaborative research may change as best practices and further sponsor requirements emerge.
‘Facilitated Review’ under the ‘Research Review Classification’ header. The Tulane Investigator will be required to complete an entire application when the Tulane PI is the Lead Investigator.

a. Clear all COI requirements and other required university approvals (SPA, IRB, Radiation Safety, Scientific Review Committee, etc.).

b. Assure that the External IRB wishing to rely on the Tulane IRB is AAHRPP accredited by visiting [http://www.aahrpp.org/learn/find-an-accredited-organization](http://www.aahrpp.org/learn/find-an-accredited-organization).

2. The Tulane PI must provide the following documents as part of the Tulane IRB submission:

a. Required HSR training certifications such as CITI, etc. (See Section 3 for training requirements).

b. All study related communications issued by the Off-Site Facility IRB. Such documents include but are not limited to: Acknowledgement Determination and reports resulting from Unanticipated Problems Involving Risks to Subjects or Others, complaints, and serious or continuing non-compliance at the Off-Site Facility site. The PI is responsible for submitting such documents to the Tulane IRB on an ongoing basis.


d. Completed and signed Individual Investigator Agreements.

e. For industry-sponsored research, Investigators must pay the appropriate fees ([https://research.tulane.edu/hrpo/irbfees](https://research.tulane.edu/hrpo/irbfees)) by completing and submitting an Interdepartmental Transfer (“IT”) to the HRPO for IRB review.

3. Failure to ensure full execution of an IRB Authorization Agreement and/or Individual Investigator Agreement could lead to the Tulane IRB not agreeing to provide IRB review and oversight for the study.

4. The Tulane PI must ensure that Research activity does not begin at the Tulane site until the Tulane IRB has issued full approval of the research and Research activity does not begin at the Off-Site Facility until the Off-Site Facility IRB has issued an “Acknowledgment” of the Off-Site Facility PI’s submission to the Off-Site Facility IRB, deferring IRB review to the Tulane IRB.

5. Ongoing requirements of the Tulane PI for submission to the Tulane IRB when providing oversight to an Off-Site Facility PI:

a. Submission of the ‘Secondary Application for Human Subjects Research’ to the Tulane IRB. The Tulane PI will be required to complete an entire Continuing Review or Amendment application when the Tulane PI is the Lead
Investigator.

b. Submission of Continuing Review Applications to the Tulane IRB and Continuing Review Acknowledgements issued by the Off-Site Facility IRB.

c. Submission of Amendment Applications to the Tulane IRB and associated Determinations issued by the Off-Site Facility IRB.

d. Unanticipated Problems Involving Risks to Subjects or Others, complaints, and serious or continuing non-compliance, and all associated reports and communications for all subjects enrolled through Tulane and the Off-Site Facility IRB.

6. The Tulane PI must ensure that Research activity does not continue at the Tulane site until the Tulane IRB has issued full approval of the research and that Research activity does not continue at the Off-Site Facility until the Off-Site Facility IRB has issued an “Acknowledgment” of the submission to the Off-Site Facility IRB.

7. Submit the Study Closure Form to the Tulane IRB at conclusion of the study and associated Acknowledgment from the Off-Site Facility IRB.

25.8 IAA where Tulane defers to/relies upon a Collaborator’s IRB

1. In some circumstances, Tulane may agree to defer responsibility for IRB review to a non-Tulane Collaborator’s IRB. In instances where Tulane agrees to defer IRB review, the non-Tulane IRB that performs the review and oversight of the study is the “Reviewing IRB” or the “IRB of Record.” However, even when Tulane defers to a Collaborator’s IRB, Tulane remains responsible for protection of Human Subjects for Research conducted Under the Auspices of the Institution.

2. The IO, in consultation with the IRB Compliance and Education Coordinator and IRB Compliance Advisor and, if appropriate, Tulane Office of General Counsel, make the final determination whether Tulane’s IRB will serve as the relied-upon IRB for another institution. Such factors that may be considered include:

   a. The funding agency requires it, for example, NIH Policy of the Use of a Single Institutional Review board for Multi-Site Research (available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-16-094.html)¹⁷

   b. The Tulane Engagement in Research is limited (e.g., data analysis only)

   c. The Research began at another institution prior to employment of the Investigator at Tulane and remains active at the other institution (and any funds supporting the Research remain under the control of the non-Tulane institution)

¹⁷ NIH Policy on Use of a Single IRB for Multi-Site Research and industry trends towards use of a single IRB for collaborative multi-site Research represent a new and evolving area in Human Subject Research Protections. The Tulane HRPP recognizes that its policies and procedures regarding collaborative research may change as best practices and further sponsor requirements emerge.
d. Whether the non-Tulane institution and the IRB of record for the study are AAHRPP accredited in order to ensure that all Engaged Institutions meet AAHRPP accreditation standards to ensure protection of the rights and welfare of Subjects

e. The expertise required to provide IRB review and oversight for the study

f. The ability to comply with the requirements for Knowledge of the Local Research Context for the study

g. The resources, ability, and willingness of the Reviewing IRB, the PI, the collaborating Off-Site Investigator(s) to handle complaints, review Unanticipated Problems Involving Risks to Subjects or Others, monitor compliance with applicable laws, regulations, and IRB requirements, review and report (as applicable) determinations of Serious Noncompliance and/or Serious Noncompliance, Suspensions, and/or Terminations

h. Compliance status and/or compliance history of the Tulane PI and/or lead PI at the Off-Site Facility

i. Compliance status and/or compliance history of the Off-Site Facility (including any OHRP and/or FDA compliance determinations as to the Off-Site Facility)

j. Compliance with the Tulane COI Policy and Tulane ICOI Policy

3. The following are required in order for Tulane to agree to defer review and continuing oversight of its human subjects research to a non-Tulane entity:

   a. The non-Tulane Collaborating institution must have an approved FWA

   b. The Reviewing IRB must be AAHRPP Accredited

   c. For Industry-sponsored research, Investigators must pay the appropriate fees by completing and submitting an Interdepartmental Transfer (“IT”) to the HRPO for IRB review.

   d. The Tulane PI must ensure that Research activity does not begin at the Tulane site until the Reviewing IRB has issued full approval of the research and the Tulane IRB has issued and “Acknowledgment” of the PI’s submission to the Tulane IRB to defer IRB review to a Reviewing IRB.

25.9 Procedures for Requesting a Facilitated Review where Tulane defers to/reliescupon an External IRB

1. Submit a request via the IRB Electronic System by starting the Initial Application for Human Subjects Research and select ‘Facilitated Review’ under the ‘Research Review Classification’ header.

   a. Clear all COI requirements and other required university approvals (SPA, IRB, Radiation Safety, etc.).
2. The Tulane PI must then seek approval from the External IRB.

3. The Tulane PI must provide the following documents as part of the ‘Facilitated Review’ submission to the Tulane IRB:
   
   a. Required HSR training certifications such as CITI, etc. (See Section 3 for training requirements).
   b. Completed and signed Institutional Authorization Agreement(s) or selection of SMART IRB/IREx or other Master Reliance Agreement.
   c. Completed and signed Individual Investigator Agreements.
   
   d. Draft Informed Consent document
   
   e. HIPAA Authorization Form, and/or requests for Waivers of HIPAA Authorization via the Initial Application for Human Subjects Research, in accordance with the executed reliance agreement.
   
   f. Emergency/Evacuation Card for greater than minimal risk research studies.
   
   g. For industry-sponsored research, Investigators must pay the appropriate fees (https://research.tulane.edu/hrpo/irbfees) by completing and submitting an Interdepartmental Transfer (“IT”) to the HRPO for IRB review.

4. Failure to ensure full execution of an IRB Authorization Agreement and/or Individual Investigator Agreement could lead to the Tulane IRB not agreeing to provide IRB review and oversight for the study.

5. The Tulane PI must ensure that Research activity does not begin at the Tulane site until:
   
   a. The External IRB has issued full approval of the research and the Approval letter has been submitted to the Tulane IRB.
   
   b. The Tulane IRB has issued an “Acknowledgment” determination of the PI’s request to defer IRB review to an External IRB.
   
   c. The Tulane IRB has issued an “Approval” determination for: all research privacy related matters (e.g., collection of PHI or other privacy related information, use of a HIPAA Authorization Form, and/or Waivers for HIPAA Authorization, in accordance with the executed reliance agreement) and engagement of local research personnel.

6. Ongoing requirements of the Tulane PI for submission to the Tulane IRB when utilizing an External IRB:
   
   a. Submission of the Secondary Application for Human Subjects Research to the Tulane IRB for modifications related to: the collection of PHI or other...
privacy related information; the HIPAA Authorization Form and/or Waivers for HIPAA Authorization, in accordance with the executed reliance agreement; subject injury language in the consent form(s); and/or the Emergency/Evacuation Cards.

b. Annual submission of the Secondary Application for Human Subjects Research to the Tulane IRB for COI review and research status assessment. The annual submission must include a copy of the Continuing Review Approval letter from the External IRB.

c. Submission of the Personnel Change Only application for non-PI related local study team personnel changes.

• Submission of the Secondary Application for Human Subjects Research for local PI changes, along with all updated corresponding documents (See Section 25.9.3)

d. Submission of Unanticipated Problems Involving Risks to Subjects or Others, complaints, non-compliance, serious or continuing non-compliance, and all associated reports and communications for all subjects enrolled through Tulane, as agreed to in the reliance agreement.

e. Submission of the Correspondence Submission application for any documents outside of the Continuing Review or Amendment submissions, in which the External IRB requires TU IRB review and Acknowledgement.

7. The Tulane PI must ensure that Research activity does not continue at the Tulane site until the External IRB has issued full approval of the research and the Tulane IRB has issued an “Approval” determination for any affected items in 6a above.

8. Submit the Study Closure Form at conclusion of the study.

25.10 Extension of FWA/Assurance

In some limited cases, the University’s FWA can cover independent Investigators who are not an affiliated with the University but only in accordance with a formal written agreement of commitment to relevant Human Subject protection policies and IRB oversight. The institutions may formalize such agreements under an Independent Investigator Agreement signed by both the Tulane PI and the unaffiliated Investigator, and/or or by a commitment agreement developed by the institutions. The institution entering into the commitment agreement maintains the agreements on file and submits copies to OHRP upon request. The RCO (in conjunction with the HRPO, General Counsel, and/or other, as applicable) can assist PIs with this process.

25.11 IRB Knowledge of Local Research Context

1. In accordance with OHRP guidance, when Tulane IRB serves as the relied-upon IRB for another institution pursuant to an IRB Authorization Agreement or when the Research involves distinct subject populations (non-English speaking populations, veterans, etc.), Tulane’s IRB must ensure that it possesses or obtains sufficient knowledge of the local research context even when the IRB is geographically removed from the off-site research location. These same responsibilities apply to the Reviewing IRB when Tulane defers IRB review and oversight to a non-Tulane IRB pursuant to an IRB Authorization Agreement.

2. The PI supports the IRB reviewing the study in understanding the local research context by submitting to the IRB as part of obtaining IRB approval for the study the necessary information, as appropriate, on:
• The anticipated scope of the Off-Site Facility’s Research activities;
• The types of subject populations likely to be involved;
• The size and complexity of the institution;
• Institutional commitments and regulations;
• Applicable law (state, local, in-country);
• Standards of professional conduct and practice;
• Method for equitable selection of subjects;
• Method for protection of privacy of subjects;
• Method for maintenance of confidentiality of data;
• Languages understood by prospective subjects;
• Method for minimizing the possibility of coercion or undue influence in seeking consent;
• Safeguards to protect the rights and welfare of vulnerable subjects.

3. In cases where Tulane’s IRB conducts non-local review, members must have sufficient knowledge of the community from which the subjects are drawn to ensure protection of subject rights and appropriateness of the consent process for the subject population. In addition, the IRB must be sensitive to community laws and norms. The IRB may ensure the necessary expertise and knowledge to make appropriate determinations regarding the local research context through one or more of the following activities, as appropriate to the level of risk and in accordance with OHRP guidance and FDA regulation:

• Personal knowledge of the local research context on the part of one or more IRB members, such knowledge obtained through extended direct experience with the research institution, its subject populations, and its surrounding community;

• Review of the proposed Research by representatives from the non-Tulane facility or by one or more ad hoc or cultural consultants with knowledge of the local research context. Ad hoc or cultural consultants may provide comments or recommendations in writing to the IRB prior to the meeting or attend the convened meeting to participate in the review, either physically or through audiovisual or telephone conference, when participation is deemed warranted by the consultant(s) or any one member of the IRB;

• Systematic reciprocal documented interchange between the IRB and elements of the local research context, for example: (1) periodic visits to the research site by one or more IRB members/HRPO staff or University representatives in order to obtain and maintain knowledge of the local research context; (2) periodic discussion with appropriate consultants knowledgeable about the local research context; (3) interaction with one or more designated institutional liaisons; and/or (4) review of relevant written materials;

• Appointment of an IRB member from the community in question.

4. The primary reviewer (or expedited reviewers) should identify the need for consultation with respect to local context considerations. Additionally, a request may be made to the IRB Chair to appoint a consultant in the following instances:
• By IRB members whenever the member determines the assigned Protocol requires expertise in a special area in which he/she is unable to review a Protocol adequately;
• By the IRB when it decides during its review that a consultant is needed to assist in the review of a Protocol; and/or
• By the IRB Chair

5. The IRB chair (or designee) shall assess whether the local context review is satisfied. See Section 2.8 for specifics with respect to use of consultants.

6. HRPO staff assists the PI in addressing the requirements for information on the local research context upon request.

7. HRPO staff assists the IRB in identifying appropriate consultants and distributing appropriate review materials pertaining to the local research context to IRB members, as appropriate.
8. HRPO staff maintains documentation in the database and the study file of the local research context and the measures taken to ensure sufficient IRB knowledge of that context.

9. In the minutes of the meeting or in the IRB file, HRPO staff or the IRB reviewer documents the procedures used to ensure that the IRB adequately considered community attitudes.
26  International Research

In addition to the usual requirements for Research involving Human Subjects, some unique issues are particularly vital for IRB review to protect Human Subjects in international populations.

The IRB reviews international research utilizing Human Subjects where the University is considered to be Engaged in Research to assure adequate provisions are in place to protect the rights and welfare of the participants.

Approval of international research is permitted if “the procedures prescribed by the foreign institution afford protections that are at least equivalent to those provided in 45 CFR 46.”

All policies and procedures that are applied to Research conducted domestically should be applied to research conducted in other countries, as appropriate.

For international research, the Tulane IRB seeks sufficient knowledge of the local research context by requesting approval for the project from local IRBs or ethics committees (which may or may not be OHRP-registered) and/or local letters of support. The source of this information will depend on the nature of the study, on the country and on the resources available to the PI. Where there is a local IRB/Independent Ethics Committee, Tulane’s IRB must receive and review the foreign institution or site’s IRB/Independent Ethics Committee review and approval of each study prior to the commencement of the Research at the foreign institution or site.

In some circumstances where Research may be performed internationally and/or in settings where there are no IRBs, the Tulane’s IRB may, prior to approval of the research, require additional verification and information from people outside the particular research project who are familiar with the customs, practices, or standards of care where the research will be taking place, such as local IRBs or ethics committees, other Tulane researchers with knowledge of the region, or other experts on the region. These individuals may either provide a written review of a particular protocol or attend an IRB meeting to provide the Tulane IRB with recommendations based on his or her expertise.

For Federally funded Research, approval of research for foreign institutions or sites Engaged in Research is only permitted if the foreign institution or site holds an Assurance with OHRP and local IRB review and approval is obtained.

Approval of research for foreign institutions or sites “not engaged” in research is only permitted if one or more of the following circumstances exist:

- When the foreign institution or site has an established IRB/Independent Ethics Committee, the Investigator must obtain approval to conduct the research at the "not engaged" site from the site’s IRB/Independent Ethics Committee or provide
documentation that the site’s IRB/Independent Ethics Committee has determined that approval is not necessary for the Investigator to conduct the proposed research at the site.

- When the foreign institution or site does not have an established IRB/Independent Ethics Committee, a letter of cooperation must be obtained demonstrating that the appropriate institutional or oversight officials are permitting the research to be conducted at the performance site.

- IRB approval to conduct research at the foreign institution or site is contingent upon receiving documentation of the performance site’s IRB/Independent Ethics Committee determination, or letter of cooperation, as applicable.

26.1 Responsibilities

1. It is the responsibility of Tulane investigators and the foreign institution or site to assure that the resources and facilities are appropriate for the nature of the research.

2. It is the responsibility of Tulane investigators and the foreign institution or site to confirm the qualifications of the researchers and research staff for conducting research in that country(ies).

3. It is the responsibility of Tulane investigators and the foreign institution or site to ensure that the following activities will occur:

   a. Initial review, continuing review, and review of modification

   b. Post-approval monitoring

   c. Handling of complaints, non-compliance and unanticipated problems involving risk to subjects or others

   The IRB will not rely on a local ethics committee that does not have policies and procedures for the activities listed above.

4. It is the responsibility of Tulane investigators and the foreign institution or site to notify the IRB promptly if a change in research activities alters the performance site’s engagement in the research (e.g., performance site “not engaged” begins consenting research participants, etc.).

26.2 Monitoring of Approved International Research

The IRB is responsible for the ongoing review of international research conducted under its jurisdiction through the continuing review process in accordance with all applicable federal regulations.

When the IRB and a local ethics committee will both be involved in the review of research, there is a plan for coordination and communication with the local IRB/IECs.

The IRB will require documentation of regular correspondence between Tulane investigators and the foreign institution or site and may require verification from sources other than Tulane investigators that there have been no substantial changes in the research since its last review.

Currently, the University’s IRB serves as the IRB-of-record for Tulane University Hospital & Clinic (“TUHC”) with respect to Research involving Human Subjects. In the event that Tulane does agree to serve as the IRB-of-record this must be documented in writing through an inter-
institution agreement signed by the duly authorized representatives of each institution, with an appropriate amendment to the other institution’s FWA to add Tulane’s IRB as the IRB-of-record. The HRPO and RCO will maintain a current list of Research involving Human Subjects where Tulane’s IRB serves as the IRB-of-record for another institution.
27 Information Security

The Institution has established standards and safeguards to protect patient’s information and to ensure compliance with federal and state information security regulations. It is the responsibility of the PIs to familiarize themselves with and comply with these standards. The use of personal laptops, desktops, USB drives, and other non-University devices for storage of Research data is discouraged. In the instances when a non-University computer or device must be utilized for the purposes of storing, even temporarily, or transmitting PHI or PII (Personally Identifiable Information) for Research, the safeguards of the device (e.g. the University disk encryption system must be utilized if PII is going to be stored on portable computers) must be verified by Information Security Officer and a User Agreement completed. Additionally, any potential or known breach of a device or of Research data must be immediately reported to both the IRB and Research Compliance Officer so that appropriate steps can be taken to assess the situation, protect the information, and comply with regulations. Lost or stolen Institutional devices must also be reported to Tulane’s Information Security Office and Tulane University Police.

Provisions for Data Security must be described in applications to the IRB and updated as necessary. When information containing direct identifiers such as Social Security Numbers or PHI including data considered sensitive is to be transferred outside of the institution, the provisions for data security may be subject to further review and approval by the Information Security Officer.

28 Special Topics

28.1 Certificate of Confidentiality (“CoC”)

Certificates of Confidentiality (CoC) protect research information by prohibiting certain disclosures and conditioning others upon consent from the subject. The protections and requirements of CoCs are outlined in 42 U.S.C. 241(d) and in written policies and requirements of certain Federal agencies such as NIH and CDC and are summarized below.

CoC’s are obtained as follows:

- CoCs are issued automatically when research is conducted or supported by NIH and falls within the scope of the NIH policy.
- CoCs are issued automatically when research is conducted or supported by the CDC and involves the collection of identifiable, sensitive information.
- CoCs are issued automatically when research is funded by the FDA in whole or in part and involves the collection or use of identifiable, sensitive information as defined in 42 U.S.C. 241(d).
- Research that is not supported by NIH, CDC, or FDA may still benefit from the protections afforded by CoCs through successful application to the NIH, FDA, HRSA, SAMHSA, or other authorized Federal agencies or departments.

Additional information about CoCs and the application process for research not covered by the NIH policy is available on the NIH CoC Website.

28.2 Definitions

Identifiable, sensitive information means information that is about an individual and that is gathered or used during the course of biomedical, behavioral, clinical, or other research and

1. Through which an individual is identified; or
2. 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 identify of an individual.

28.3 Protections and Requirements

When a CoC is issued, whether automatically or under an approved application, the person(s) engaged in the research must not disclose or provide the name of a subject or any information, document, or biospecimen that contains identifiable, sensitive information about the subject and that was compiled for the purposes of the research:

1. In any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding, unless the disclosure is made with the consent of the individual to whom the information, document, or biospecimen pertains; or
2. To any other person not connected with the research, unless:
a. Required by Federal, State, or local laws (e.g., adverse event reporting to the FDA, transmissible disease reporting required under State law), but excluding proceedings as described in “1” above;

b. Necessary for the medical treatment of the subject to whom the information, document, or biospecimen pertains and made with the consent of the subject;

c. Made with the consent of the individual to whom the information, document, or biospecimens pertains; or

d. Made for the purposes of other scientific research that is in compliance with applicable Federal regulations governing the protection of human subjects in research.

Additional Protections

Identifiable, sensitive information protected under a CoC, and all copies thereof, are immune from the legal process, and shall not, without the consent of the of the individual to whom the information pertains, be admissible as evidence or used in any action, suit, or other judicial, legislative, or administrative proceeding.

Identifiable, sensitive information that has been collected under a CoC, and all copies thereof, are protected for perpetuity. If identifiable, sensitive information covered by a CoC is shared with other researchers or organizations, the researchers or organizations must be informed that the information is covered by a CoC and of their responsibility to protect the information accordingly.

Nothing in the rule (42 U.S.C. 241(d)) may be construed to limit the access of a subject to information about himself or herself collected during the research.

When consent is obtained, the consent should inform subjects that a CoC is in place and describe the protections and limitations.

28.4 NIH and CDC

The NIH Policy on CoCs applies to “all biomedical, behavioral, clinical, or other research funded wholly or in part by the NIH, whether supported through grants, cooperative agreements, contracts, other transaction awards, or conducted by the NIH Intramural Research Program, that collects or uses identifiable, sensitive information” that was commenced or ongoing on or after December 13, 2016.

The CDC requirements for CoCs apply to “CDC supported research commenced or ongoing after December 13, 2016 and in which identifiable, sensitive information is collected, as defined by Section 301(d).”

CoCs are automatically granted, and the requirements of such must be complied with, whenever a NIH or CDC funded activity falls within the scope of the NIH policy or CDC’s requirements. Investigators and institutions are responsible for determining when research with NIH or CDC support are covered by a CoC.

NIH and CDC expand upon 42 U.S.C. 241(d) by explaining that NIH and CDC consider research in which identifiable, sensitive information is collected or used, to include:
• Human subjects research as defined in 45 CFR 46, including research determined to be exempt (except for exempt research when the information obtained is recorded in such a manner that human subjects cannot be identified or the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects);

• Research involving 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;

• Research that involves 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 subjects can be identified or the identity of the human subjects can readily be ascertained; or

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, as defined in subsection 301(d) of the Public Health Service Act.

28.5 FDA

The FDA requires, as a term and condition of all FDA funding and grant awards, compliance with the requirements of 42 U.S.C. 241(d) when research is funded in whole or in part by the FDA and involves the use or collection of identifiable, sensitive information. Certificates are deemed issued through FDA funding/award terms and conditions and are not issued as a separate document.

Investigators and institutions are responsible for determining when research with FDA support is covered by a CoC and for ensuring compliance with the requirements of 42 U.S.C. 241(d). Awardees are expected to ensure that any investigator or institution not funded by FDA who receives a copy of identifiable, sensitive information protected by these requirements, understand they are also subject to the requirements of 42 U.S.C. 241(d). Awardees are also responsible for ensuring that any subrecipient that receives funds to carry out part of the FDA award involving a copy of identifiable, sensitive information protected by these requirements understand they are also subject to subsection 42 U.S.C. 241(d).

When research is not funded by the FDA but involves “the use or study of a product subject to FDA’s jurisdiction and subject to FDA’s regulatory authority” (e.g., a clinical investigation of a drug, device, or biologic), the sponsor or sponsor-investigator can request a discretionary CoC from the FDA. Information about discretionary CoC’s issued by FDA is available in the FDA guidance document: Certificates of Confidentiality.

28.6 NIH, CDC, and FDA CoC Determination

At Tulane, Sponsored Programs Administration (SPA) staff will, in consultation with the investigator(s) (or Program or Project Director, if applicable), determine if the NIH policy or CDC or FDA requirements applies to research with NIH, CDC, or FDA involvement or support. The questions outlined in the NIH policy and CDC requirements will be used to guide the analysis for research conducted or supported by NIH and CDC. The definitions and text of 42
U.S.C. C. 241(d) will be used to guide the analysis for research supported by FDA funding/awards. When it has been determined that the NIH policy or CDC requirements do not apply, investigators (or Program or Project Directors, if applicable) are responsible for consulting with SPA whenever they are proposing changes to the supported activity that may impact or change the analysis.

### 28.7 NIH Policy and CDC Requirements

The NIH Policy and CDC requirements include additional responsibilities and requirements for internal controls and for ensuring that recipients of identifiable, sensitive information protected by a CoC understand that they are also subject to the requirements of subsection 301(d) of the Public Health Service Act. Likewise, FDA requires awardees ensure that recipients of identifiable, sensitive information protected by an FDA CoC understand that they are also subject to the requirements of 42 U.S.C. (241(d).

Application Procedures for Research Not Automatically Issued a CoC.

Any person engaged in human subjects research that collects or uses identifiable, sensitive information may apply for a CoC. For most research, CoCs are obtained from NIH, an investigator may apply for a CoC through the NIH Institute or Center funding research in a scientific area similar to the project.

When a researcher is conducting a research project that is covered by the Agency for Healthcare Research and Quality (AHRQ) confidentiality statute (42 U.S.C. section 299c-3(c)), a CoC is not needed (AHRQ notice NOT-HS-18-012). While the AHRQ statute does not define “identifiable”, AHRQ applies the PHS Act definition of “identifiable, sensitive information”. Investigators should consult with AHRQ when they believe that data might be considered “non-identifiable” or when otherwise uncertain whether a research project falls within the scope of the statute.

When a researcher is conducting a research project that is covered by the Department of Justice (DoJ) confidentiality statute, 28 CFR 22, and/or a NIJ Privacy Certificate, a CoC may not be needed. Investigators should consult with DoJ/NIJ to determine whether a CoC should be obtained.

If there is an Investigational New Drug Application (IND) or an Investigational Device Exemption (IDE), the sponsor can request a CoC from the FDA. When FDA funds or conducts research, a CoC is automatically issued.

CoCs may also be issued by other Federal agencies and departments, such as SAMSHA and HRSA.

For more information, see the NIH CoC Website.
28.8 IRB Review

Investigators are responsible for clearly representing in the IRB submission that a CoC is in place, or that an application for CoC has been submitted or is pending. When the CoC application is in process or pending, the IRB may condition final approval upon its receipt.

For studies that are already underway, investigators must submit an Amendment to the IRB via the Secondary Application for Human Subjects Research, along with updated consent language (if applicable), when a CoC is applied for, or when automatically issued under the NIH policy or CDC requirements.

When reviewing research under a CoC, the Tulane IRB will evaluate whether the research plan is consistent with the obligations to protect information and specimens under a CoC and, when consent will be obtained, whether the proposed consent language or other form of notification properly discloses the CoC and appropriately describes the associated protections and limitations. Sample consent language is available on the NIH CoC Website and in the template consent forms available on Tulane’s HRPP/IRB website.

When research is not under a CoC, the IRB may require an investigator to apply for a CoC if the research includes identifiable, sensitive information and the IRB determines that a CoC is necessary to minimize risks and adequately protect subjects’ privacy and the confidentiality of subjects’ information or specimens.

28.9 Mandatory Reporting of Abuse and Neglect

28.9.1 Definitions

*Abuse*: Is the infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon a Child or Elder by another person. It also entails the involvement of the Child in any sexual act with any other person; the involvement of the Elder in any unconsented sexual act with any other person; the aiding or toleration by the Parent or the caretaker of the Child/Elder's sexual involvement with any other person; the Child/Elder's involvement in pornographic displays; or any other involvement of a Child/Elder in sexual activity constituting a crime under the laws of this state.

*Elder*: means an adult over the age of 60.

28.9.2 Reporting Obligation of Abuse & Neglect

The Abuse and Neglect of Children, Neonates and Elders create attendant human and financial costs to those that are Abused/Neglected as well as society at large. For this reason, Louisiana law requires that health care providers and practitioners (e.g., health, mental health, and social service practitioners) involved in the delivery of care report findings of suspected Abuse or Neglect to appropriate State and local agencies. [LA Children’s Code, Art. 601, et seq. (re. mandatory reporting for Children and Neonates; and LA R.S.14:403.2 (re. mandatory reporting for Elders].

Consistent with Louisiana law, the HRPP has established a policy and procedure to protect the health, safety, and well-being of Children, Neonates and Elders who are involved as subjects in Research under the purview of Tulane’s IRB. It also establishes an attendant duty to notifying appropriate State and local agencies of instances of suspected Abuse and Neglect.
28.9.3 Confirming the Existence of Abuse or Neglect

During the consenting process, enrollment or Research activities, PIs, Investigators and/or Research staff may become aware of conditions that gives them cause to believe that potential Abuse or Neglect may exist of either (1) subjects who are Children or elders; and/or (2) to Children or elders of subjects.

It is imperative that the facts be reviewed and carefully considered before notifying appropriate governmental entities, especially in light of the gravity of the potential allegations that may be disclosed. For this reason, the following considerations should be had:

- **Confirming Abuse:**
  
  o Notwithstanding any claim of privileged communication, to the extent that a person has cause to believe that a Child or Elder's physical or mental health or welfare is endangered as a result of Abuse or that Abuse was a contributing factor in a Child or Elder's death or injury, he/she shall report the good faith suspicion to the appropriate State and local authorities in accordance with this policy and Louisiana law.

  o In the event that a drug screen test of a mother is positive for an illegal controlled dangerous substance (“CDS”) and negative for a newborn, then this is deemed by the University to be Abuse. There is no need to retest for confirmation purposes due to the methodology currently used by the laboratory.

- **Confirming Neglect:** Notwithstanding any claim of privileged communication, to the extent that a person has cause to believe that a Neonate's physical or mental health or welfare is endangered as a result of Neglect, the following steps must be taken in conjunction with a Louisiana licensed physician:

  o Look for a positive drug screen test of a Neonate for an illegal CDS. Note well that there is no need to retest for confirmation purposes due to the methodology currently used by the laboratory; AND

  o A physician makes a positive medical diagnosis within thirty (30) days of birth that the Neonate either (i) is dependent upon the use of an illegal CDS; (ii) suffers from withdrawal symptoms from an illegal CDS; or (iii) a Neonate suffers from an illness, disease or condition in utero attributable to exposure to an illegal CDS.

28.9.4 What is the Reporting Procedure?

1. When a triggering event exists, mandatory reports are required by Louisiana law to report to Child Protective Services (“CPS”), Adult Protective Services (“APS”), the Department of Social Services, and/or Louisiana DHH their findings with respect to suspected Abuse or Neglect.

2. The PI (or delegate) is responsible for reporting all instances of Abuse and Neglect to CPS, as determined by this policy.

3. Reports of Abuse or Neglect or that such was a contributing factor in a Child's death, where the abuser is believed to be a Parent or caretaker, a person who maintains an interpersonal dating or engagement relationship with the Parent or caretaker, or a person living in the same residence with the Parent or caretaker as a spouse whether married or not, shall be made immediately to the local CPS or APS.
4. Reports in which the Abuse or Neglect is believed to be perpetrated by someone other than a caretaker, a person who maintains an interpersonal dating or engagement relationship with the Parent or caretaker, or a person living in the same residence with the Parent or caretaker as a spouse whether married or not, and the caretaker is not believed to have any responsibility for the Abuse or Neglect shall be made immediately to a local or State law enforcement agency. Dual reporting to both the local CPS and/or APS unit and the local or State law enforcement agency is permitted.

5. Questions with respect to whether to report an incident to CPS should be referred to the University’s Office of General Counsel for assistance.

28.9.5 Immunity from civil or criminal liability

No cause of action shall exist against any person who in good faith makes a report or who cooperates in any investigation arising as a result of such report. State law protects the identity of all mandated reporters, who are given immunity from legal liability as a result of reports made in good faith.

Conversely, though, failure to report known instances of Abuse and/or Neglect may subject the offender to criminal prosecution. [LA R.S. 14:403(A)(1)].

28.10 Tulane Students and Employees as Subjects

When Tulane students and/or employees are being recruited as potential subjects, Researchers must ensure that there are additional safeguards for these subjects. The voluntary nature of their participation must be primary and without undue influence on their decision. Researchers must emphasize to subjects that neither their academic status or grades, or their employment, will be affected by their participation decision.

To minimize coercion, Investigators should avoid, whenever possible, the use of their students and employees in procedures which are neither therapeutic nor diagnostic. In these latter situations, Investigators should solicit subjects through means such as bulletin board notices, flyers, advertisements in newspapers, and announcements in classes or laboratories other than their own. When entering a classroom to recruit students and conduct Research (e.g. administer a survey), Investigators must do so at the end of the class period to allow non-participating students the option of leaving the classroom, thereby alleviating pressure to participate.

28.11 Student Research

28.11.1 Human Subjects Research and Course Projects

Learning how to conduct ethical Human Subjects Research is an important part of a student’s educational experience. Research activities that are designed as part of a course requirement for purposes of learning experience only and are NOT designed to develop or contribute to generalizable knowledge MAY not require IRB review and approval if all of the following conditions are true:

- Results of the Research are viewed only by the course instructor for teaching purposes and discussed within the classroom for teaching and learning purposes;
- Results of the Research are not made public through presentation (outside of the classroom) and are not published in paper or electronic format (e.g., cannot be made available on the internet, cannot be published in a journal, etc.);
• Research procedures are no more than Minimal Risk;
• Vulnerable populations are not targeted (e.g., Children under age 18, Prisoners, persons who are cognitively impaired, etc.);
• Data collected are recorded in such a manner that the subjects are not identifiable (images in videotapes and photographs and voices on audiotape are identifiable); and
• When appropriate, an informed consent process is in place.

Responsibility of the Course Instructor: The course instructor is responsible for communicating to the students the ethics of Human Subjects Research, for ensuring the protection of Human Subjects (including a process is in place for obtaining voluntary Informed Consent from Research subjects when appropriate), and for monitoring the students’ progress.

When designing a project, students should be instructed on the ethical conduct of Research and on the preparation of the Initial Application for Human Subjects Research when such is required. In particular, instructors and students should:

• Understand the elements of Informed Consent;
• Develop appropriate consent documents;
• Plan appropriate strategies for recruiting subjects;
• Identify and minimize potential risks to subjects;
• Assess the risk-benefit ratio for the project;
• Establish and maintain strict guidelines for protecting Confidentiality; and
• Allow sufficient time for IRB review (if necessary) and completion of the project.

In making a determination of whether or not a class Research project requires IRB review, the instructor is encouraged to err on the side of caution and to contact the HRPO for assistance.

28.11.2 Individual Research Projects Conducted by Students

Independent study projects, senior theses, undergraduate Research projects, masters and advanced degree Research, and similar exercises that involve Human Subjects must be independently submitted for IRB review. It is important to keep in mind that any Human Subjects Research activity that will ultimately contribute to part or all of a thesis, dissertation, or other type of publication or presentation must go through the IRB review process prior to enrolling Human Subjects and collecting data. IRB review cannot occur after a study has begun.

Students and advisors should contact the HRPO with any questions.

Tulane policy and procedures, educational module, forms and related information can be found on the Tulane University HRPP Website.

28.11.3 Independent Study, Theses and Dissertations

These Research activities are considered to meet the Federal definition of Human Subject Research and should be independently submitted to the IRB. See Section 26.4.3 “Student Investigators,” regarding the requirements for Student PIs.
28.12 Oral History

“Oral history” is a technique in which the researcher conducts a series of recorded interviews with the Participants in a particular historical event or period. Often, the intention is that these recordings become available to the public at a specified future period of time (e.g., frequently after a substantial delay) in order to convey historical insight.

In many cases, these interviews will be historical recollections of the character of a society or an institution rather than the interviewee's subjective perceptions. Such activities may or may not be considered Human Subjects Research requiring the prospective review and approval of the IRB before commencing the activity pursuant to 45 CFR §46.101(b)(2) and §46.101(b)(3).

If in doubt, an oral history project should be submitted in advance to the HRPO via the IRB electronic submission system to determine whether it is subject to IRB review or, conversely, whether it is Exempt from review.

The threshold question in determining whether an oral history is subject to Human Subject protections is whether the activity meets the definition of Research. A decision whether oral history or other activities solely consisting of open ended qualitative type interviews are subject to the policies and regulations outlined in an institution’s FWA and HHS regulations for the protection of Human Subjects Research is based on the prospective intent of the Investigator and the definition of “research” under HHS regulations at 45 CFR §46.102(d): “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.” Interviews conducted with questionnaires and anonymous sources, from which generalized conclusions are drawn, fit the definition of Research. Open-ended, individualistic interviewing about events that have occurred in the past represents a fundamentally different form of research than federal regulations were intended to encompass.

Focus should be on the prospective intent of the PI and the definition of Research (i.e., does it involve a “systematic investigation, including Research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.” [OHRP Guidance]

An activity is considered to not be an oral history and not Exempt if it satisfies both of the following requirements:

1. The activity involves a prospective Research plan which incorporates data collection, including qualitative data, and data analysis to answer a Research question; and
2. The activity is designed to draw general conclusions (i.e., knowledge gained from a study may be applied to populations outside of the specific study population), inform policy, or generalize findings.

When reviewing activity to determine whether it is an oral history that qualifies for Exempt Review, the following general principles may be useful for evalulative purposes:

1. Oral history activities, such as open-ended interviews, that ONLY document a specific historical event or the experiences of individuals without intent to draw conclusions or generalize findings would NOT constitute Research.
Example: An oral history video recording of interviews with holocaust survivors is created for viewing in the Holocaust Museum. The creation of the video tape does NOT intend to draw conclusions, inform policy, or generalize findings. The sole purpose is to create a historical record of specific personal events and experiences related to the Holocaust and provide a venue for Holocaust survivors to tell their stories.

2. Systematic investigations involving open-ended interviews that are designed to develop or contribute to generalizable knowledge (e.g., designed to draw conclusions, inform policy, or generalize findings) WOULD constitute Research.

Example: An open-ended interview of surviving Gulf War veterans to document their experiences, and to draw conclusions about their experiences, inform policy, or generalize findings.

10. Oral historians and qualitative Investigators may want to create archives for the purposes of providing a resource for others to do Research. Since the intent of the archive is to create a repository of information for other Investigators to conduct Research.

Example: Open ended interviews are conducted with surviving Negro League Baseball players in order to create an archive for future Research. The creation of such an archive would constitute Research since the intent is to collect data for future Research.

Investigators are advised to consult with the HRPO regarding whether their oral history project requires IRB review.

28.13 Community Based Research (CBR)

Community based research is research that is conducted as an equal partnership between academic investigators and members of a community. In CBR projects, the community participates fully in all aspects of the research process. Community is often self-defined, but general categories of community include geographic community, community of individuals with a common problem or issue, or a community of individuals with a common interest or goal.

Where research is being conducted in communities, PIs are encouraged to involve members of the community in the research process, including the design and implementation of research and the dissemination of results when appropriate. The HRPO will assist the PI in developing such arrangements. The Institution assures that the IRB has the appropriate expertise to review CBR research such as: inclusion of consultants to the IRB with expertise in community based participatory research.

The following are some questions that PIs should ask as they develop CBR. These are also the questions that the IRB should consider when reviewing CBR.

CBR Questions for consideration:

Background, purpose, objectives

How was the community involved or consulted in defining the need?
Who came up with the research objectives and how?
Is this research really justified with respect to community concerns?
Are there concrete action outcomes?
Who benefits? How?

**Research methodology**

How will the community be involved in the research? At what levels?
What training or capacity-building opportunities will be built in?

**Procedures**

Will the methods used be sensitive and appropriate to various communities (consider literacy issues, language barriers, cultural sensitivities, etc.)?
How will scientific rigor and accessibility be balanced?

**Participants**

Are the appropriate people being included to get the questions answered (e.g., service providers, community members, leaders etc.)?
How will the research team protect vulnerable groups?
Will the research process include or engage marginalized or disenfranchised community members? How?
Is there a reason to exclude some people? Why?

**Recruitment**

What provisions have been put in place to ensure culturally relevant and appropriate recruitment strategies and materials?
Have “power” relationships been considered in the recruitment strategies to minimize coercion?
Who approaches people about the study and how?

**Risks and benefits**

What are the risks and benefits of the research for communities? For individuals?
Are the risks (including risks to the community) being presented honestly?
How will risks be minimized?

**Privacy and confidentiality**

Where will data be stored? Who will have access to the data? How?
What processes will be put in place to be inclusive about data analysis and yet maintain privacy of participants?
What will be the rules for working with transcripts or surveys with identifying information?
How will boundaries between multiple roles (e.g., researcher, counselor, peer) be maintained?
Compensation

How will people be reimbursed for their time and honor their efforts without it becoming coercive.

How will compensation be approached?

What provisions have been made for minimizing barriers to participation (e.g., providing for food, travel, childcare)?

Who is managing the budget? How are these decisions negotiated?

Conflicts of interest

What happens when the PI/research staff is the friend, peer, service provider, doctor, nurse, social worker, educator, funder, etc.

How will power differentials be appropriately acknowledged and negotiated?

Informed consent process

What does informed consent mean for “vulnerable” populations (e.g., children, mentally ill, developmentally challenged)?

What processes are in place for gathering individual consent?

Where written informed consent is not being obtained, explain why.

What processes are in place for gathering community consent?

Where minors are to be included as participants, how will assent be obtained?

Are the consent processes culturally sensitive and appropriate for the populations being included?

Outcomes and results

How will the research be disseminated to academic audiences?

How will the research be disseminated to community audiences?

What are the new ways that this research will be acted upon to ensure community/policy/social change?

Ongoing reflection and partnership development

Is there a partnership agreement or memorandum of understanding to be signed by all partners that describes how they will work together?

What internal process evaluation mechanisms are in place?

When plans change to accommodate community concerns (as they invariably do in CBR), how will this be communicated to the IRB?

AAHRPP Standards for Accreditation(Standard I-4, Element I.4.C)

The FDA, NIH, other sponsors as applicable, and journals requires that certain trials be publicly registered at “clinicaltrials.gov” before any subjects are enrolled. [See PHSA; Section 26.7of MMA; 21 CFR §312; 42 USC 282(i)]. The URL for the registration site is: https://register.clinicaltrials.gov/.

28.14.1 Who Must Register?

The responsible party for registering applicable clinical trials is the Sponsor of the clinical trial, which means the person who initiates a clinical investigation.

- For investigator-initiated trials, the lead PI responsible for initiating, conducting and coordinating the overall clinical trial is responsible for registration;
- For Sponsor-initiated trials the Sponsor is responsibility for registration;
- For trials Sponsored or funded wholly or in part by the NIH the grantee is responsible for registration; and
- For trials associated with IND or IDE applications with the FDA the IND/IDE holder is responsible for registration.

The Sponsor, grantee, contractor, or awardee may designate the PI of a clinical trial as the responsible party, provided that the PI is responsible for conducting the trial, has access to and control over the data from the clinical trial, has the right to publish the results of the trial, and has the ability to meet all of the requirements for submitting information under the law.

Once a trial is registered, the responsible person also must ensure on an ongoing basis that the information is complete, accurate and updated. This includes reviewing the listing and making necessary changes every 6 months or more frequently if significant changes occur. You are also responsible for noting when enrollment ceases.

If unclear who is responsible registering an applicable clinical trial, Investigators should consult with the Sponsor, funding agency, and/or other study Investigators to define who the responsible party will be.

28.14.2 Which Studies Must Be Registered?

Registration is required for any Research study that:

- Prospectively assigns Human Subjects to intervention and at least one concurrent control or comparison groups; AND
- Uses a Drug, Biological Products, or Device as the intervention or control/comparison; AND
- Studies the safety, efficacy or cause-and-effect relationship between an intervention and a health outcome

The registration requirement does not apply to:

- The use of FDA approved, marketed products used in the course of medical practice;
- Phase I Clinical Investigations of Drugs or Biological Products;
- Small clinical trials to determine the feasibility of a device or clinical trial to test prototype devices where the primary outcome measure relates to feasibility and not to health outcomes;
• FDA required pediatric post-marketing surveillance of devices;
• Purely observational studies, meaning those studies where the assignment of the intervention is not at the discretion of the Investigator; and/or
• Investigators and Sponsors are encouraged to register all clinical trials to ensure they meet the publication requirements of the International Committee of Medical Journal Editors (“ICMJE”) and to promote transparency in clinical research.

28.14.3 When Must the Information Be Submitted?

Information about new Protocols open for enrollment must be registered no later than 21 days after Protocol approval. [42 U.S.C. 282(j)(3)]. Supplemental information can be submitted at 30-day intervals. The FDA strongly encourages you to update information about trials that are unexpectedly closed (e.g., clinical hold) within 10 days after the closing or sooner if possible.

28.14.4 How To Register a Clinical Trial?

Search ClinicalTrials.gov to ensure that the trial is not already listed. NIH-sponsored clinical trials and many industry-sponsored trials have already been registered on this site. If the trial is not listed, continue with registration.

Establish an account with the ClinicalTrials.gov. Within 2 business days, you will receive an E-mail message from ClinicalTrials.gov containing your login name and temporary password.

Once you have received your login information, register the trial. This process will take approximately 1 hour, and it will be helpful to have the Protocol, informed consent document, and IRB approval (if available) on hand. IRB approval is not required to register a trial. Note that this system offers the option to save data if you do not have time to complete the entire process.

Some suggestions for completing certain items that you might not have available are:

• Unique Protocol ID: The Tulane IRB number is recommended. An IRB number can be generated by starting an application in the IRB electronic submission system. IRB approval is not required to register a trial. The IRB number is also used in the Board Approval Number field.
• Secondary IDs: The grant number, funding agency number or other funding source number is recommended.
• Board Name (Full name of the approving human subjects review board): Tulane University Biomedical Institutional Review Board
• Board Affiliation (Official name of organizational affiliation of the approving human subjects review board): Tulane University Biomedical Institutional Review Board
• Board Contact (Contact information for the human subjects review board):
  Name: Roxanne R. Johnson, MSPH, CHRC
  Director, Human Research Protection Office
  Phone: 504-988-2665
  Email: irbmain@tulane.edu
Oversight Authorities: should always include United States: Institutional Review Board; other oversight authorities such as the FDA may also apply depending on the clinical trial.

When the template is complete, hit “Submit” for release of the content to ClinicalTrials.gov. Information should be reviewed and updated as needed every 6 months or more frequently if changes occur.

Please note that IRB approval will not be granted until this clinical trial has been registered with ClinicalTrials.gov and the ClinicalTrials.gov registration number has been uploaded to the IRB electronic submission system.

28.14.5 What Information Must Be Submitted?

The following are examples of information to be submitted:

- **Descriptive Information**
  - Brief Title (in lay language)
  - Brief Summary (in lay language)
  - Study Design/Study Phase/Study Type
  - Condition or Disease
  - Intervention

- **Recruitment Information**
  - Study Status Information including
  - Overall Study Status (e.g., recruiting, no longer recruiting)
  - Individual Site Status
  - Eligibility Criteria/Gender/Age

- **Location and Contact Information**
  - Location of Trial
  - Contact information (includes an option to list a central contact person for all trialsites)

- **Administrative Data**
  - Unique Protocol ID Number
  - Study Sponsor
  - Verification date

28.14.6 Who Receives the Submitted Information?

The DHHS Secretary acting through the NIH Director receives information submitted to ClinicalTrials.gov.
28.14.7 Who Can Access the Registered Information?
Studies will be made available to the public through ClinicalTrials.gov within two to five days after submission by the Sponsor. Except for the IND number, serial number, and FDA center designation, all information submitted through the PRS is made available to the public.

28.14.8 Must Information Be Included About Foreign Trial Sites?
Yes, a Sponsor must include information about foreign trials when those trials are conducted under an IND submitted to FDA and the trial meets the criteria for submission to the Clinical Trials Data Bank. [42 U.S.C. 282(j)(3)]. Sponsors may voluntarily conduct a foreign trial under the IND regulations. Sponsors are not required to submit information to the Clinical Trials Data Bank when a foreign trial is not conducted under an IND.

28.14.9 Can Intermediaries Act on Behalf of a Sponsor?
Yes. For example, in some cases a Sponsor might want to contract with an information management company to serve as an intermediary in preparing data for inclusion in ClinicalTrials.gov. The information management company, when authorized by the Sponsor, could act on behalf of the Sponsor for this purpose.

28.14.10 Can Intermediaries Act on Behalf of a Sponsor?
Yes. When Sponsors register to become a PRS data provider, they will be given information, including instructions, for creating additional users for their accounts. A Sponsor can control access to the account by designating users and administrators for the account.

28.14.11 What are the NIH Requirements for ClinicalTrials.gov Registration Information in Applications and Progress Reports?
On September 27, 2007 Congress enacted U.S. Public Law 110-85 (also known as H.R. 3580, or Food and Drug Administration Amendments Act of 2007). This act mandates the expansion of ClinicalTrials.gov expands the required submission elements and establishes penalties for not listing a trial. Investigators and Sponsors must ensure that applicable Drug, Biological Products and Device trials are registered within 21 days of enrollment of the first subject and preferable before first subject enrollment. The legislation also requires applications or progress reports for any clinical trials required to be registered which are funded in whole or in part by a grant from any agency of the DHHS to contain specific information certification registration in ClinicalTrials.gov.

28.14.12 How do the FDA registration requirements affect NIH funded studies?
- Competing renewal applications that include studies that are required to be registered must include as part of the Human Subjects Section of the Research Plan the following items:
  - A statement that “This application includes a trial which requires registration in ClinicalTrials.gov;”
  - The National Clinical Trial (“NCT”) number (i.e., the ClinicalTrials.gov number);
  - Brief Title as listed in ClinicalTrials.gov; and
  - The name of the individual or entity responsible for registering the study (responsible party) for each study being conducted under the application. (As grantee, Tulane University designates the lead Investigator of the trial as the responsible party.)

If the application does not includes studies that are required to be registered the Human Subjects Section of the Research Plan should include a statement that “This application does not include a trial which requires registration in ClinicalTrials.gov.” These requirements apply to all competing applications submitted to the NIH on or after January 25, 2008.
• New applications that include studies that are required to be registered must include as part of the Human Subjects Section of the Research Plan a statement that “This application includes a trial which requires registration in ClinicalTrials.gov.” The study would then need to be registered and the National Clinical Trial (“NCT”) number, brief title as listed in ClinicalTrials.gov and the individual or entity responsible for registering the study (responsible party) for each study being conducted under the application as part of the Just-In-Time (“JIT”) information. If a new application does not include studies that are required to be registered the Human Subjects Section of the Research Plan should include a statement that “This application does not include a trial which requires registration in ClinicalTrials.gov.”

• Non-competing progress reports that include studies that are required to be registered must include as part of the Human Subjects Section of the Progress Report the following items:
  • A statement that “This application includes a trial which requires registration in ClinicalTrials.gov;”
  • The National Clinical Trial (NCT) number (i.e., the ClinicalTrials.gov number);
  • Brief Title as listed in ClinicalTrials.gov; and
  • The name of the individual or entity responsible for registering the study (responsible party) for each study being conducted under the application. (As grantee, Tulane University designates the lead investigator of the trial as the responsible party.)

If the application does not include studies that are required to be registered the Human Subjects Section of the Research Plan should include a statement that “This application does not include a trial which requires registration in ClinicalTrials.gov.” These requirements apply to all non-competing progress reports with budget start dates of April 1, 2008 or later (applications due on or after 2/1/08).

28.14.13 Do the FDA regulations have any special requirements for IND, IDE or BLA studies?

Studies conducted under an IND or IDE must include in the informed consent documents and the informed consent process a statement that clinical trial information for the study has been or will be submitted for inclusion in ClinicalTrials.gov as required by FDA regulations.

A certification must accompany human Drug, Biological, and Device product submissions made to FDA. At the time of submission of an IND, IDE or BLA application or submission of a report, amendment, supplement or resubmission, such application or submission must be accompanied by a certification that all applicable requirements related to clinical trial registration
have been met. Where available, such certification must include the appropriate National Clinical Trial (“NCT”) numbers.

The official certification form, Form FDA 3674 entitled "Certification of Compliance with Requirements of ClinicalTrials.gov Data Bank”, is available on FDA’s Web site.

For Sponsor held INDs, IDEs and BLAs the Sponsor must provide the certification. For Investigator held INDs, IDEs and BLAs the individual holding the IND, IDE or BLA must provide the certification.

28.14.14 Resources for Investigators regarding ClinicalTrials.gov

Refer to the Tulane University Research Compliance and Research Integrity website at: https://research.tulane.edu/compliance/policies-procedures.

28.15 Research Involving or Generating Genetic Information

Research that generates or uses genetic information may create special risks to human subjects and their relatives. These involve medical, psychosocial, legal and economic risks, such as the possible loss of privacy, insurability, and employability, and may result in stigmatization and discrimination. Information about one's own genetic make-up may also provide information about family members.

In studies involving genetic testing or analysis of genetic information, several questions should be addressed to ensure that potential risks are well understood and that the rights and interests of subjects and their family members are carefully considered and planned for. For example:

1. Is the testing intrinsic to the study? If not, has participation in the genetic testing component been provided as an opt-in?

2. Will test results be given? Is there an appropriate plan for return of results?

3. Does the subject or family member be provided the option to receive or not receive results? How will this decision be recorded?

4. Could the results provide information about individual disease risk? Disease risk for family members?

5. Could other clinically relevant information or incidental findings be uncovered by the study? Is there a plan for the management of such findings?

6. Will testing that could produce clinically relevant information occur in a CLIA-certified lab? If not, are there tests available that could validate or support findings?

7. Could a change in a family relationship be disclosed, such as mistaken paternity?

8. Could/will the research provide information about the origins, ancestry, or natural history of families, indigenous peoples, tribal populations, or other populations? What are the possible risks?

9. Could/will the research generate information that could place subjects or family members at risk or be stigmatizing?

10. Could/will the research generate information of other value or importance to subjects/families?
11. Do any practical limitations exist on the subject's right to withdraw from the research, withdraw data, and/or withdraw biological materials (e.g., specimens, cell lines, extracted genomic DNA)?

12. How will the information and/or biological materials be protected and who will have access?

13. What is the potential for re-identification of individual subjects (e.g., through the combination of their genetic information and/or materials with other sources of information (e.g., public records))? What measures can be taken to mitigate these risks?

14. Is a Certificate of Confidentiality (CoC) in place or should one be considered?

15. Will the specimens, cell lines, or genetic information be stored and/or made available for future research? Is this provided as an opt-in when not intrinsic to the study?

Investigators should carefully consider the above and other factors relevant to their specific study when developing the protocol, consent process, and consent form. The President’s Bioethics Commission, the National Academies of Sciences, Engineering, and Medicine, and others have produced reports, recommendations, and materials that investigators and the IRB may find helpful in protocol development and review, including:

- Returning Individual Research Results to Participants: Guidance for a New Research Paradigm
- Anticipate and Communicate: Ethical Management of Incidental and Secondary Findings in the Clinical, Research, and Direct-to-Consumer Contexts
- Privacy and Progress in Whole Genome Sequencing
- Genetics Research and American Indian and Alaska Native Communities
- National Human Genome Research Institute:
  - Human Subjects Research in Genomics
  - Return of Research Results
  - Data Sharing and Privacy
  - Informed Consent for Genomics Research

In addition to the ethical considerations, investigators must ensure that research involving genetic testing or use of genetic information is consistent with applicable law (e.g., GINA, HIPAA, EU GDPR, state law) and policy (e.g., NIH).

### 28.15.1 Genetic Information Nondiscrimination Act (GINA)

GINA generally makes it illegal for health insurance companies, group health plans, and most employers to discriminate against individuals based on their genetic information. This law protects individuals, including research subjects, in the following ways:

- Health insurance companies and health plans are generally prohibited from requesting or requiring genetic information of an individual or their family members, including genetic information generated from research;
- If health insurance companies and health plans do receive such genetic information, they may not use it to make decisions regarding coverage, rates, or preexisting conditions; and
- Employers with 15 or more employees generally may not use genetic information for hiring, firing, promotion, or other decisions regarding terms of employment.
GINA’s protections do not extend to life insurance, disability insurance, or long-term care insurance.

GINA defines genetic information as information about:

- An individual’s genetic tests;
- Genetic tests of an individual’s family members;
- Genetic tests of any fetus of an individual or family member who is a pregnant woman, and genetic tests of any embryo legally held by an individual or family member utilizing assisted reproductive technology;
- The manifestation of a disease or disorder in an individual's family members (family history); or
- Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services (genetic testing, counseling, or education) by an individual or an individual's family members.

GINA includes a “research exception” that allows health insurers and health plans who are engaged in research to request, but not require, that an individual undergo a genetic test so long as certain requirements are satisfied. Additional information on GINA and this exception are available on this [OHRP website](#).

The Tulane IRB will consider the protections and limitations of GINA when it assesses the risks of research generating or using genetic information and the adequacy of the measures to protect privacy and maintain confidentiality.

### 28.16 Who Determines If Coded Private Information (or Specimens) Constitutes Human Subjects Research

The PI in consultation with the IRB Chair or HRPO/HRPP will determine if the Research involving Coded information or specimens requires IRB review. If the request is verbal (by phone or in person) or by E-mail, it is the PI’s responsibility to maintain documentation of such a decision. If the PI submits a formal submission, the request must include sufficient documentation of the activity to support the determination. Formal submissions will be responded to in writing and a copy of the submitted materials and determination letter/E-mail will be kept on file.

### 28.17 Case Reports Requiring IRB Review

In general, an anecdotal retrospective report on a single patient or small series (up to 3) of patients seen in one’s own practice and a comparison of these patients to existing reports in the literature is not research and would not require IRB approval. Going beyond one’s own practice to seek out and report cases seen by other clinicians creates the appearance of a systematic investigation with the intent to contribute to generalizable knowledge and therefore would be considered research and would require IRB approval.

All TU policies on the protection of patient(s) privacy and confidentiality (including the HIPAA compliance policies) and the principles of the Belmont Report apply. Clinicians should be especially sensitive to protecting the privacy of individuals with unique or unusual diagnoses or illnesses that could result in the individual being identified or recognized.
28.17.1 Definitions

Single Case Report: The external reporting (e.g., publication or poster/verbal presentation) of an interesting clinical situation or medical condition of a single patient. Case reports normally contain detailed information about an individual patient and may include demographic information and information on diagnosis, treatment, response to treatment, follow-up after treatment, as well as a discussion of existing relevant literature. The patient information used in the report must have been originally collected solely for non-research purposes as the result of a clinical experience.

Case Series: The external reporting (e.g., publication or poster/verbal presentation) of an interesting clinical situation or medical condition in a series of patients (i.e., more than one patient). Case series usually contain detailed information about each patient and may include demographic information and information on diagnosis, treatment, response to treatment, follow-up after treatment, as well as a discussion of existing relevant literature. The information used in the report must have been originally collected solely for non-research purposes as the result of a clinical experience.

28.18 Deception and Incomplete Disclosure

28.18.1 Definitions

Deception occurs when an Investigator gives false information to subjects or intentionally misleads them about some key aspect of the Research. This is sometimes referred to as “active deception.” Examples of Deception:

- The Subject is given a “cover story” which falsely describes the purpose of the study but provides a feasible account of the researcher’s objective.
- The Study includes a researcher’s “confederate,” an individual who poses as a Participant, but whose behavior in the study is actually part of the researcher’s experimental design.

Incomplete disclosure occurs when an Investigator withholds information about the specific purpose, nature, or other aspect of the Research. Withholding information may or may not be considered Deception. Examples of Incomplete Disclosure:

- The Subject is informed about the purpose of the study or a certain procedure in general terms that are true, but not detailed enough to reveal the researcher’s main or specific objective.

An example of Incomplete Disclosure that is also deception:

- The Study involves audiotaping or videotaping of subjects without their knowledge or prior consent.

28.18.2 Overview

Tulane recognizes that Deception and Incomplete Disclosure may be valuable research methodologies, yet their use presents special challenges to ensure that the Research is conducted ethically. At times, especially in social and behavioral research, deception or incomplete disclosure is necessary to avoid study bias or test a hypothesis that requires the participant’s
misdirection. On the other hand, the regulations for obtaining Informed Consent from research participants (§45 CFR 46.116) in general require full disclosure of all elements relevant to the subject’s participation in the research. Deception and Incomplete Disclosure raise concern as they may interfere with ability of the Subject to make a fully informed decision about whether or not participate in the research.

As a result, proposed Research involving Deception or Incomplete Disclosure necessitates special considerations. To determine when certain restrictions apply, Tulane’s IRB will consider the extent to which the Deception in a given study interferes with the Subject’s ability to give Informed Consent. This includes distinguishing whether “deception” or only “incomplete disclosure” (without deception) is involved, whether there is sufficient justification for use of such measures, and whether there is an appropriate consent and debriefing process in place.


28.18.3 Points to Consider:

In keeping with federal regulations and ethical codes established by the Belmont Report and the American Psychological Association, Tulane’s IRB will consider the following points when reviewing Research involving the use of Deception or Incomplete Disclosure:

1. The Study must not involve any more than Minimal Risk to the subjects.
2. The use of deceptive techniques must be justified by the study’s prospective value AND there should be no reasonable alternative method that would be equally effective (i.e., the researcher must demonstrate that the deception is necessary to conduct the study).
3. Prospective subjects must not be deceived about any physical or psychological risks, discomforts, or unpleasant emotional experiences of the study.
4. Nothing should be withheld from a subject that would affect their decision to participate.
5. If the study design allows, subjects should be told during the original consent process that some information is being withheld or is incomplete, and that they will receive more information after the Research is over. However, researchers often believe that even vague references to hidden purposes will affect subjects’ behavior and make the study impracticable. Investigators should either add such language to their consent forms when it is possible or note in their Protocols why it is not feasible to do so.
6. In addition, the Research must meet the criteria for a waiver of one or more elements of Informed Consent, as described below in Section 26.11.4, Informed Consent.
7. Whenever appropriate, researchers should debrief Participants. The debriefing should take place as early in the study as the design permits, preferably at the conclusion of a subject’s participation, but no later than the conclusion of the Research. See information about the debriefing process below in Section26.11.5, Debriefing.

28.18.4 Informed Consent:

In studies involving deception and/or incomplete disclosure, fully Informed Consent is not obtained from subjects prior to participation. When the consent process will not disclose pertinent information about the Research, Tulane’s IRB must consider whether the Research meets all of the criteria for a waiver of one or more elements of Informed Consent as set forth in federal regulations at 45 CFR 46.116(d).
The criteria for a waiver of one or more elements of Informed Consent can be found in Section 11.6.

28.18.5 Debriefing:
Debriefing the Participant is an important aspect of the informed consent process in deceptive studies. It gives the Investigator an opportunity to explain any Deception or Incomplete Disclosure involved, as well as to help the subjects deal with any distress or discomfort occasioned by the Research. If the study involves deception at the time of subject enrollment or consent that may have influenced the subject’s decision about participation, and/or the deception would likely be perceived by subjects as an invasion of privacy (e.g., videotaping without prior consent), Tulane’s IRB may require a re-consent for use of data as part of the debriefing process after study participation.

28.18.6 Exceptions to Debriefing Requirement:
There may be rare instances when debriefing would be inappropriate, such as when the debriefing itself may present an unreasonable risk of harm without a countervailing benefit. For example, if an individual were selected for participation in a study about group behavior based on a previously measured “negative” behavior or characteristic, it might not be appropriate for the debriefing to describe the selection process. In such cases, the Investigator likely would not recommend or require detailed debriefing.

28.18.7 Delayed Debriefing:
In certain cases, debriefing immediately after a subject’s participation would compromise study results (e.g., the study is ongoing and early subjects might tell others about it, making it impossible for the researchers to obtain valid/unbiased results from later subjects). Under such circumstances, Tulane’s IRB may approve a delayed debriefing process, such as sending debriefing information to Participants via email or regular mail (if subjects’ contact information is kept) or giving subjects a website URL where they can get debriefing information when the study has been completed. In some cases, it may be sufficient to ask the subject being debriefed to not reveal such information to others.

28.18.8 Debriefing as an Educational Tool:
A PI may recommend that feedback be provided at the conclusion of the study to further the education of the Participants (as opposed to giving information that was previously withheld or falsified). In such cases, the original consent may mention this will be done, and the debriefing may include bibliographical citations advising subjects where they can obtain additional information on the topic if they wish. A debriefing form typically is not used if the deception is innocuous.

In general, the debriefing process should consist of the following:

1. Disclosure of the deceptive aspect(s) of the study, and what the actual study objective was. This should be presented in simple, clear lay terms, similar to the consent document. Extremely technical/detailed explanations of study hypothesis, intentions of each task, etc., are not typically required.

2. An explanation of the reasons for the deception. These reasons should also be clearly explained, in language that is sensitive to the subjects’ possible discomfort or embarrassment at having been deceived.
3. An opportunity for the subject to ask questions.

4. *If indicated,* an opportunity for the subject to withdraw the provided data. Tulane’s IRB will decide on a case-by-case basis whether it is necessary to re-consent subjects to use study data obtained under deceptive premises. For example, in cases that involve only incomplete disclosure, a debriefing form that gives additional information about the study but does not ask for re-consent to use data will usually be acceptable. In contrast, when deception at the time of subject enrollment or consent is likely to have influenced the subject’s decision about whether or not to participate in the Research, or when the deception would likely be perceived by the subject as an invasion of privacy, the subject’s signature to permit use of such data will usually be required.

The debriefing document should be submitted on TU letterhead as part of the consent documentation for TUHRPP review. Please refer to the attached sample for assistance in creating an appropriate debriefing form.

28.19 Establishment and Use of Research Repositories

28.19.1 Data or Biological Sample Repositories

A repository is a collection of data or biological specimens whose organizers:

- Receive data or specimens from multiple sources
- Maintain the data or specimens over time
- Control access to and use of data or specimens by multiple individuals and/or for multiple purposes, which may evolve over time

These policies and procedures apply to both data and biological sample repositories. For simplicity, both will be referred to as data in this document.

There are two types of repositories:

- Non-research repositories created and maintained for purposes that are unrelated to research. Such purposes may include diagnosis, treatment, billing, marketing, quality assurance, and public health surveillance.
- Research repositories created and maintained specifically for research purposes. Such purposes may include databases to identify prospective subjects, patient outcome information to evaluate treatment effectiveness, tissue samples for future research, and social-behavioral science research repositories such as research repositories containing mental and/or behavioral health survey outcomes, or other types of social science research (e.g., political science, psychological, sociological, communication). Non-research repositories that are altered to facilitate research (e.g., through the addition of data fields not necessary for the core purpose of the repository) are considered research repositories.

Research involving data from a repository must satisfy the requirements of applicable regulations such as the Common Rule (45 CFR pt. 46), FDA (21 CFR pts. 50, 56, etc.), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR pts. 160 and 164). Research that is not subject to specific federal regulations is reviewed in accordance with the
principles described in the Common Rule and HIPAA, if the research is subject to HIPAA. For more detail, see Section 23, HIPAA, below.

28.19.2 Non-research Repositories

Even though repositories were not created for research purposes, they may contain data that is of great interest to researchers. The creation (or operation) of non-research databases or repositories does not involve human subject research and does not require IRB oversight (unless the repository has been altered to facilitate research as noted above). However, IRB oversight is required for use in research of identifiable private information or identifiable human specimens from non-research databases and repositories (including data/tissue banks and registries).

- When research involves identifiable private information or identifiable human specimens, each research project must receive prospective IRB review and approval and continuing IRB oversight.
- When research involves coded private information or human specimens, IRB review may be required. For more detail, see Section below entitled Coded Human Data or Biological Specimens.
- When research involves the use of human specimens with or without associated identifiers for the evaluation of an FDA-regulated product (e.g., an in vitro diagnostic (IVD)), prospective IRB review and approval and continuing IRB oversight is required unless the research qualifies for an exemption under FDA rules.
- Researchers should submit an application for IRB review and receive IRB approval before initiating the research. When uncertain if IRB review is required, investigators should consult with HRPO prior to initiating the research.
- Where available, the application should include any available information about the circumstances under which the information or specimens were originally collected.
- Investigators who believe their research may be exempt (e.g., under category #4) from the human subject regulations should include a request for exemption with the IRB application.

The IRB may require researchers to obtain the informed consent of subjects for research involving information or specimens contained in non-research databases or repositories. The IRB can waive the requirement for informed consent if the research meets the criteria for such a waiver.

If the repository includes PHI and is housed within a covered entity or uses PHI from a covered entity, the investigator must comply with HIPAA. See Section 23 below.

28.19.3 Research Repositories

Research repositories involve three principle components:

- the collectors of samples;
- the data storage and management center; and
- the recipient investigators.
28.19.3.1 Sample collection

If the data were collected for research purposes or are associated with information that can identify the donor, then informed consent must be obtained from the donor unless the requirement is waived by the IRB or if the research qualifies for an exception (e.g., FDA enforcement discretion guidance for certain IVD research).

Informed Consent information should include:

- A clear description of
  - the operation of the database;
  - a sufficient description of the anticipated types of research for which the data may be used such that potential subjects should be able to make an informed decision about participation;
  - the conditions under which data will be released to recipient-investigators;
  - procedures for protecting the privacy of subjects and maintaining the confidentiality of data
- A description regarding the potential for future withdrawal of data from the repository (i.e., whether and how subjects may, in the future, request that their data be destroyed or that their personal identifiers be removed from the data and any restrictions or limitations on their ability to do so).
- A statement that identifiers might be removed from the identifiable data and that, after such removal, the data might be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject.
- A statement that the subject’s data may be used for commercial profit and whether the subject will or will not share in the commercial profit.
- A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions.
- For research involving biological samples, whether the research will (if known) or might include whole genome sequencing

Other information, such as the length of time that data will be stored and management of incidental findings (when anticipatable) should be considered where appropriate.

28.19.3.2 Sample Storage and Management

Each repository should have written policies and operating procedures on:

- Data and tissue submission requirements
  - Informed consent
  - IRB review
- Physical and procedural mechanisms for the secure receipt, storage, and transmission of information and specimens
• Policies on release of information and specimens
  ▪ Coding
  ▪ Release of identifiers
  ▪ Terms of use

Certificates of Confidentiality, when applicable

28.19.3.3 Recipient Investigators

Recipient-investigators should have a written agreement, such as an MOU, Data Sharing Agreement, Data Use Agreement, and/or a Materials Transfer Agreement, with the repository. The agreement should specify under what conditions the data is being released to the recipient-investigator(s). The terms under which the data is released inform whether the research requires IRB oversight.

28.19.3.4 HIPAA Compliance in Establishment and Use of Research Repositories

The Privacy Rule recognizes the creation of a research database or a repository to be a research activity if the data/specimens to be stored include Protected Health Information (“PHI”) and the repository is housed at a covered entity and/or PHI is disclosed by a covered entity for creation of the repository. PHI is health information that includes one or more of the following HIPAA identifiers:

1. Names;
2. Address information smaller than a State (including street address, city, county, precinct, zip code, and their equivalent geocodes)
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. 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; and
18. Any other unique identifying number, characteristic, or code, unless it is a non-derived code.

There are two separate activities that the covered entity must consider: (1) the use or disclosure of PHI for creating a research database or repository and (2) the subsequent use or disclosure of PHI in the database for a particular research plan.

Individual authorization for the storage of PHI for future research must be sought unless the IRB has determined that the criteria for a waiver of the authorization requirement are satisfied. This authorization is distinct from the subject’s consent to participate in research, which is required under the Common Rule and FDA regulations. Federal regulations allow written authorization to be separate, stand-alone authorization documents or combined with informed consent documents. In either case, the authorization document must include all required elements under HIPAA. IRBs are not typically responsible for reviewing the content of stand-alone authorizations but must review combined authorization documents.

As with any research activity, the authorization (whether stand-alone or combined with a consent form) for future research must describe the future research uses in sufficient detail to allow the potential subject to make an informed decision regarding whether or not to permit their data to be used for future research. HHS does not permit authorizations to simply state that PHI may be used for future, unspecified research. An authorization for future research must adequately describe such purposes such that it would be reasonable for the individual to expect that his or her PHI could be used or disclosed for such future research. The investigator and IRB should be cognizant of uses of information/specimens that the target community may consider particularly sensitive, such as genetics, mental health, studies of origin, and use of tissues that may have cultural significance. When the repository will include use or disclosure of PHI that has not yet been generated (e.g., future medical records relating to a particular disease or condition), this should be described within the authorization.

The authorization for future research can be a stand-alone document or may be incorporated into another authorization if the information/specimens will originate from another research activity, such as a clinical trial, unless the research involves the use or disclosure of psychotherapy notes. Authorizations for the use or disclosure of psychotherapy notes can only be combined with another authorization for a use or disclosure of psychotherapy notes.

If the authorization for future research is combined with another research authorization, the authorization must clearly differentiate between the research activities and allow the individual to opt-in to the future research. Opt-outs for future research are not permitted under the Privacy Rule because an opt-out process does not provide individuals with a clear ability to authorize the use of their information/specimens for future research, and may be viewed as coercive.

For more detailed information on HIPAA, see Section 23 of these SOPs, “Health Insurance Portability and Accountability Act (“HIPAA”).
28.19.4 IRB Oversight

Operation of a research repository under the auspices of Tulane University is subject to oversight by the Tulane University HRPP. When the research repository is subject to IRB oversight, proposals to establish a repository should be submitted to the IRB specifying:

- The purpose of the repository.
- Data/specimens to be included.
- Policy and procedures for submission of data.
- Procedures for consent and HIPAA authorization.
- Procedures for security and confidentiality.
- Oversight over the repository.
- Policy and procedures for releasing data.

The repository policies and procedures should include a statement that no research will occur as part of the repository and that a separate protocol will be submitted for IRB approval for each specific research study that uses data from the repository. Each study is considered to be a research activity that is separate from the activity of the repository itself.

When the research repository may not be subject to IRB oversight (e.g., it qualifies for exemption or may not include human subjects as defined by the Common Rule, FDA, or applicable regulations), proposals to establish a research repository should be submitted to the IRB for an Exempt or Human Subject Research Determination.

28.19.5 Biological Specimens, Survey Outcomes, and other types of Social/Behavioral Outcomes

The collection and use of human biological specimens, as well as mental and/or behavioral health survey outcomes, or other types of social science research (e.g., political science, psychological, sociological, communication)(either identifiable or de-identified) for research, including specimens originally collected for clinical purposes, must comply with all applicable laws and regulations for research involving human biological specimens (as applicable), survey results (as applicable), other types of social science research (as applicable), or superseding requirements. IRB approval is required unless the collection or use is determined to be exempt or not human subjects research.

28.19.6 Regulatory Oversight

Under HHS regulations, a human subject is a living individual about whom an investigator conducting research obtains

- data through intervention or interaction with the individual, or
- identifiable private information

Whether research involving biological specimens, survey outcomes, or other types of social behavioral outcomes meets the definition of human subjects research is based on a) how the specimens, survey outcomes, other types of social behavioral outcomes were obtained and b) whether the specimens, survey outcomes, or other types of social behavioral outcomes include identifiable private information. If the specimens, survey outcomes, or other types of social
behavioral outcomes are obtained specifically for research purposes, then they have been collected through intervention or interaction with the individual and, thus, the research meets the definition of human subjects research. If the specimens, survey outcomes, or other types of social behavioral outcomes were not collected for research purposes but as part of routine clinical care or other non-research purpose, then the research only meets the definition of human subjects research if the specimens, survey outcomes, or other types of social behavioral outcomes include identifiable private information or if the specimens will be used for FDA-regulated research (see below).

An exception to this is federally funded research involving Newborn Blood Spots. Per the Newborn Screening Saves Lives Reauthorization Act of 2014 (Public Law No: 113-240), federally funded research using newborn dried spots is considered human subjects research regardless of whether the specimens are identifiable. Further, the law eliminates the ability of the IRB to approve alterations or waivers of informed consent under 45 CFR 46.116(c) and 116(d) for such research.

FDA regulations do not apply to biological specimens, survey outcomes, or other types of social behavioral outcomes unless they are gathered as part of a clinical investigation involving human subjects or are being used in a clinical investigation of a FDA-regulated product (e.g., an IVD). HIPAA does not cover biological specimens, survey outcomes, or other types of social behavioral outcomes but does cover protected health information (PHI) linked to the specimens, survey outcomes, or other types of social behavioral outcomes.

If the research meets the definition of human subjects research, then all of the requirements of this document apply.

28.19.7 IRB Review

Research not subject to FDA regulations and involving only biological specimens, survey outcomes, or other types of social behavioral outcomes may be exempt under Exemption Category #4: “Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.” However, in order to qualify under this category, all of the specimens survey outcomes, or other types of social behavioral outcomes must exist prior to the research being submitted to the IRB. Additionally, this exemption cannot be applied to federally funded research involving Newborn Blood Spots. For more detail on Exempt Studies, see Section 7 of these SOPs, “Exempt Studies.”

Non-exempt research only involving biological specimens, survey outcomes, or other types of social behavioral outcomes may be eligible for expedited review if it is minimal risk and falls within one of the following Categories of Research Eligible for Expedited Review:

- Clinical studies of drugs and medical devices when an IND or IDE is not required (or the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling) [with restrictions – see section of these SOPs on Categories of Research Eligible for Expedited Review]

- Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture [with restrictions – see section of these SOPs on Categories of Research Eligible for Expedited Review]
• Prospective collection of biological specimens for research purposes by noninvasive means.

• Research involving materials that have been collected or will be collected solely for non-research purposes. [NOTE: Some Research in this category may be exempt from the DHHS regulations for the protection of Human Subjects. See Exempt Categories and 45 CFR §46.101(b)(4). This listing refers only to Research that is not Exempt.]

• Collection of data from voice, video, digital, or image recordings made for Research purposes.

• Research on individual or group characteristics or behavior or research employing survey, interview, and other methodologies. [with restrictions – see section of these SOPs on Categories of Research Eligible for Expedited Review] [NOTE: Some Research in this category may be Exempt from the DHHS regulations for the protection of Human Subjects. See Exempt Categories and 45 CFR §46.101(b)(2) and (b)(3). This listing refers only to Research that is not Exempt]. For more detailed information, see Section 8.3.1 of these SOPs, “Categories of Research Eligible for Expedited Review.”

All non-exempt research involving biological specimens, survey outcomes, or other types of social behavioral outcomes that are not eligible for expedited review must be reviewed at a convened IRB meeting.

For all non-exempt research involving biological specimens, survey outcomes, or other types of social behavioral outcomes informed consent and documentation of consent is required unless waived by the IRB. Informed consent is required for all federally funded research using Newborn Blood Spots.

28.19.8 Coded Human Data or Biological Specimens

Tulane University IRB policy is based on the OHRP guidance document entitled, “Guidance on Research Involving Coded Private Information or Biological Specimens” (October 16, 2008 Coded Private Information or Specimens Use in Research). This document:

1. Provides guidance as to when research involving coded private information or specimens is or is not research involving human subjects, as defined under HHS regulations for the protection of human research subjects (45 CFR part 46).

2. Reaffirms OHRP policy that, under certain limited conditions, research involving only coded private information or specimens is not human subjects research (see next Section, 26.13.9 “Guidance,” for more details on research involving only coded private information or specimens, and Section 26.13.10 “Who Should Determine Whether Coded Private Information or Specimens Constitutes Human Subjects Research” for the process for determining whether such research constitutes Human Subjects Research).

3. Clarifies the distinction between (a) research involving coded private information or specimens that does not involve human subjects and (b) human subjects research that is exempt from the requirements of the HHS regulations.

4. References pertinent requirements of the HIPAA Privacy Rule that may be applicable to research involving coded private information or specimens.
Note: The FDA definition of human subjects research differs from the Common Rule definition. Use of coded specimens for FDA-regulated research, such as research on In Vitro Diagnostic Devices, requires assessment according to the FDA regulations and guidelines. Investigators should contact the HRPO for guidance.

For purposes of this policy, coded means that: (1) identifying information (such as name or social security number) that would enable the investigator to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, or combination thereof (i.e., the code); and (2) a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens.

28.19.9 Guidance

Obtaining identifiable private information or identifiable specimens for research purposes constitutes human subjects research. Obtaining identifiable private information or identifiable specimens includes, but is not limited to:

1. Using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that have been provided to the investigator from any source; and
2. Using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that were already in the possession of the investigator.

In general, private information or specimens are considered to be individually identifiable when they can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

Private information or specimens are not considered to be individually identifiable when they cannot be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

Research involving only coded private information or specimens (other than federally funded research using Newborn Blood Spots) do not involve human subjects per the Common Rule definition if both of the following conditions are met:

1. The private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals; and
2. The investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:
   a. The investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the HHS regulations do not require the IRB to review and approve this agreement);
   b. There are IRB-approved written policies and operating procedures for a repository or data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased; or
c. There are other legal requirements prohibiting the release of the key to the investigators, until the individuals are deceased.

In some cases, an investigator who obtains coded private information or specimens about living individuals under one of the conditions cited in 2(a)-(c) above may (1) unexpectedly learn the identity of one or more living individuals, or (2) for previously unforeseen reasons now believe that it is important to identify the individual(s). If, as a result, the investigator knows, or may be able to readily ascertain, the identity of the individuals to whom the previously obtained private information or specimens pertain, then the research activity now would involve human subjects. Unless this human subjects research is determined to be exempt, IRB review of the research would be required. Informed consent of the subjects also would be required unless the IRB approved a waiver of informed consent.

Notably, if investigator uses the coded private information or coded specimens in a facility that is a “covered entity” under HIPAA, the activity will remain subject to HIPAA unless (i) the coded private information and/or coded specimens are de-identified to the standard set forth at 45 CFR § 164.514(b); and (ii) the code meets the requirements of a re-identification code set forth at 45 C.F.R. § 164.514(c), i.e., it is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual, and the covered entity does not use or disclose the code for any other purpose.

28.19.10 Who Should Determine Whether Coded Private Information or Specimens Constitutes Human Subjects Research

OHRP guidance recommends that “…institutions have policies in place that designate the individual or entity authorized to determine whether research involving coded private information or specimens constitutes human subjects research. The person(s) authorized to make the determination should be knowledgeable about the human subject protection regulations. In addition, the institution should ensure the appropriate communication of such a policy to all investigators. OHRP recommends that investigators not be given the authority to make an independent determination that research involving coded private information or specimens do not involve human subjects.”

The procedures for making this determination at Tulane University are as follows:

The Investigator should submit a Human Subjects Research Determination Application via the IRB Electronic Submission System for determination as to whether the research involving coded information or specimens requires IRB review.

28.20 Genomic Data Sharing (GDS) Policy

28.20.1 Purpose

Tulane complies with the NIH GDS Policy, which allows for “broad and responsible sharing of genomic research data”, via submission of said data into an NIH-designated data repository. The intent of NIH’s policy is to speed discoveries to diagnose, treat, and prevent disease. To ensure consistency in the protection of human subjects, Tulane applies the NIH principles for informed consent and for a genomic data sharing plan to all research that involves or contemplates genomic data sharing. The NIH policy applies to grant activities requesting support from NIH for research involving the generation of large-scale human (and/or non-human) genomic data, regardless of funding level, such as:
• Research project grants (Rs);
• Program projects (Ps) and SCORs (Ss);
• Cooperative agreements for research (Us);
• Individual career development awards (Ks) that include a research component;
• S activities that include a research component; and
• All other activities that include a research component.

Also covered under this policy is research involving data derived from these activities for subsequent research. All basic and clinical research, including clinical trials, supported by NIH that involves the generation or use of large-scale genomic data fall within the scope of the policy. The policy does not apply to:

• Institutional training grants (T32s, T34s, T35s, and TL2s);
• K12 career development awards (KL2s);
• Individual fellowships (Fs);
• Resource grants and contracts (Ss);
• Linked awards derived from previously reviewed applications (KL1, KL2, RL1, RL2, RL5, RL9, TL1, UL1);
• Facilities or coordinating centers funded through related initiatives to provide genotyping, sequencing, or other core services in support of GDS.

Because of the potential for re-identification of genomic data, Certificates of Confidentiality (CoCs) are automatically issued by the NIH for any research it supports, in part or in whole, that involves “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 subjects can be identified or the identity of the human subjects can readily be ascertained as defined in the Federal Policy for the Protection of Human Subjects (45 CFR 46).” Research covered by the NIH policy and/or the underlying PHS Act is protected by the CoC in perpetuity; as such any downstream recipients of such information must comply with the requirements of the PHS Act.

Investigators without NIH support who intend to submit genomic data to a NIH repository are encouraged to obtain a CoC. Investigators conducting research generating or using genomic data are encouraged to obtain a CoC when one is not already in place (e.g., for downstream use of data that was collected under a CoC). For more information on CoCs, see Section 28.1.

28.20.2 Definitions

Genomic data: information derived from study of an organism’s genome, i.e., the set of DNA (including all the genes within) in every cell that provides all of the information needed to build and maintain that organism.

Genomic Summary Results (GSR): GSR (also referred to as “aggregate genomic data” or “genomic summary statistics”) are results from primary analyses of genomic research that convey information relevant to genomic associations with traits or diseases across datasets rather than associations specific to any one individual research participant (e.g., genotype counts and frequencies; allele counts and frequencies; effect size estimates and standard errors; likelihood; and p-values). Sensitive GSR refers to GSR where the privacy risks may be heightened for
study populations (e.g., populations from isolated geographic regions or with rare traits) or the study populations may be more vulnerable to group harm (e.g., because the data includes potentially stigmatizing traits). Information regarding NIH’s updated policy on the access, use, and management of GSR may be found here: https://grants.nih.gov/grants/guide/notice-files/NOT-OD-19-023.html

**Large-scale data** include genome-wide association studies (GWAS), single nucleotide polymorphisms (SNP) arrays, and genome sequence, transcriptomic, epigenomic, and gene expression data. Examples of genomic research projects that are subject to the Policy and the timeline for submission and sharing of data from such projects may be found here: https://osp.od.nih.gov/wp-content/uploads/Supplemental_Info_GDS_Policy.pdf

**NIH-Designated Data Repository**: any data repository maintained or supported by NIH either directly or through collaboration. Examples of such repositories is available here: https://osp.od.nih.gov/scientific-sharing/data-repositories-and-trusted-partners/. Data may be unrestricted or controlled access:

- **Unrestricted-Access ("Open Access")**: data are publicly available to anyone (e.g., The 1000 Genomes Project). Non-sensitive GSR are made available through unrestricted access.

- **Controlled-Access**: the data are available to an investigator for a specific project only after the investigators and institution certify to abide by specified terms and conditions and NIH has approved the use. Sensitive GSR are made available through controlled access.

**28.20.3 Procedures**

**IRB Submissions and GDS**

For any cell lines created or specimens to be collected, analyzed, and shared subject to the GDS Policy, the IRB expects that informed consent will be obtained from the research subject for the future research uses and broad sharing of data required under the policy, including GSR. **This is the case even if the specimens or cell lines are de-identified.** If there are compelling scientific or legal reasons that necessitate the use of genomic data from cell lines or clinical specimens that lack consent for research use and data sharing, investigators will need to provide a justification in the funding request to NIH for their use. The funding NIH institute/center will review the justification and decide whether to make an exception to the consent expectation. Exceptions from the NIH are not required if only some participants decline to consent to broad sharing, rather an exception request must be granted by NIH for research when consent for broad sharing has not or will not be sought.

Subjects asked to allow for future research uses and broad sharing of their genomic data have the ability to decline, and still remain in the research (however their data cannot be placed into a repository or otherwise broadly shared). The only exception to this is when sharing of the data is intrinsic to the study (e.g., the purpose of the study is to establish a repository for sharing biological specimens and/or data for future research).

Sample consent language for studies subject to GDS is available in the consent template, from the HRP Office. NIH and NHGRI also provides guidance and resources to assist in the
development of appropriate consent forms for research involving or generating genetic or genomic data.

Applications to the Tulane IRB should include information about the proposed generation or use of genomic data including, as applicable:

- Whether the research will generate or use data subject to the NIH GDS policy;
- The name of the NIH data repository/database, or other repository or database, that data will be submitted to or acquired from;
- Whether the data is or should be classified as restricted access or unrestricted access;
- Whether the data is or should be classified as sensitive (e.g., studies involving populations from isolated geographic regions or with rare traits, studies that include data on potentially stigmatizing traits, etc.)
- Whether there are any data use limitations or modifiers (e.g., use limited to a specific disease, restricted to not-for-profit organizations, IRB approval requirement, etc.);
- The plan for informed consent and the proposed consent language; and
- Storing Data or Specimens for Future Use (questions related to Storing Data or Specimens for Future Use are included in the Privacy and Confidentiality Section of IRB Electronic System); and
- A copy of the genomic data sharing plan.

The IRB will review the proposal for genomic data sharing or subsequent use of such genomic data in accordance with the criteria for approval of research and the guidelines for IRBs provided by NIH.

When Tulane is responsible for NIH Institutional Certification (see below), the IRB review will specifically address the required assurances outlined on the Extramural Institutional Certification. When appropriate, if the IRB is unable to confirm that a certification element is satisfied (e.g., because the IRB has not yet granted final approval), Provisional Institutional Certification will be provided.

**Grant Applications and GDS**

Investigators planning to apply to NIH for research that will generate large-scale human genomic data as defined above should contact the appropriate NIH Program/Project officials to discuss expectations and timelines for complying with this policy. Along with the grant, the following will need to be submitted:

- **Notification in a cover letter** of the intent to generate large-scale human genomic data
- **Institutional Certification** from the Office of Sponsored Projects Administration (SPA) (templates available here: [https://osp.od.nih.gov/scientific-sharing/institutional-certifications/](https://osp.od.nih.gov/scientific-sharing/institutional-certifications/)). Certification must be provided for all sites contributing samples. If more than one site is contributing samples, the primary site may submit one certification on
behalf of all collaborating sites (or each site may provide their own certification if this is the site’s preference). This certification assures that:

- The data submission is consistent, as appropriate, with applicable national, tribal, and state laws and regulations as well as relevant institutional policies;
- Any limitations on the research use of the data, as expressed in the informed consent documents, are delineated within the certification;
- The identities of research participants will not be disclosed to the repositories;
- An IRB and/or Privacy Board has reviewed the investigator’s proposal for data submission and assures that:
  - the protocol for the collection of genomic and phenotypic data is consistent with 45 CFR 46;
  - data submission and subsequent data sharing for research purposes are consistent with the informed consent of study participants from whom the data were obtained;
  - consideration was given to the risks to individual participants and their families associated with data submitted to the repositories and subsequent sharing, including unrestricted access to GSR; and
  - that the investigator’s plan for de-identifying datasets is consistent with the standards outlined in the NIH Genomic Data Sharing (GDS) Policy. (See Section 28.19).

- **In situations where the sharing of human data is not possible** (i.e., the Institutional Certification criteria cannot be met), a justification is required to explain why these data cannot be shared, and an alternative data sharing plan will need to be provided. Exceptions to NIH expectations for data submission to an NIH-designated data repository will be considered on a case-by-case basis by the NIH funding Institute or Center (IC).

Investigators who wish to use controlled-access human genomic data from NIH-designated data repositories should briefly address their plans for requesting access to the data and state their intention to abide by the NIH Genomic Data User Code of Conduct in the Research Plan of the application. The code of conduct is available here: [https://osp.od.nih.gov/wp-content/uploads/Genomic_Data_User_Code_of_Conduct.pdf](https://osp.od.nih.gov/wp-content/uploads/Genomic_Data_User_Code_of_Conduct.pdf). Access to controlled-access data is dependent on an approval process that involves the relevant NIH Data Access Committee(s). Applicants may wish to secure access to the data prior to submitting their application for NIH support. Secondary users of controlled-access data are not expected to deposit their findings into NIH-designated data repositories, unless appropriate.

Investigators who wish to use/download data from NIH unrestricted-access repositories, including non-sensitive GSR:

- Should use the data to promote scientific research or health;
- Should not use the data to re-identify individuals or generate information that could allow participant’s identities to be readily ascertained; and
- In all oral and written presentations, disclosures, or publications, acknowledge the specific dataset or accession numbers and the repository through which the data were accessed.
Procedures for submitting data into, or requesting access for data from an NIH-designated repository, are available here: https://osp.od.nih.gov/scientific-sharing/researchers-institutional-certifications/.

28.21 General Data Protection Regulation (GDPR)

Please review the Secretary’s Advisory Committee on Human Research Protections (SACHRP) recommendations regarding GDPR compliance and human subjects research, found here: SACHRP Recommendations for EU GDPR. Note, IRB review does not assure GDPR compliance. Please consult with the Office of General Counsel for further guidance on GDPR regulations in research.
29  Emergency or Disaster (e.g., public health or weather-related)

In the event of an emergency or disaster (e.g., public health or weather-related), the procedures in these SOPs may be modified as appropriate for the situation. Such modifications may include alternative meeting procedures, alternative procedures for the submission and review of modifications, alternative procedures for prompt reporting, and any other changes necessary to ensure appropriate ongoing oversight and conduct of research. Because procedural modifications may vary based on the nature of the event, these cannot be anticipated and described in these SOPs. Instead, such procedural modifications will be recorded in an addendum to the SOPs, note-to-file, or other appropriate means of documentation and communicated to the research community. This documentation will be maintained in accordance with applicable record retention requirements.
Glossary

Administer (or “Administration” or “Administering”): means the direct application of a Drug to the body of a patient or Research subject by injecting, inhalation, ingestion, or any other means. [LA R.S. 37:1164]. See Section 13.2 for details.

Abuse: is the infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon a Child or Elder by another person. It also entails the involvement of the Child in any sexual act with any other person; the involvement of the Elder in any unconsented sexual act with any other person; the aiding or toleration by the Parent or the caretaker of the Child/Elder's sexual involvement with any other person; the Child/Elder's involvement in pornographic displays; or any other involvement of a Child/Elder in sexual activity constituting a crime under the laws of this state. See Section 26.2.1 for details.

Adverse Device Effect: Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a Device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other serious Unanticipated Problem associated with a device that relates to the rights, safety, or welfare of subjects [21 CFR 812.150(a)]. See Section 13.9.2 for details.

Adverse Events: is any untoward physical or psychological occurrence in a Human Subject participating in Research, including any abnormal sign (e.g., abnormal physical exam or laboratory finding, symptoms or disease associated with the Research or the use of a medical investigational Test Article), symptom, or disease, temporarily associated with the Subject’s participation in the Research. An Adverse Event is not necessarily an Unanticipated Problem although it can be one. An Adverse Event does not necessarily have to have a causal relationship with the Research, or any risk associated with the Research or the Research intervention, or the assessment. See Section 14.2 for details.

Affiliated IRB Member: is an employee or agent of Tulane University (or a member of that person’s immediate family). Affiliated members include, but are not limited to individuals who are: Full- or part-time employees; current students; members of any governing panel or board of the institution; paid or unpaid consultants; health care providers holding credentials to practice at the institution; and, volunteers working at the institution on business unrelated to the IRB. See Section 4.4 for details.

Agent(s): are chemical agents that affect the function of living things. See Section 13.2 for details.

Allegation of Noncompliance: means an unconfirmed report of Noncompliance. See Section 16 for details.

Alternate Member: is an individual who has the experience, expertise, background, professional competence, and knowledge comparable to that of the primary IRB member(s) whom the alternate would replace. See Section 14.4 for details.

Approved (or “Approved,” “Approval,” or “IRB Approval”): means the determination by the IRB that the investigation has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and other institutional and Federal regulations. The Research
may begin as of the IRB approval date. [DHHS 45 CFR §46.102(h); FDA 21 CFR §56.102(m)]. See Section 8.12.1 for details.

**Approval in Principal:** is IRB approval, as requested by a Sponsor, without the IRB having reviewed all of the study procedures and consent documents. [45 CFR §46.118]. See Section 8.12.5 for details.

**Assent:** means a Child’s affirmative agreement to participate in Research. Mere failure of a Child to object may not, absent affirmative agreement, be construed as Assent. [DHHS 45 CFR §46.402(b); FDA 21 CFR §50.3(n)]. See Section 12.9.3 for details.

**Authorization (or “HIPAA Authorization”):** for HIPAA purposes, is a written document completed and signed by the individual that allows use and Disclosure of PHI for specified purposes, which are generally other than treatment, payment, or health care operations of a Covered Entity. [45 CFR §164.501 and §164.508]. See Section 23 for details.

**Blinded:** a study is considered to be Blinded if when it is designed to compare two or more interventions in which the Investigator, the subjects, or some combination thereof, do not know the treatment group assignments of individual subjects. A Blinded study sometimes is called a masked study design.

**Biological Products (or “Biologics”):** are used for the treatment, prevention or cure of disease in humans and include a wide range of products such as vaccines, blood, and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Biologics are isolated from a variety of natural sources—human, animal, or microorganism—and may be produced by biotechnology methods and other cutting-edge technologies. FDA regulations and policies have established that Biological Products include blood-derived products, vaccines, in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products. Biological Products, like other Drugs, can be studied in clinical trials involving Humans Subjects under an IND in accordance with the regulations at 21 CFR §312. See Section 13.2 for details.

**Case History (or “Case Histories”):** is a record of all observations and other data pertinent in the investigation on each Research subject. A PI is required to prepare and maintain adequate and accurate Case Histories. Case Histories include the case report forms and supporting data (e.g., signed and dated consent forms), and medical records (e.g., physician progress notes, the subject’s hospital chart(s), nurses’ notes, etc.). The Case History for each subject must document that Informed Consent was obtained prior to participation in the study. See Section 10.11.2 for details.

**Child (or “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. [DHHS 45 CFR §46.402(a); FDA 21 CFR §50.3(o)].

According to Louisiana Law, the legal age for consent for treatment or medical procedures is 18 years or older. [LA Children’s Code 116; LA R.S. 40:1095]. Louisiana law is silent with respect to the legal age to consent with respect to Research. For purposes of these SOPs, any person who is under the age of 18 generally is unable to consent for him/herself. Several important exceptions exist under Louisiana law that effectively treat Children as adults and gives them the
capacity to consent to their own medical care and to participate in Research. They include the following:

- For a Child to receive medical and/or surgical care at a hospital and/or to receive physicians’ services [LA R.S. 40:1095]. This may or may not overlap with the proposed Research;
- If a Child is emancipated by marriage. Regardless of age, a Child is fully emancipated upon his or her marriage [LA Children’s Code Art 379];
- If a Child is judicially emancipated. This requires a court order for Child older than 16 years of age [LA Children’s Code Art 366 and 1922];
- If a Child is emancipated by authentic act. This requires a Child older than 16 years of age and the Child’s Parents to execute a written document of emancipation, signed before two witnesses and a notary [LA Children’s Code Art 368];
- If a Child seeks to be treated for venereal disease [LA R.S. 40:1065.1]; and
- If a Child seeks to be treated for drug abuse [LA R.S. 40:1096].

Because Louisiana law does not specifically address consent of Children with majority status to Research, the University’s IRB will review issues of consent related to enrollment of these Children in Research on a case-by-case basis. See Section 12.9 for details.

**Clinical Investigation:** any experiment that involves a Test Article and one or more Human Subjects and that either is subject to requirements for prior submission to the FDA under section 505 of the Federal Food, Drug, and Cosmetic Act (the “FDA Act”) [21 U.S.C. §355] or to, or held for inspection by the Food and Drug Administration (“FDA”) as part of an application for a Research or marketing permit. [21 CFR §50.3].

**Coded:** means (1) Individually Identifiable Private Information (e.g., name or social security number) that would enable the Investigator to readily ascertain the identity of the individual to whom the Private Information (or specimens) pertains has been replaced with a number, letter, symbol, or combination thereof (i.e., the Code); and (2) a key to decipher the Code exists, enabling linkage of the Individually Identifiable Private Information (or specimens). See Section 23.4 for details.

**Color Additive:** means any dye, pigment or substance which when added or applied to a food, Drug or cosmetic, or to the human body, is capable—alone or through reactions with other substances—of imparting color. The term “color” includes black, white and intermediate grays. [Section 201(t) of the FDA Act; 21 U.S.C. 321(t)].

**Common Rule:** refers is the “Federal Policy for the Protection of Human Subjects” that provides for the primary source of regulation of Research. It has been adopted by a number of Federal agencies. Although the Common Rule is codified by each agency separately, the text is identical to Department of Health and Human Services (“DHHS”) regulations contained in 45 CFR 46 Subpart A. For the purposes of the HRPP, references to the Common Rule will cite the DHHS regulations. See Section 1 for details.

**Conditions Required for Approval:** is a situation where the IRB may approve the Research with conditions if, given the scope and nature of the conditions, the IRB is able, based on the assumption that the conditions are satisfied, to make all of the determinations required for...
approval (i.e., approval criteria, waiver/vulnerable population determinations, etc.). Any time the IRB cannot make one or more of the determinations required for approval, the IRB may not approve the research project. See Section 8.12.2 for details.

Confidentiality: methods used to ensure that information obtained by Researchers about their Research subjects is not improperly divulged. Do not confuse this Research term with HIPAA Privacy requirements. See Section 8.5.6 for details.

Conflict of Interest: a set of circumstances in which the professional interests or duties of an individual, such as professional obligations or judgment owed to the University and its constituencies by a faculty member, staff member, or affiliated Investigator, are compromised by, or could reasonably be perceived as being compromised by, his or her leadership role(s), financial interest(s), research leadership role(s), or research financial interest(s). [Tulane University COI Policy, Part A(V)]. See Sections 8.6.6 and 8.6.7 for details.

Consultant: is an individual with competence in a special area that the IRB has invited to assist in the review of issues which require expertise beyond or in addition to the availability on the IRB. These individuals do not count for IRB Quorum purposes and cannot vote on any issue before the IRB [45 CFR §46.107(f)]. See Section 4.7 for details.

Continuing Noncompliance: means any noncompliance (whether Minor Noncompliance or Serious Noncompliance) that occurs repeatedly after appropriate remedial education or corrective action has been instituted taking into consideration all relevant factors, including, for example:

1. whether the continuing noncompliance was intentional, and/or
2. whether the investigator collaborated in remedial activity and the continuing noncompliance was not intentional.

See Section 16 for details.

Contract Research Organization (or “CRO”): means a person that assumes, as an independent contract with the Sponsor, one or more of the obligations of a Sponsor (e.g., design of a Protocol, selection or monitoring of Investigators, evaluation of reports, and preparation of materials to be submitted to regulatory agencies. [FDA 21 CFR §312.3(b)]. See Section 18.2 for details.

Covered Entity: for HIPAA Privacy purposes, is the term applied to institutions that must comply with the HIPAA Privacy and Security Rule. They include: health plans, health care clearinghouses; and health care providers. [DHHS 45 CFR §160.103; 45 CFR §164.504]. See Section 23.2 for details.

Convened IRB Review (or “Convened IRB”): means review by a fully convened IRB. See Section 8.4 for details.

Cooperative Research: is defined as Research conducted in cooperation with and at a performance site of an institution or facility that is not owned or operated by Tulane or TUHC or that does not fall under Tulane IRB’s authority. An Off-Site Institution or Off-Site Facility may be domestic or international and may or may not have its own IRB. See Section 24.5 for details.
**Dead Fetus**: is a Fetus that exhibits neither a heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord, if still attached. [DHHS 45 CFR 46§202(a)]. See Section 11.12.6 for details.

**Deception**: occurs when an Investigator gives false information to subjects or intentionally misleads them about some key aspect of the Research. This is sometimes referred to as “active deception.” Compare this with the definition of Incomplete Disclosure. See Section 26.11 for details.

**Deferred for Modifications**: is a situation where the IRB cannot approve the Research as submitted because (1) the Proposal and/or Consent Form require major modification or clarification; or (2) insufficient information is provided to adequately judge the Protocol application (e.g., the risks and benefits cannot be assessed with the information provided). IRB approval of the proposed Research will not be granted until a subsequent review of the material submitted by the PI, is deemed to be satisfactory by the convened IRB. See Section 8.12.3 for details.

**De-Identified Information**: for HIPAA Privacy purposes, Health Information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. If information is de-identified, it no longer is subject to the Privacy Rule and exempt from HIPAA. [45 CFR §164.514(a) and (b); 45 CFR §164.502(d) (permitted uses and Disclosures of De-Identified Information)] (see Section 23.4 for details.

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

**Deviation (or “Protocol Deviation”)**: means a violation that is unanticipated and happens without any prior agreement (e.g., a protocol visit scheduled outside the Protocol window; blood work drawn outside the Protocol window, etc.). The IRB will review these reports for frequency and may request, among other reasons, that an audit be conducted for any Protocol reporting frequent deviations. [Not defined by Common Rule or FDA regulations]. See Section 14.2 for details.

**Device (or Medical Device)**: is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related Test Article, including a component part, or accessory which is (a) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in humans, or (b) intended to affect the structure or any function of the body, and which does not achieve any of it primary intended purposes through chemical action within or on the body, and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes. See Section 1.4 for details.

**Disapproved (or “Disapproval”)**: means that the IRB cannot approve the Protocol as written. See Section 8.12.4 for details.

**Disclosure (or “Disclosure of PHI”)**: for HIPAA Privacy purposes, a Disclosure is the release, transfer, provision of access to, or divulging in any other manner IIHI outside of the Covered Entity. [45 CFR §164.501]. See Section 23.4 for details.

**Dispense (or Dispensing)**: means the interpretation, evaluation, and implementation of a prescription Drug order, including the preparation and delivery of a Drug or Device to a patient.
or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient. “Dispense” necessarily includes a transfer of possession of a Drug or Device to the patient or the patient's agent. [LA R.S. 37:1164]. Louisiana law requires that Dispensing may only be done by a licensed pharmacist or a physician who is registered with the board as a dispensing physician. [LA R.S. 37:1201]. See Section 13.2 for details.

**Distribute (or Distribution):** means the delivery of a Drug or Device other than by Administering or Dispensing. See Section 13.2 for details.

**Drug:** is a substance whose primary intended use is achieved through chemical action or by being metabolized by the body. Drug has the following legal definitions:

- Louisiana law defines Drug as meaning: (a) any substance recognized in the official compendium, or supplement thereto, designated by the Louisiana Board of Pharmacy (or other appropriate jurisdiction) for use in the diagnosis, cure, mitigation, treatment or prevention of diseases in humans, (b) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans, or (c) any substance other than food intended to affect the structure or any function of the body of humans. [LA-R.S. 37:1164].

- The FDA defines Drug as meaning: (A) articles recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than Food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in clause (A), (B), or (C). A Food or dietary supplement is not a Drug solely because the label or the labeling contains such a claim. A Food, dietary ingredient, or dietary supplement for which a truthful and not misleading statement is made is not a Drug under clause (C) solely because the label or the labeling contains such a statement. [21 U.S.C. 321(g)(1)].

**Elder:** means an adult over the age of 60. See Section 13.2 for details.

**Emergency Use:** means the use of an investigational Drug or Biological product with a Human Subject in a Life-Threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval. [FDA 21 CFR 56.102(d)]. The Emergency Use provision in the FDA regulations [FDA 21 CFR 56.104(c)] is an exemption from prior review and approval by the IRB. See Section 13.8.3.1 for details.

**Employee or Agent** – For the purposes of this document, employees or agents refers to individuals who: (1) act on behalf of the University; (2) exercise Institutional authority or responsibility; or (3) perform Institutionally designated activities. “Employees and agents” can include staff, students, contractors, and volunteers, among others, regardless of whether the individual is receiving compensation. See Section 13.8.3.1 for details.

**Enrolled participants:** individuals who are eligible for participation (i.e., meet the inclusion criteria for the study), have given informed consent and participated in some or all of the study procedures (excluding screening procedures where applicable). An individual who fails screening procedures is not considered to be enrolled. See Section 8.2 for details.
Engaged (or “Engaged in Research”): an institution is engaged in a Research project when its employees or Institutional Agents, for the purposes of the research project obtain: (1) data about the subjects of the Research through intervention or interaction with them; or (2) Individually Identifiable Private Information about the subjects of the Research or identifiable biological specimens; or (3) the Informed Consent of Human Subjects for the Research. Obtaining Individually Identifiable Private Information includes, but is not limited to: (1) observing or recording private behavior; (2) using, studying, or analyzing for Research purposes identifiable Private Information or identifiable specimens provided by another institution; and (3) using, studying, or analyzing for Research purposes Individually Identifiable Private Information or identifiable specimens already in the possession of the Investigators. See Section1.9 and 24 for details.

Exceptions (or “Protocol Exceptions”): means a circumstance in which the specific procedures called for in a Protocol are not in the best interests of a specific patient/subject (e.g., patient/subject is allergic to one of the medications provided as supportive care). Usually it is a violation that is anticipated and happens with prior agreement from the sponsor. [Not defined by Common Rule or FDA regulations]. See Section 8.15 for details.

Exempt Research (or “Exempt” or “Exempt Review”): is Research determined by the IRB to involve Human Subjects only in one or more of certain Minimal Risk categories [45 CFR §46.101(b)]. See Section 7 for details.

Ex-Officio Guest: Certain ex officio individuals (e.g., University Counsel, the RCO, and HRPO staff) regularly attend IRB meetings as ex officio guests. While they are not voting members of the IRB, they may participate in the IRB discussion and may provide additional information to the IRB. They need only sign a confidentiality agreement once. See Section8.4.8 for details.

Expedited Research (“Expedited” or “Expedited Research”): is Research determined by the IRB to present no more than Minimal Risk to Human Subjects and involves only procedures in certain specific categories. Minor Changes to previously approved Research during the period for which approval is authorized may also be approved through the Expedited process. [45 CFR §46.110 (b)]. See Section 8.3 for details.

Fetus: Is the product of conception (i.e., fusion of a human spermatozoa with a human ova) from the time of implantation until Delivery. [DHHS 45 CFR §46.202(c); LA R.S. 40:1299.35.1]. See Section 12.6.1 for details.

Financial Interest: is (1) aggregate investments (whether in the form of debt, stock or other equity ownership, options or warrants to purchase stock or other securities or similar instruments) with a value exceeding $10,000 or representing a five (5%) percent or greater interest in any entity, enterprise or trust; (2) royalties on any patent or other intellectual property interests with a value exceeding $10,000, unless paid by Tulane; or (3) income, salary or remuneration in cash or in kind, emoluments, benefits, gifts, honoraria, travel expenses, goods or services with a value exceeding $10,000. Financial Interest does not include holdings in mutual funds or other equity funds in which the day-to-day control of investments is held by a person not subject to any Tulane COI policy. This definition is extracted from the Institution’s COI policy contained in the Faculty Handbook, Part III, D, Part A. The definition in the Faculty Handbook shall prevail to the extent that there is a conflict. See Section 21.2 for details.
Finding of Non-Compliance: is an Allegation of Non-Compliance that is proven true or a report of Non-Compliance that is clearly true. (e.g., a finding on an audit of an unsigned consent document, or an admission of an Investigator that the Protocol was willfully not followed would represent reports of non-compliance that would require no further action to determine their truth and would therefore represent findings of Non-Compliance.) See Section 16 for details.

Food: include dietary supplements that bear a nutrient content claim or a health claim. [Section 201(f) of FDA Act].

Food Additive: In its broadest sense, a food additive is any substance added to food. The FDA defines the term as “any substance the intended use of which results or may reasonably be expected to result—directly or indirectly—in its becoming a component or otherwise affecting the characteristics of any food.” [Section 201(s) of the FDA Act].

Federal-Wide Assurance (“Assurance” or “FWA”): is a written commitment by an institution to protect Human Subjects participating in Research. Under Federal regulations, any institution conducting or engaged in federally supported Research involving Human Subjects must obtain an Assurance in accordance with 45 CFR §46.103. This requirement also applies to any collaborating “performance site” institutions. “Engaged in Research” is defined in Section 1.9.

Generalizable Knowledge: Activities that are designed to draw general conclusions, inform policy, or generalize findings. Generalizable knowledge includes one or more of the following concepts: (1) The information contributes to a theoretical framework or an established body of knowledge; (2) The primary beneficiaries of the study are other researchers, scholars, and practitioners in the field of study; (3) Publication, presentation or other distribution of the results intended to inform the field of study; and, (4) The results are intended to be replicated in other settings.

Infant Formula: means a Food which purports to be or is represented for special dietary use solely as a Food for infants by reason of its simulation of human milk or its suitability as a complete or partial substitute for human milk. [Section 201(z) of the FDA Act].

Guardian (or Legal Guardian): means an individual who is authorized under applicable State or local law to consent on behalf of a Child to (a) general medical care when general medical care includes participation in Research; or (b) to participate in Research. [DHHS 45 CFR §46.402(e); FDA 21 CFR 50.3(s); LA. Children’s Code 116(12.1) (a)(i) (b)]. A Guardian of a Minor retains the duty and authority to (1) act in the best interests of the Minor, subject to residual Parental rights and responsibilities (if any); (2) make important decisions in matters having a permanent effect on the life and development of the Minor; and (3) to be concerned with the Minor’s general welfare. For Research conducted in jurisdictions other than Louisiana, the Research must comply with the laws regarding guardianship in all relevant jurisdictions where the Research will take place. See Section 11.2 for details.

Health Agent: Is an authorized representative legally acting for a person pursuant to a Durable Power of Attorney for Health Care (“Medical Power of Attorney”) or other legal document permitted within a jurisdiction that allows a person to appoint another person(s) to make medical decisions for the patient if the patient should become temporarily or permanently unable to make those decisions for himself/herself. Any adult (18 or older) can be granted this power. [LA R.S.40:1299.53(A) (13)]. See Section 12.9 for details.
**Health Information**: for HIPAA Privacy purposes, it means any information, whether oral or recorded in any form or medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. [DHHS 45 CFR §160.103]. See Section 23.4 for details.

**Human Subject(s) Research**: means any activity that meets the definition of Research and involves Human Subjects as defined by either the Common Rule or FDA regulations. See Section 6 for details.

**Human Research Protection Program (‘‘HRPP’’)**: Tulane’s HRPP is a comprehensive system to ensure the protection of Human Subjects participating in Research. The objective of this program is to assist the institution in meeting applicable ethical principles and regulatory requirements for the protection of Human Subjects in Research. See Section 1.4 for details.

**HumanSubject(‘‘Subject,”“Participant,”“HumanParticipant,”“HumanResearchSubject”)**: a living individual about whom an investigator (whether professional or student) 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. [45 CFR46.102(e)(1)]

For purposes of this definition, the following definitions are germane:

- **‘‘Interaction’’** means communication or interpersonal contact between Investigator and subject. [45 CFR46.102(e)(3)]

- **‘‘Intervention’’** means both physical procedures by which information or biospecimens regathered (example, veni-puncture) and manipulations of the subject or the subject’s environment that are performed for Research purposes. [DHHS 45 CFR§46.102(e)(2)]

- **‘‘Private information’’** means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). [45 CFR 46.102(e)(4)]

- **‘‘Identifiable private information’’** means private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information. [45 CFR46.102(e)(5)]. Note: This definition is within the Common Rule. For a discussion of identifiable under HIPAA, please see Section 23.

- **‘‘Identifiable biospecimen’’** means a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen [45CFR46.102(e)(6)]

- **‘‘Individually identifiable’’** means private information or specimens that can be linked to specific individuals by the Investigators(s) either directly or through coding systems. [45 CFR 46.102(f)]

- **Obtaining**: Obtaining identifiable private information or identifiable specimens
includes, but is not limited to: (1) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that have been provided to investigators from any source; and (2) using, studying, or analyzing for research purposes identifiable private information or identifiable specimens that were already in the possession of the investigator.


For Research covered by FDA regulations [21 CFRParts50 and56], Human Subject means an individual who is or becomes a Participant in a Clinical Investigation, either as a recipient of the Test Article or as a control. A subject may be in normal health or may have a medical condition or disease. [21 CFR§50.3(g),21 CFR §56.102(e)]. In the case of a Medical Device, a Human Subject/Participant also includes any individual on whose tissue specimen an Investigational Device is used or tested.[21 CFR§812.3(p)]. When medical device Research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as Human Subjects.

NOTE: The FDA definition of Human Subject differs according to the applicable regulation.[See21 CFR§812.3(p),21 CFR§50.3(g),§312.3(b),and§56.102(e)].

**Humanitarian Use Device (“HUD”):** the FDA defines HUD as a Device intended to benefit patients by treating or diagnosing a disease that affects fewer than 4,000 individuals in the U.S. per year. [FDA 21 CFR 814.3(n)]. See Section 13.9.9 for details.

**Humanitarian Device Exemption:** A Humanitarian Device Exemption (HDE) is a “premarket approval application” submitted to FDA pursuant to Subpart A, 21 CFR Part 814 “seeking a humanitarian device exemption from the effectiveness requirements of sections 514 and 515 of the [FD&C Act] as authorized by section 520(m)(2) of the [FD&C Act].” HDE approval is based upon, among other criteria, a determination by FDA that the HUD will not expose patients to an unreasonable or significant risk of illness or injury and the probable benefit to health from use of the device outweighs the risk of injury or illness from its use while taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. See Section 13.9.9.1 for details.

**Hybrid Entity:** for HIPAA Privacy purposes, it is a single legal entity that (a) is a Covered Entity; (b) whose business activities include activities covered and not covered under the HIPAA Privacy Regulations; and (c) that designates health care components that will be subject to HIPAA. [45 CFR §164.103]. See Section 23.4 for details.

**Identifiable Information:** for research privacy purposes, this means information where the identity of the subject is or may readily be ascertained by the Investigator or associated with the information. This term should not be confused with IIHI used with HIPAA. See Section 8.5.6.1 for details.
Incomplete Disclosure: occurs when an Investigator withholds information about the specific purpose, nature, or other aspect of the Research. Withholding information may or may not be considered Deception.

Individually Identifiable Health Information ("IIHI"): for HIPAA Privacy purposes, this is information, including demographic information collected from an individual, that: (i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (iii) identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. [45 CFR §160.103]. This term should not be confused with “Individually Identifiable Private Information,” which is not covered by HIPAA. See Section 22.4 for details.

Individually Identifiable Private Information: is information where, for Research purposes, the identity of the subject is or may readily be ascertained by the Investigator or associated with the information. See Section 18.5.6.1 for details.

Institutional Agent: is all individuals performing Institutionally designated activities or exercising Institutionally delegated authority or responsibility under Tulane’s FWA. See Section 1.4 for details.

Institutional Research Conflict of Interest ("ICOI"): An Institutional Research Conflict of Interest exists whenever the financial interests of the University, or of University Research Official acting within his or her authority on behalf of the University, could directly and significantly affect or reasonably appear to affect University processes for the design, conduct, reporting, review or oversight of research. [Tulane University ICOI Policy, Section II]. See Section 21.2 for details.

Institutional Official ("IO"): the University Vice President for Research ("VPR") serves as the Institution’s IO for carrying out the HRPP. The IO is responsible for ensuring that the HRPP has the resources and support necessary to comply with all Federal regulations and guidelines that govern Human Subject Research. The IO is legally authorized to represent the Institution, is the signatory official for all Assurances, and assumes the obligations of the Institution’s Assurance. See Section 1.12.2 for details.

Institutional Review Board ("IRB"): is an independent board(s) designated by the Institution to review, to approve the initiation of, and to conduct periodic review of Research involving Human Subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the Human Subjects. The IRB may be assigned other review functions as deemed appropriate by the Institution. This independent board is composed of medical, scientific, and non-Scientific Members. See Section 1.12.6 for details.

Investigational Device: as defined by the FDA, an Investigational Device is a Device that is the object of a clinical study designed to evaluate the safety or effectiveness of the Device. [21 CFR §812.3(g)]. Investigational Devices include transitional Devices [21 CFR §812.3(r)] that are objects of investigations. However, for the purposes of this document, an Investigational Device may be an approved Device that is being studied for an unapproved use or efficacy. See Section 13.9 for details.
**Investigational Device Exemption ("IDE"):** is an FDA-approval of the application for an exemption that permits an un-marked Device to be shipped for the purpose of doing Research on the Device. [See 21 CFR §812.1 and §812.2 for the scope and applicability]. See **Section 13.9** for details.

**Investigational Drug (or “Investigational New Drug”):** means a new Drug or Biological Product that is used in Research. It also includes a Biological Product used *in vitro* for diagnostic purposes. The FDA considers the term “Investigational New Drug” or “Investigational Drug” to be synonymous with Investigational Drug. [FDA 21 CFR §312.3]. However, for purposes of this document, an Investigational Drug includes the following:

- An approved Drug that is being studied for an unapproved or approved use in a controlled, randomized or Blinded clinical trial.
- Those new Drugs for which the PI or a Sponsor has filed an IND application [FDA 21 CFR §312] which are exempt from pre-marketing approval requirements and may be lawfully shipped for use in Clinical Investigations in Human Subjects.

A Drug that is lawfully marketed in the U.S. that may still be considered investigational and required that an IND be filed if the proposed use of such a Drug involves a controlled study aimed towards seeking a significant change in labeling, advertising, route of Administration, dosage level, or other factor that affects the risks associated with the use of the product. [FDA 21 CFR §312.3(b)]

See **Section 13.7** for details.

**Investigational Drug Application (or “IND”):** refers to either an Investigational New Drug application or to a new Drug that is used in Clinical Investigations. IND is synonymous with “Notice of Claimed Investigational Exemption for a New Drug.” [FDA 21 CFR §312]. See **Section 13.8** for details.

**Investigator:** is an individual under the direction of the PI who is involved in some or all aspects in the Research project, including (1) the design of the study; (2) conduct of the study; (3) analysis and interpretation of the collected data; (4) directly involved in seeking the voluntary Informed Consent of potential subjects; and (5) writing of resulting manuscripts. Investigators can include physicians, scientists, nurses, Research staff members, administrative staff, teachers, and students. Investigators must be included on the FDA Form 1572 and/or the IRB Application request signature page. While the FDA considers an Investigator and a PI to be synonymous, this document does not. [FDA 21 CFR §50.3(d); 21 CFR §56.102(h); 21 CFR §312.3(b)]. OHRP considers the term Investigator to include anyone involved in conducting the research. See **Section 13.2** for details.

**Investigator Hold:** is a situation where an Investigator or Sponsor wishes to temporarily or permanently, stop some or all approved Research activities. Investigator Holds are not Suspensions or Terminations. (See **Section 9.1.1**).

**IRB Records:** See **Section 10.3** for the definition.

**Form 1572 (or “FDA Form 1572” or “Statement of Investigator FDA Form”):** is the form submitted by the PI to the Sponsor acknowledging their obligations in the conduct of the Research. PIs on treatment Protocols that involve an IND must complete FDA Form 1572. The FDA Form 1572 is the contract between the Investigator and the Federal government assuring
that he or she will comply with FDA regulations. [21 CFR §312.53]. By signing the Form 1572, the Investigator assumes full responsibility for the study.

**Key Personnel**: has the same definition as used by NIH, which means those individuals who contribute to the scientific development or execution of a project in a substantive, measurable way, whether or not salaries are requested. Key Personnel must devote measurable effort to the project. Key Personnel are required to be listed in the grant application, progress report or any other report submitted to the Federal funding agency by the Institution.

**Legally Authorized Representative**: is an individual, judicial, or other body authorized under applicable law to consent or otherwise provide permission on behalf of a subject, either prospectively or during the course of Research, to the subject's participation in the procedure(s) involved in the Research. [DHHS 45 CFR §46.102(c); FDA 21 CFR §50.3(l)]. For the purposes of this document, a Legally Authorized Representative includes a person appointed as a Health Agent, a court-appointed Legal Guardian of the person, as well as next-of-kin in the following order of priority unless otherwise specified by applicable State law: the subject’s spouse; adult Child(ren) of subject (18 years of age or older); Parent of subject; adult sibling(s) of subject (18 years of age or older); grandparent(s) of subject; or adult grandchild(ren) of subject (18 years of age or older). If there is more than one person within the above-named class, the consent shall be given by a majority of those members of the class available for consultation. [LA R.S. 40:1299.53] Legally Authorized Representative should not be confused with Legal Guardian. See Section 11.2 for details.

**Life Threatening**: for the purposes of this Section, it means both life-threatening and Severely Debilitating. It includes diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria of life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather the Subjects must be in a life-threatening situation requiring intervention at a Convened IRB meeting of the IRB infeasible. [FDA 21 CFR 56.102; see also FDA Information Sheet: Emergency Use of an Investigation Drug or Biologic]. See Section 13.8.3.1 for details.

**Limited Data Set**: for HIPAA Privacy purposes, is PHI that excludes specific direct identifiers of the individual or of relatives, employees or household members of an individual. A limited data set can only be used for the purposes of research, public health, or healthcare operations, and disclosed for the purposes of research. See Section 23.4 for details.

**Protocol Deviation**: means a deviation that is unanticipated and happens without any prior agreement (e.g., protocol visits outside protocol windows, blood withdrawn outside protocol, etc.). Protocol Deviations may have an impact on subject safety, may substantially alter risks to subjects, may have an effect on the integrity of the study data, or may affect the subject’s willingness to participate in the study. Protocol deviations can vary in the degree of seriousness according to how the changes impact subject safety, the degree of non-compliance with the Federal regulations, state laws or Tulane’s policies or procedures, and the degree of foreknowledge of the event.

Examples of deviations include:

- Failure to obtain Informed Consent from the subject;
- Enrolling a subject who does not meet the inclusion and exclusion criteria;
• Performing study procedures that have not been approved by the IRB;
• Failure to perform a required laboratory test or procedure that could impact upon the safety of the subject;
• Continuing research activities after IRB approval has expired;
• Use of recruitment procedures that have not been approved by the IRB;
• Enrolling significantly more subjects than was proposed to and approved by the IRB; and
• Enrollment of a subject from a federally defined vulnerable population (i.e. Children, Pregnant Women, Prisoners) without prior IRB approval for that vulnerable population.

See Section 14.2 for details.

**Medical Device:** means “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory that is: (a) recognized in the official National Formulary, or United States Pharmacopoeia, or any supplement to them; (b) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or (c) intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.” [Section 201(h) of FDA Act].

**Minor** means any person under the age of 18 years. [LA Children’s Code Art 116]. Do not confuse the definitions of Minor (pertaining to a person’s age) with Child/Children (pertaining to a person’s ability to consent). See Section 12.9.1 for details.

**Minor Change:** A minor change is one which, in the judgment of the IRB reviewer, makes no substantial alteration in:

• The level of risks to subjects;
• The research design or methodology (i.e., adding procedures that are not eligible for Expedited Review (see Section 8.3 for details) would not be considered a minor change);
• The number of subjects enrolled in the Research (i.e., not greater than 10% of the total requested in the initial application);
• The qualifications of the research team;
• The facilities available to support safe conduct of the Research;
• Any other factor which would warrant review of the proposed changes by the convened IRB.

**Minimum Necessary:** for HIPAA Privacy purposes, this refers to the principle that any access (i.e., obtaining or using PHI by any means or in any medium) to PHI by Tulane workforce members should be limited to the minimum amount of PHI needed to accomplish the intended purpose of the use or Disclosure. [DHHS 45 CFR §164.502(b) and §514(d)]. See Section 8.3 for details.

**Minimal Risk (or “Minimum 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. See Section 8.2 for details.

**Minimal Risk for Prisoners:** is the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons. [DHHS 45 CFR §46.303(d)]. The definition of Minimal Risk for Prisoners contained in the Subpart C of the Federal regulations is different than the definition of Minimal Risk (for non-Prisoners). See Section 12.8.1 for details.

**Minor Noncompliance:** means any Noncompliance that is not Serious Noncompliance or Continuing Noncompliance. For example, Minor Noncompliance might include the following:

1. missing an original signed and dated research consent form;
2. missing pages of executed research consent forms;
3. inappropriate documentation of informed consent, e.g., missing one or more signatures or date;
4. obtaining informed consent using an invalid/ outdated research consent form that contains all of the information required by the IRB;
5. failure to submit continuing review forms/documents prior to expiration of IRB approval; and
6. unplanned deviation from the approved protocol where the deviation does not impact the rights and welfare of subjects or the integrity of the research.

See Section 16.2 for details.

**Neglect:** of Neonate means a medical finding by a Louisiana licensed physician that a Neonate either is dependent upon or suffers from withdrawal symptoms from an illegal controlled dangerous substance (“CDS”). It also includes a medical finding by a physician that a Neonate suffers from an illness, disease or condition attributable to the exposure of the newborn, in utero, of an illegal CDS. See Section 12.7.1 for details.

**Neonate:** means Newborn. [DHHS 45 CFR 46.202(d)]. See Section 12.7.1 for details.

**Noncompliance:** means any failure to comply with any applicable federal, state, or local laws and regulations or the requirements or determinations of the IRB, which include IRB and institutional policies related to human subject protection. See Section 16 for details.

**Non-Scientific Member:** is any IRB Member who has formal education and training in a discipline generally considered to be non-scientific (e.g. humanities, law, business) and/or is engaged in an occupation or role that is generally considered to be non-scientific (e.g. law enforcement, minister). See Section 14.4 for details.

**Non-Significant Risk Device:** is an Investigational Device other than a Significant Risk Device. See Section 13.9.8 for details.

**Non-Viable Neonate (or “Non-Viable Fetus”):** is a Fetus ex utero that, although living, is not able to survive to the point of independently maintaining a heartbeat and respiration. [DHHS CFR 46.202(e)]. See Section 12.7.1 for details.

**Obtain (or “Obtaining”):** means to receive or access Individually Identifiable Private Information (or identifiable specimens) for Research purposes. This includes an Investigator’s
use, study, or analysis for Research purposes of Individually Identifiable Private Information (or identifiable specimens) already in the possession of the Investigator.

**Off-Site Research (or “Non-Tulane Site,” “Off-Site Institution” or “Off-Site Facility” or “Off-Site Location”):** is Human Subjects Research conducted under the auspices of Tulane’s IRB at performance sites that are not owned or operated by Tulane University or TUHC. See Section 24.2 for details.

**On-Site Research (or “Tulane Site”):** is Human Subjects Research conducted under the auspices of Tulane’s IRB at performance sites that are owned or operated by Tulane University or TUHC. See Section 24.2 for details.

**Other Study Personnel:** are individuals who are part of the research team who intervene or interact directly with Human Subjects (including the recruitment or consenting thereof), or who analyze data and/or tissue derived from humans for the purposes of the activity in question. Other Study Personnel cannot be the PI, an Investigator or Key Personnel. See Section 19.3.5 for details.

**Parent:** means a Child’s biological or adoptive parent. [DHHS 45 CFR §46.402(c); FDA 21 CFR §50.3(p)]. See Section 12.9.1 for details.

**Planned Emergency Research:** is the conduct of planned Research in life-threatening emergencies where the requirement to obtain prospective Informed Consent has been waived. [21 CFR §50.24]. The Research plan must be approved in advance by the FDA or DHHS and the IRB, and publicly disclosed to the community in which the Research will be conducted. This term should not be confused with Emergency Use. See Section 13.2 for details.

**Preparatory Research:** for HIPAA Privacy purposes, Preparatory Research is the method applied to developing or designing a research study. [45 CFR §164.512(i) (1) (ii)]. See Section 23.8.1.1 for details.

**Pregnant (or Pregnancy):** is the period of time from confirmation of implantation (through any of the presumptive signs of pregnancy, such as missed menses, or by a medically acceptable pregnancy test), until expulsion or extraction of the Fetus. [DHHS 45 CFR §46.202(f)]. See Section 12.6.1 for details.

**Principal Investigator (“PI”):** is an individual who conducts Research or under whose immediate direction Research is conducted; or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team. While the FDA considers a PI and an Investigator to be synonymous, this document does not. See Section 19.3.1 for details.

**Prisoner:** is any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures that provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing. [DHHS 45 CFR §46.303(c)]. See Section 12.8.1 for details.

**Privacy:** means having control over the extent, timing, and circumstances of sharing oneself (i.e., physically, behaviorally, or intellectually) with others. Do not confuse this Research term with HIPAA Privacy requirements. See Section 7.5.6.1 and 22.4 for details.
**Privacy Board**: for HIPAA Privacy purposes, Privacy Board is the term used to describe a board comprised of members of varying backgrounds and appropriate professional competencies, as necessary, to review individual’s private rights. It is an alternative to an IRB for privacy issues only. It cannot replace the IRB for Common Rule or FDA purposes. Tulane’s IRB shall serve as the Privacy Board for the Institution. See Section 23.4 for details.

**Private Information**: for research privacy purposes, this means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (e.g., a medical record). [45 CFR §46.102(f)]. Do not confuse this Research term with HIPAA Privacy requirements. See Section 26.9 for details.

**Proposal (or “Research Proposal”)**: includes the complete packet of materials submitted to the IRB for review, including the Protocol, a description of the Research design and methodology as well a complete description of the procedures for the protection of Human Participants in the Research. See Section 12.5.1 for a listing of materials required to be submitted to the IRB.

**Protected Health Information (“PHI”)**: for HIPAA Privacy purposes, PHI means IIHI that is transmitted or maintained in any form or medium (i.e., electronic, paper or verbal). [45 CFR §164.501]. PHI does not include IIHI in:

- Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g;
- Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
- Employment records held by a covered entity in its role as an employer.

See Section 23.4 for details.

**Protocol**: is a document (including subsequent amendments) that describes the objective(s), design, methodology, statistical considerations, and organization of a trial. A Protocol usually also gives the background and rationale for the trial, but this could be provided in other Protocol reference documents. [Good Clinical Practice: Consolidated Guidance (ICH-E6) (Protocol includes initial Protocol and Protocol amendments)]. See Section 1.4 for details.

**Protocol Deviation(s)**: means a violation that is unanticipated and happens without any prior agreement (e.g., a protocol visit scheduled outside the Protocol window; blood work drawn outside the Protocol window, etc.). The IRB will review these reports for frequency and may request, among other reasons, that an audit be conducted for any Protocol reporting frequent deviations. [Not defined by Common Rule or FDA regulations].

**Protocol Exception (or “Exception”)**: means a circumstance in which the specific procedures called for in a Protocol are not in the best interests of a specific patient/subject (e.g., patient/subject is allergic to one of the medications provided as supportive care). Usually it is a violation that is anticipated and happens with prior agreement from the sponsor. [Not defined by Common Rule or FDA regulations].

**Quorum**: means the minimum number of persons required for the IRB to convene, transact business, deliberate and vote on all matters requiring IRB vote. For purposes of this document, a Quorum of the IRB is a majority (i.e., more than 50%) of the voting IRB membership for an IRB
committee or subcommittee, including at least one member whose primary concern is in a non-scientific area as required by 45 CFR §46.108. A quorum is defined as a majority of the quorum members present (attendance by teleconference is acceptable in order to be counted towards a quorum). Assuming all applicable composition requirements are satisfied, the number of IRB members necessary for a quorum is calculated by dividing the number of members in half and “rounding up” when there is an odd number of members or “adding one” for an even number. Examples of how to calculate the majority of the Quorum members is as follows: e.g., If the number of Members that count towards a Quorum (Quorum Members) = 16, a Majority = 9; if Quorum Members = 15, a Majority = 8; if Quorum Members = 14, a Majority = 8.If Research involves an FDA-regulated Test Article, a licensed physician also must be present for a Quorum to exist. See Section 8.2 for details.

**Related (or “Possibly Related”):** means that there is a reasonable possibility that the event, incident, experience or outcome may have been caused by the procedures involved in the Research, underlying disease, disorder, or condition of the Subject, or other circumstances unrelated to either the Research or any underlying disease, disorder, or condition of the Subject. Note that this is modified from the definition of associated with use of the drug in FDA regulations at 21 CFR §312.32(a). [OHRP 7/15/2007 Guidelines]. See Section 14.2 for details.

**Research:** is defined by the Common Rule as a “systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge.” [DHHS 45 CFR §46.102(d)].

FDA regulations define Research as meaning any experiment that involves a Test Article and one or more Human Subjects, and that either must meet the requirements for prior submission to the FDA under section 505(i) or 520(g) of the Federal Food, Drug, and Cosmetic Act (the “FDA Act”), or need not meet the requirements for prior submission to the FDA under these sections of the FDA Act, but the results of which are intended to be later submitted to, or held for inspection by, the FDA as part of an application for a Research or marketing permit. The terms Research, clinical Research, clinical study, study, and Clinical Investigation are synonymous for purposes of FDA regulations. [FDA 21 CFR §50.3(c), 21 CFR §56.102(c)].

- Experiments that must meet the requirements for prior submission to the FDA under section 505(i) of the FDA Act means any use of a Drug other than the use of an approved Drug in the course of medical practice. [21 CFR §312.3(b)].

- Experiments that must meet the requirements for prior submission to the FDA under section 520(g) of the FDA Act means any activity that evaluates the safety or effectiveness of a Device. [21 CFR §812.2(a)].

- Any activity in which results are being submitted to or held for inspection by FDA as part of an application for a Research or marketing permit is considered to be FDA-regulated Research [21 CFR §50.3(c), 21 CFR §56.102(c)]. See Section 1.4 for details.

**Research Financial Interest:** is any investments (whether in the form of debt, stock or other equity ownership, options or warrants to purchase stock or other securities or similar instruments) or interest in a Sponsor, research or healthcare related organization; royalties on any patent or other intellectual property interests, unless paid by Tulane; or income, salary or remuneration in cash or in kind, emoluments, benefits, gifts, honoraria, travel expenses, goods or
services received from a Sponsor or research or healthcare related organization. Research Financial Interest does not include holdings in mutual funds or other equity funds in which day-to-day control of investments is held by a person not covered by any Tulane University Conflict of Interest policy. Please note that Research Financial Interest has no dollar or ownership thresholds; therefore, any interest related to a Sponsor or to the research must be disclosed, however small. This definition is extracted from the Institution’s COI policy contained in the Faculty Handbook, Part III, D, Part C. The definition in the Faculty Handbook shall prevail to the extent that there is a conflict. See Section 21.2 for details.

**Research Oversight Officials**: include all faculty and staff of any institutional office or body (for instance, all IRB, IACUC, and IBC members) at the University who perform research oversight functions in which they exercise professional or administrative-level discretion. [Tulane University COI Policy, Part D(I)]. See Section 4.6.1 for details.

**Research Records (or “Investigator Records”)**: consist of records (as well as Case Histories or any data) prepared, created, gathered, or maintained by a PI, Investigator or research staff for Research Under the Auspices of the Institution. See Section 10.2 for details.

**Research Under the Auspices of the Institution**: this includes Research conducted at this Institution, conducted by or under the direction of any employee or Institutional Agent of this Institution (including students) in connection with his or her Institutional responsibilities, conducted by or under the direction of any employee or Institutional Agent of this Institution using any property or facility of this Institution, or involving the use of this Institution’s non-public information to identify or contact Human Subjects. See Section 1.9 for details.

**Researcher**: is the PI and/or Investigator. See Section 19.2 for details.

**Scientific Member**: is an individual who has formal education and training as a physician or other medical professional, and M.S. and/or Ph.D. level physical, biological, or social behavioral scientists. See Section 14.4 for details.

**Screen failures**: individuals who have given informed consent and participated only in screening procedures to determine eligibility, but who were determined to be ineligible to take part in the Study. Screen failures are not considered to have enrolled in a study.

**Screened participants**: individuals who have given informed consent and participated in screening procedures to determine eligibility. Note that informed consent is required before any data can be collected for screening purposes. A screening process where persons are simply informed of inclusion/exclusion criteria and allowed to self-identify as eligible for enrollment does not require informed consent because no data about the individuals are collected.

**Self-Sponsored (or “Investigator-Initiated” or “Investigator-Sponsored”)**: refers to a situation in which the individual Investigator is a Tulane Investigator and is the holder of the IND or IDE and therefore assumes the duties of the Sponsor of the clinical Investigator under the applicable FDA regulations. A Self-Sponsored, Investigator-Initiated, or Investigator-Sponsored study may be required to undergo full-board (convened) review by the IRB, even if the study may otherwise qualify for expedited or exempt review. See Section 20.2 for details.
**Serious Noncompliance**: means any noncompliance that negatively impacts the rights and welfare of subjects, the research benefits to subjects, and/or compromises the integrity of the study data. For example, serious noncompliance might include, but is not limited to:

1. failure to obtain prospective IRB approval for non-exempt research;
2. failure to obtain informed consent of subject(s);
3. enrollment of subject(s) who do not meet all eligibility criteria;
4. obtaining informed consent using an invalid/outdated research consent form that is missing information that might affect the individual’s willingness to participate or continue to participate in the research;
5. making substantive changes to a previously approved protocol without IRB approval
6. failure to perform follow-up as outlined in the protocol where the lack of follow-up places the subject at increased risk of harm;
7. failure to report a serious unanticipated problem involving risks to subjects or others, including adverse events; and/or
8. inappropriate oversight of the research to ensure safety of human subjects and the integrity of the research/data.

Whether the conduct was inadvertent, careless or reckless, or intentional may be taken into consideration by the IRB in a determination of Serious Noncompliance. See **Section 16** for details.

**Severely Debilitating**: for the purposes of this Section, it means diseases or conditions that cause major irreversible morbidity. Examples include blindness, loss of limb, loss of hearing, paralysis or stroke. [FDA 21 CFR 56.102; see also FDA Information Sheet: Emergency Use of an Investigational Drug or Biologic]. See **Section 13.8.3.1** for details.

**Significant Risk Device**: is an Investigational Device that:

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a Human Subject;
- 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 Human Subject;
- Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presented a potential for serious risk to the health, safety, or welfare or a Human Subject;
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a Human Subject. See **Section 13.9.2** for details.

**Sponsor**: is any person or party that provides funding to support the conduct of Research, usually through a specific statement of work and often with a related transfer of value to the Sponsor. A Sponsor does not actually conduct the investigation. A sponsor can be governmental (e.g., Federal, State or a local government) or private (e.g., a company, individual donor or private foundation), as well as self-sponsored (e.g., where Institution is responsible for
funding the involved activity). The funding mechanism may be through a grant, contract or cooperative agreement. [FDA 21 CFR §50.3; 21 CFR §56.102(j); 21 CFR §312.3(b)]. See Section 20.2 for details.

**Substantive**: an action taken by an IRB that materially alters the substance and meaning of a Protocol, informed consent form or process, or Investigator status, including, but not limited to, Restriction, Suspension or Termination of a study or Investigator participation, and actions taken to prevent future occurrence(s) of the Unanticipated Problem in Research. See Section 10.2 for details.

**Suspension (or “Suspend”)**: is an action of the convened IRB, IRB Chair and/or HRPO/HRPP to temporarily cease some or all previously approved research activities to protect the rights and welfare of study Participants. Suspended Protocols remain open and require Continuing Review. See Section 9.1 for details.

**Systematic Investigation**: is an activity that involves a prospective study plan which incorporates data collection, either quantitative or qualitative, and data analysis to answer a study question. Investigations designed to develop or contribute to generalizable knowledge.

**Termination (or “Terminate”)**: is an action of the convened IRB to stop all activities in a previously approved research Protocol permanently. Terminated Protocols are considered closed and no longer require Continuing Review. See Section 9.1 for details.

**Test Article**: The FDA defines “Test article” as meaning any drug (including a biological product for human use), medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 and 354-360F of the Public Health Service Act [42 U.S.C. 262 and 263b-263n]. [21 CFR 50.3(j)]

Test articles covered under the FDA regulations include, but are not limited to:

- **Human Drug** – The primary intended use of the product is achieved through chemical action or by being metabolized by the body. A drug is defined as a substance recognized by an official pharmacopoeia or formulary; a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; a substance (other than food) intended to affect the structure or any function of the body; a substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device. Biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process).
- **Medical Devices** – A device is “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any
of its primary intended purposes.”
http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/ClassifyYourDevice/ucm051512.htm

- **Biological Product**—include a wide range of products such as vaccines, blood and blood components, allergens, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Biologics are isolated from a variety of natural sources—human, animal, or microorganism—and may be produced by biotechnology methods and other cutting-edge technologies. Gene-based and cellular biologics, for example, often are at the forefront of biomedical research, and may be used to treat a variety of medical conditions for which no other treatments are available.
http://www.fda.gov/Drugs/InformationonDrugs/ucm079436.htm

- **Food Additives**—A food additive is defined in Section 201(s) of the FD&C Act as any substance the intended use of which results or may reasonably be expected to result, directly or indirectly, in its becoming a component or otherwise affecting the characteristics of any food (including any substance intended for use in producing, manufacturing, packing, processing, preparing, treating, packaging, transporting, or holding food; and including any source of radiation intended for any such use); if such substance is not Generally Recognized As Safe (GRAS) or sanctioned prior to 1958 or otherwise excluded from the definition of food additives. FDA Food Ingredient and Packaging Terms

- **Color Additives**—A color additive is any dye, pigment or substance which when added or applied to a food, drug or cosmetic, or to the human body, is capable (alone or through reactions with other substances) of imparting color. Color additives for use in food, drugs, and cosmetic require premarket approval. Color additives for use in or on a medical device are subject to premarket approval, if the color additive comes in direct contact with the body for a significant period of time. FDA Food Ingredients and Packaging Terms

- **Foods**—Foods include dietary supplements that bear a nutrient content claim or a health claim.

- **Infant Formula**—Infant formulas are liquid foods intended for infants which substitute for mother’s milk.

- **Electronic Products**—The FDA regulates certain classes of electronic products including radiation-emitting electronic products such as microwaves and x-rays.

**Unanticipated Adverse Device Effect:** An Unanticipated Adverse Device Effect (UADE) means any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that related to the rights, safety, or welfare of Subjects [21 CFR 812.3(s)].
Unanticipated Problems Involving Risk to Subjects or Others (or “Unanticipated Problem”): means any incident, experience, outcome, or new information where all three exist:

1. Is unexpected;
2. Is related or Possibly Related to participation in the Research, and
3. Indicates that subjects or others are at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

For purposes of this definition, the following definitions are germane:

“Others:” means individuals other than Research Participants (e.g., Investigators, research assistants, students, the public, etc.).

See Section 15.1 for additional details.

University Research Official: The Tulane University Policy on Conflicts of Commitment and Interest defines Research Oversight Officials in part to include all faculty and staff of any institutional office or body (for instance, all IRB...members) at the University who perform research oversight functions in which they exercise professional or administrative-level discretion. See Section Tulane University Policy on Conflicts of Commitment and Interest, Part D “Policy for Conflicts of Interest of Research Oversight Officials,” Section I (Tulane University Policies on Conflicts of Commitment and Interest). See Section 21.2 for details.

Use: means, with respect to IIHI, the sharing, employment, application, utilization, examination, or analysis of such information within the organization that maintains such information. [45 CFR §164.501]. See Section 23.4 for details.

Viable Neonate (or “Viable Fetus”): means a Fetus that is able, after Delivery, to survive to the point of being able to independently maintain a heartbeat and respiration (given the benefit of available medical therapy). [DHHS 45 CFR §46.202(h)]. See Section 12.7.5 for additional details.

Vulnerable Population (or “Vulnerable Subjects”): this includes the following classes of potential or actual Research subjects: Children, Prisoners, Pregnant Women, mentally disabled persons, or economically- or educationally disadvantaged persons. See Section 12 for details.

Waiver of Authorization (or “Waiver of HIPAA Authorization”): for HIPAA Privacy purposes, this is a means of requesting approval from an IRB or Privacy Board rather than asking each Research subject for an Authorization to access PHI. [45 CFR §164.512(i) (1) (i)]. See Section 23.4 for details.

Withdrawals: individuals who have given informed consent and participated in some study procedures, but who withdrew or were withdrawn from the study.
31 Common Acronyms

AAHRPP: Association for Accreditation of Human Research Protection Programs
APS: Adult Protective Services
VPR: Vice President for Research
CC: Louisiana Children’s’ Code
CDS: Controlled Dangerous Substance
CFR: Code of Federal Regulations
CPS: Child Protective Services
CHRC: Certified Healthcare Research Compliance
CIP: Certified IRB Professional
CIRB: Central IRB for the National Cancer Institute
CITI: Collaborative Institute Training Initiative
CoC: Certificate of Confidentiality
COI: Conflict of Interest
Co-PI: Co-Principal Investigator
CRO: Contract Research Organization
CTA: Clinical Trial Agreement
CV: Curriculum Vitae
DHHS: U.S. Department of Health and Human Services
DoA: U.S. Department of Agriculture
DoD: U.S. Department of Defense
DoE: U.S. Department of Education
DSMB: Data Safety Monitoring Board
DTA: Data Transfer Agreement
EPA: U.S. Environmental Protection Agency
FDA: Food and Drug Administration
FWA: Federal Wide Assurance
GCP: Good Clinical Practice
HIPAA: Health Insurance Portability and Accountability Act
HRPO: Human Research Protection Office
HRPP: Human Research Protection Program
HUD: Humanitarian Use Device